Beyond the Battlefield: Restoring Connection for Missouri's Rural Veterans

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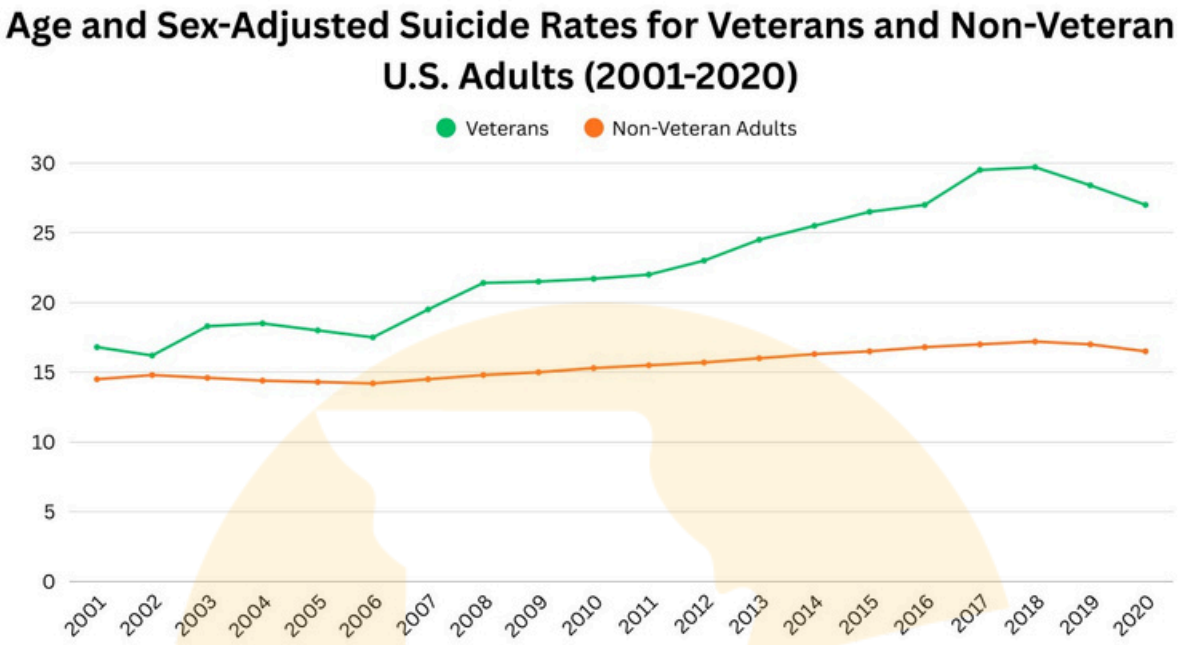
Missouri's rural veterans are navigating a level of isolation, illness, and system breakdown that is culminating in a devastating loss of life. Veterans in Missouri face a significantly elevated suicide risk, with death rates 74% higher than those of non-veterans statewide and 23% higher than the national veteran average (U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, [OMHSP], 2024). Many veterans have multiple complex chronic illnesses (Boersma et al., 2021) that require consistent care they cannot reach, a matter that is especially pressing in counties where the nearest Veterans Health Administration (VHA) facility is more than 40 miles away (Rasmussen & Farmer, 2023). Digital exclusion further limits continuity of care, with the lack of internet isolating one in four rural veterans from telehealth services and online benefits (National Rural Health Association, 2025). Structural inequities tied to race and disability deepen these access barriers through discrimination, cultural barriers, and gaps in available services (Umucu et al., 2025). Administrative and staffing issues within the VHA continue to limit many eligible veterans' access to authorized care (Mathis, 2025), while persistent workforce shortages further constrain service capacity (Gordon, 2025). Together, these conditions create a fragmented care environment that requires a formal, statewide coordination mechanism to organize the systems that already serve Missouri's veterans.

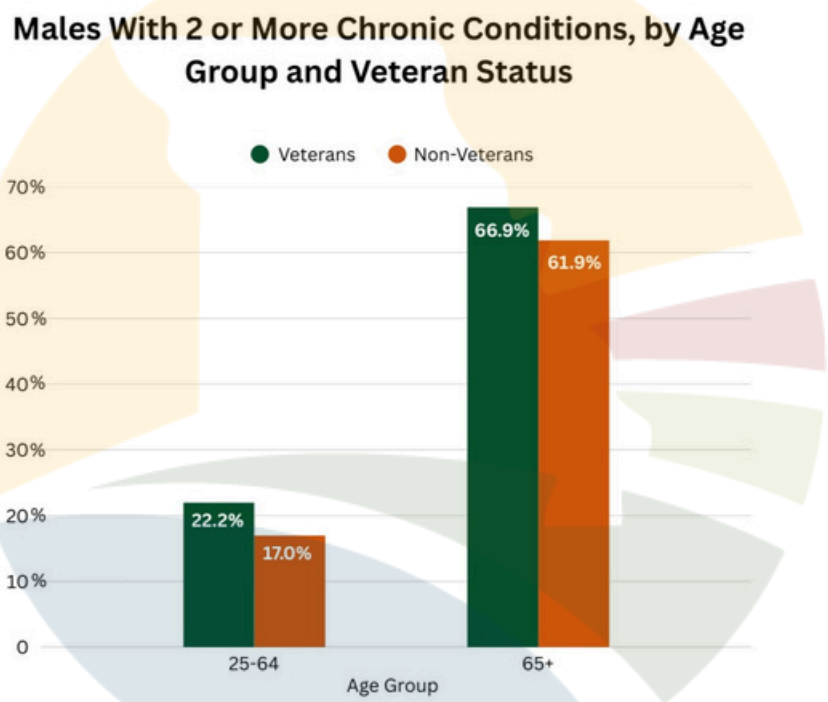
Figure 1 (OMHSP, 2022)



Older rural veterans in Missouri face interconnected health risks shaped not only by age and chronic disease, but by persistent failures in access and benefits. More than half of Missouri's veterans are over the age of 65 (U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics [NCVAS], 2021), and they experience disproportionately high rates of chronic conditions such as diabetes, hypertension, and heart disease compared to their urban peers (U.S. Department of Veterans Affairs, Office of Rural Health [ORH], 2025). At the same time, gaps in coverage further undermine health management: over 85% of rural veterans lack VHA dental benefits, and nearly two-thirds report significant oral-health problems (American Institute of Dental Public Health & CareQuest Institute for Oral Health, 2024). More than 60% also live with service-related health issues, increasing clinical complexity and the need for sustained, coordinated care (Rural Health Information Hub, 2025; National Rural Health

Association, 2025). As these burdens accumulate, routine care becomes harder to maintain in regions already facing shortages of geriatric-focused services (Pimentel et al., 2019; Hastings et al., 2025), creating conditions in which delayed treatment and preventable complications become routine. Without targeted support for older veterans, chronic diseaseburden is likely to increase, placing additional pressure on hospitals and widening longstandinghealth disparities.

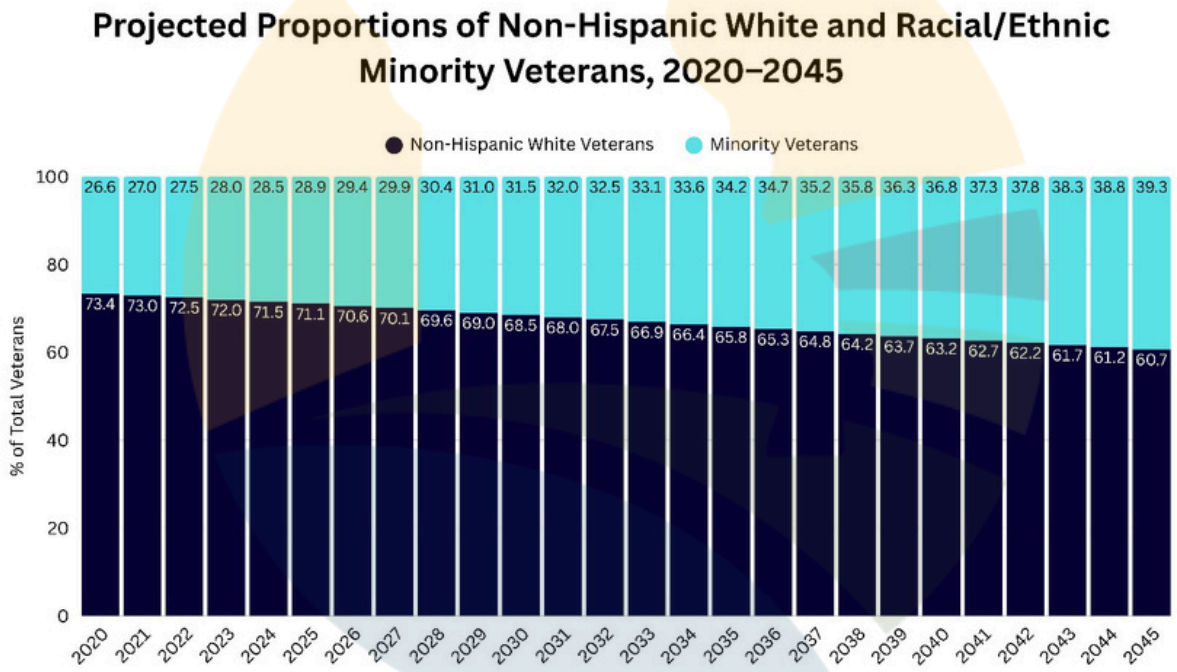
Figure 2 (Boersma et al., 2021)



Structural inequities tied to race and disability create substantial gaps in access to both physical and mental health care for Missouri's veterans, and these access barriers are associated with a higher burden of mental health conditions among rural veterans (Umucu et al., 2025). This pattern is likely to intensify as the veteran population becomes more diverse; by 2045, the share of non-Hispanic White veterans is projected to decline from 74% to 61%, while racial and ethnic minority veteran populations continue to grow (U.S. Department of Veterans Affairs, Office of

Health Equity [OHE], 2025). At the same time, disability prevalence is rising, with the number of veterans with service-related injuries doubling from 2008 to 2022 (Vespa & Carter, 2024). As minority and disabled veteran populations grow, the share of veterans facing the greatest access barriers is projected to increase, placing overall health outcomes at greater risk. For many of the veterans most affected by these inequities, where they live is one of the most significant determinants of whether care is reachable at all.

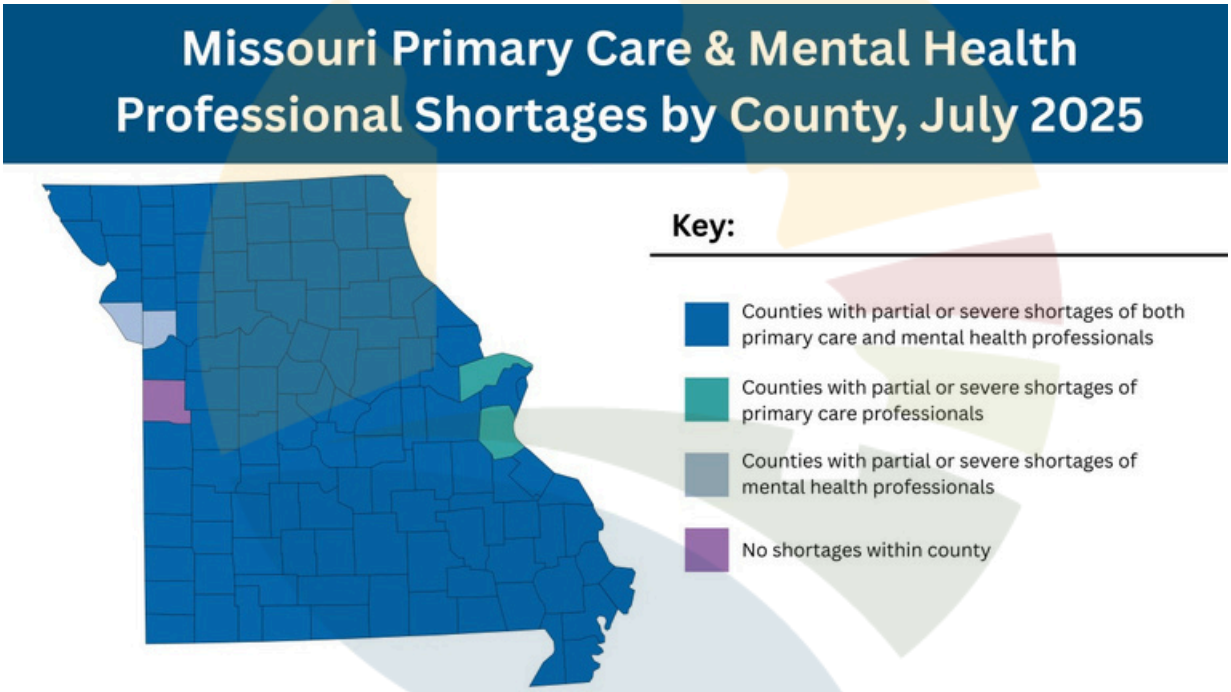
Figure 3 (OHE, 2025)



Geography remains a central constraintonaccess to consistent, high-quality care for Missouri's rural veterans. Only 26% of veteranslive within 40 miles of a VHA facility offering full specialty services such as advanced imaging,neurology, and cardiology, placing most veterans far outside the practical reach of complexcare (Rasmussen & Farmer, 2023). Long travel distances and limited transportation optionsrestrict access to timely appointments and

continuity of care (Hahn et al., 2023), while gaps in rural broadband infrastructure further limit effective use of telehealth (OHE, 2020). These access barriers are compounded by Missouri's provider landscape, where all rural counties in Missouri face shortages in both primary care and mental health professionals (Gordon, 2025). For veterans utilizing the VHA or private medical practices, these overlapping geographic inequities and workforce shortages translate directly into delayed treatment and preventable complications.

Figure 4 (Gordon, 2025)



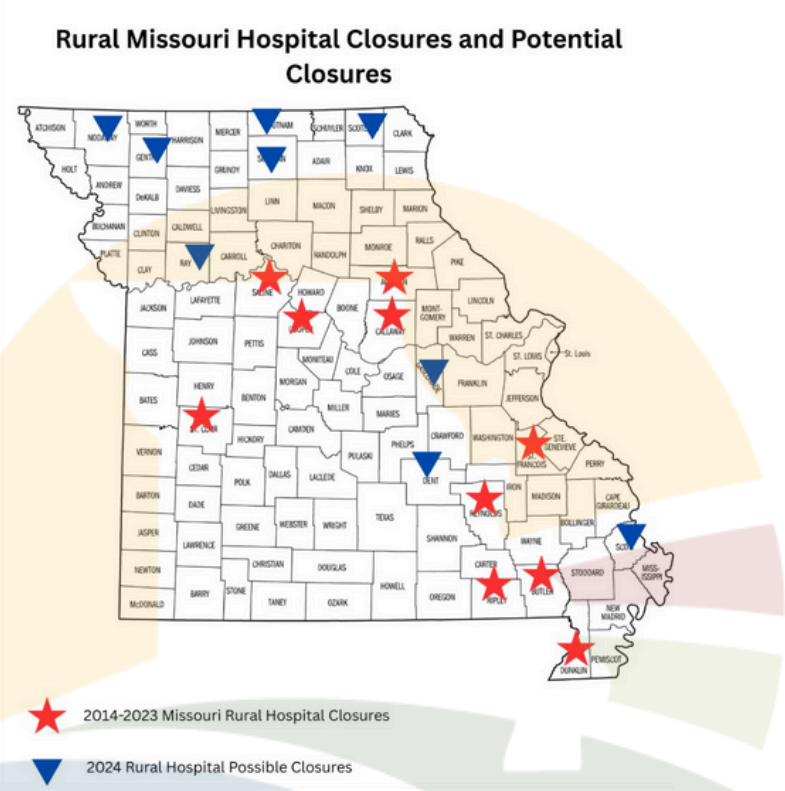
A combination of access barriers, workforce shortages, and rising patient complexity increasingly constrains the VHA's ability to meet veterans' healthcare needs. Of the roughly 9 million veterans eligible for VHA benefits nationwide (U.S. Department of Veterans Affairs, Veterans Health Administration [VHA], 2025), only about two-thirds are enrolled (NCVAS, 2025), indicating ongoing access and navigation challenges. Veterans who do rely on the VHA

disproportionately present with complex chronic and service-related conditions requiring frequent care (Rasmussen & Farmer, 2023). At the same time, workforce shortages within the VHA have constrained its ability to meet this level of clinical demand: more than half of VHA medical centers report unfilled psychologist positions (Abrams, 2025), while the system more broadly continues to struggle with recruiting and retaining physicians and nurses (Armstrong et al., 2025). When the VHA cannot meet demand, rural providers become the de facto safety net for veterans that the federal system cannot absorb. Without stronger VHA access and expanded capacity, Missouri's most medically complex veterans are likely to face mounting delays and poorer outcomes along with their communities.

As constraints within the VHA displace more veterans into the private sector, pressure on Missouri's already limited rural healthcare capacity continues to increase. With 92% of Missouri counties facing primary-care shortages and 96% lacking adequate mental-health providers (Gordon, 2025), veterans referred to community care must compete with non-veteran residents for a shrinking pool of appointments. Over the past decade, 10 rural hospitals have closed, and nearly half of those remaining operate at a loss, increasing the risk of further closures and deepening strain on the health infrastructure both veterans and civilians depend upon (Dockins & Lingerfelt, 2024). Although community care can expand access in some settings, it also introduces persistent challenges, including fragmented medical records, uneven care quality, and weak coordination between VHA and non-VHA clinicians (Rasmussen & Farmer, 2023). As it currently stands, these dynamics demonstrate that shifting veterans into private practices is not a sufficient solution; without stronger coordination and a more robust workforce, both rural

veterans and their fellow neighbors face longer waits, diminished access to medical facilities, and lower-quality care.

Figure 5 (Dockins & Lingerfelt, 2024)



To begin addressing the challenges identified in this assessment, MRHA recommends establishing a sponsored veterans-focused community within The Causeway. Rather than launching a standalone program, this approach would bring together the stakeholders who already serve veterans (VHA staff, rural providers, community clinics, behavioral health teams, transportation partners, social-service organizations) into a single multidisciplinary space for practical collaboration. A veteran's communitywould support real-time problem-solving, shared learning, and the development of a centralized,living repository of resources and best practices that partners statewide can access. It would alsoformally link veterans' issues to parallel efforts

in workforce development, transportation, rural access, and suicide prevention, reducing the silos that have long limited coordinated action. Sponsorship at the Community Partner ($5,000), Strategic Partner ($20,000), Leadership Partner ($50,000), or Statewide Sponsor ($100,000) level would provide the foundational infrastructure to maximize existing resources and strengthen Missouri's collective capacity to support its rural veterans.

Missouri's rural veterans face escalating and intersecting risks driven by aging, chronic illness, geographic isolation, digital exclusion, and shrinking access to both VHA and community-based care. Workforce constraints within the VHA and long-standing capacity gaps in rural health systems have created conditions in which even basic services are increasingly difficult to secure, particularly for veterans with the most complex medical and mental health needs. These disparities are further intensified by structural inequities tied to race, disability, and poverty, leaving a large population of veterans with few viable pathways to timely, coordinated care. This assessment identifies an opportunity for The Causeway to serve as a practical coordination structure that aligns key stakeholders and mobilizes existing resources to coordinate a response. Missouri now faces a clear policy choice: continue allowing rural veterans to navigate a fragmented system alone or invest in deliberate statewide coordination that aligns the systems already charged with serving them.

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