



**VA Capitol  
Health Care  
Network**

**VISN 5**

FIVE STAR SERVICE FOR  
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# **Collaboration with Rural Community Health Centers**

## **VISN 5**

### **Task 4: Final Report**

**June 2011**

**Prepared by the National  
Association of Community Health  
Centers and Atlas Research**

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*Honor America's Veterans as Heroes by Providing the Highest Quality Health Care*

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## EXECUTIVE SUMMARY

The Collaboration with Rural Community Health Centers (CHCs) project is a joint initiative of the Department of Veterans Affairs (VA) Capitol Health Care Network (also referred to as the Veterans Integrated Service Network (VISN) 5) and the National Association of Community Health Centers (NACHC) to increase coordination and collaboration between VA and four CHC systems located within VISN 5's borders. The purpose of this project is to: increase Veterans Health Administration (VHA) enrollment, improve access to care for rural Veterans that are currently not utilizing care within the VHA, and improve care coordination for dual users of the VHA and CHCs.

CHCs have been a predominant health care provider for over 45 years, serving 23 million patients in over 8,000 sites, of which half are located in rural areas. CHCs serve high numbers of low-income and/or uninsured patients regardless of their ability to pay. Nationwide, 71% of CHC patients have family incomes at or below the poverty level, and nearly all are below 200% of poverty level. Since 2008, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) has actively sought to better understand the number of Veteran patients who are served by CHCs. According to HRSA, the CHCs within VISN 5 served approximately 6,500 Veterans in 2009. And because rural CHCs serve predominately low-income and uninsured individuals, there is a high likelihood that these Veteran patients are potentially eligible for VHA services.

Through four interrelated tasks, this project seeks to identify, assess and engage the population of rural Veterans who seek care at CHCs in addition to, or instead of VHA. These include: Task 1 Analysis of CHC Patient Population; Task 2 Strategies to Increase Enrollment in VHA; Task 3 Improve Coordination of Care Between CHCs and VHA; and, Task 4 Complete a Final Report and Presentations. The project team analyzed CHC and VHA data, and using an assessment tool, ranked CHCs according to their suitability for a four-month pilot project. The project included (1) site visits to the four CHC systems selected for participation in the project; (2) telephone surveys with over 200 Veteran patients to assess their demographic and care utilization patterns; (3) interviews with CHC staff to review the Veteran patient intake processes; and (4) a series of face-to-face focus groups to better understand some of the reasons why and how individuals use both VHA and CHC systems of care.

Each of the four CHC systems, composed of 17 participating sites, implemented an additional outreach and educational program for Veteran patients. CHC intake personnel distributed VHA enrollment and information packets to Veteran patients presenting in the CHC over a four-month period. In addition, two VISN 5 Rural Health Outreach Coordinators engaged in strategic efforts

to establish relationships with CHC staff, increase enrollment among rural Veterans, provide informational services and guidance through the enrollment process, and provide limited case management support for rural CHC Veteran patients. The Rural Health Outreach Coordinators developed relationships that will enable community-based providers to improve coordination of care between CHCs and VISN 5, as well as establish ongoing communication channels for referring Veterans to eligibility certifying personnel and VHA medical services.

This final report outlines the steps involved in implementing the pilot project for those who may potentially desire to replicate it; describes project findings; articulates lessons learned from the implementation process; and concludes with a set of project recommendations in the areas of increasing enrollment, improving data collection, improving outreach and education, establishing communication channels, and developing a framework for clinical collaboration between VHA and CHCs at the local, national, and clinical service level.

The significant findings of the project are:

1. Most (64%) Veterans served by the rural CHCs in this pilot are not enrolled in the VHA, and a majority (78%) have never tried to enroll. The top reasons these Veterans are not enrolled are: a) they have other health insurance; b) they believe or were told they do not meet VHA's income eligibility or length of service requirements; c) they forgot, or never got around to applying; and d) they feel VHA services are too far away and/or have financial or logistical challenges to get to a VHA facility. Barriers to care identified during the focus groups include travel distance to VA, perceived lack of women's health services and equipment, loss of VA health records, access to dental care, lack of female counselors for MST.
2. Most (59%) Veterans who use CHCs also bring their families to the CHC for care. Alternatively, the majority (83%) of Veterans who use both CHC and VHA services do not bring their families to the VHA to receive care.
3. The majority (66%) of Veterans not enrolled in the VHA want to be contacted to learn more about their potential eligibility and, when CHC staff and Rural Health Outreach Coordinators work together, more rural Veterans apply for VHA benefits. Of the total number of non-enrolled Veterans contacted through this project (200 Veterans), the Rural Health Outreach Coordinators succeeded in enrolling 11%. Outreach Coordinators also established ongoing communications channels that will enable them to continue to enroll Veterans at project sites beyond the duration of the project.

4. CHCs represent a reasonable point of access for distribution of 1010EZ enrollment forms and VHA information packets for rural Veterans. Veterans who are enrolled in the VHA and are not aware of service locations or benefits available to them will become more aware when CHCs understand and distribute VHA service information.
5. A CHC intake staff member stated that some Veterans reported that the packets contained too much information and too many confusing charts. In addition to the 1010EZ enrollment form and Rural Health Outreach Coordinator contact information, the pilot packets included all of the components listed in **Table 3**, and in some cases were 13 pages long.
6. The team learned that it is important to change the informational packets to be more appealing to the eye, patient friendly and less data oriented. Some patients were put off by how statistical and data oriented the packets were, and seem less inclined to go through the process.
7. CHC Veteran patients who face particular challenges navigating the VHA health care system, or who experience mental or physical health issues for which the VHA is uniquely suited to provide services can be better served when CHC Case Managers and Rural Health Outreach Coordinators work together to meet the individual Veterans' needs.
8. Project data provide support for improved data collection at CHCs regarding Veteran status and needs. Project findings also provide useful background and context for improved communication policy between VHA and CHCs to better meet Veteran health and behavioral health needs.
9. Lessons learned regarding project implementation support the notion that rural populations are best served through highly personal interaction. Similarly, rural health providers and stakeholders must be engaged in one-on-one points of contact and relationship building in order to achieve collaboration and build buy-in for project initiatives.
10. This project is highly replicable in other VISNs and with other CHCs within VISN 5 through the processes and lessons learned presented in this report.
11. Veterans who participated in this pilot project generally reported high satisfaction with their care and services whether they used both systems of care, or either the VHA or CHC

exclusively (six participants in the Focus Groups used VHA services exclusively for their healthcare).

## PROJECT OVERVIEW

The Collaboration with Rural Community Health Centers (CHCs) project is a joint initiative of the Department of Veterans Affairs (VA) Capitol Health Care Network (also referred to as the Veterans Integrated Service Network (VISN) 5) and the National Association of Community Health Centers (NACHC) to increase coordination and collaboration between VA and four CHC systems located within VISN 5's borders (see **Appendix 1** for the list of participating CHCs). The purpose of this project is to increase Veterans Health Administration (VHA) enrollment, improve access to care for rural Veterans that are currently not utilizing care within the VHA, and improve care coordination for dual users of the VHA and CHCs. This project contains the following components:

**Task 1 Analysis of CHC Patient Population:** The project team analyzed CHC patient populations, as well as VHA enrollment data to better understand the number and VHA enrollment status of Veterans served by CHCs who are rural, women, homeless, and/or Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF). This task also included the development of specific recommendations for improved data collection on rural Veterans among all CHCs (see **Appendix 2**). See page 14 for an overview of each task.

Deliverables for Task 1:

- Baseline assessment and rural Veteran population estimates
- Assessment tool for selecting participating CHCs
- Specific recommendations to improve data collection procedures

**Task 2 Strategies to Increase Enrollment in VHA:** The project team developed a pilot project designed to increase enrollment in VHA among the Veterans seeking care at four CHC systems composed of 17 CHC sites. The first component of the pilot project was a telephone survey instrument designed to assess the demographic and utilization patterns of Veterans seeking care at participating CHCs (hereafter "Veteran Assessment"). The project team identified and assessed a sample of rural Veterans who may be enrolled in or eligible for VHA services and sought care within a CHC in the previous 12-months. Concurrently, the project team implemented a four-month outreach and educational program within the four CHC systems. The project team developed and distributed information packets for intake personnel, enrolled Veterans, and non-enrolled Veterans as part of the outreach and educational program (hereafter "Pilot Packets"). The program was designed to facilitate enrollment in VHA, educate Veterans and CHC personnel

on health care services available through the VHA, and improve access to and coordination of VHA services for those already enrolled. See page 20 for an overview of each task.

Deliverables for Task 2:

- Site visits to participating rural CHCs
- Veteran Assessment telephone surveys
- Pilot packets including instructions on referring Veterans to VA eligibility certifying personnel and medical services

**Task 3 Improve Coordination of Care Between CHCs and VHA:** This initiative established ongoing communication channels between CHC staff, Rural Health Outreach Coordinators, and other VISN 5 staff. During the period of performance, the project team visited each CHC participating in the pilot project. Project team members performing these visits conducted interviews with appropriate CHC management to obtain all necessary background information, enlist the support of CHC staff, and review the current patient intake documentation processes. The project team also conducted three Veterans focus groups to better understand some of the reasons why and how individuals use both VHA and CHC systems of care. The purpose of this task was to develop relationships that enable community-based providers to improve coordination of care between CHCs and VISN 5, as well as establish ongoing communication channels for referring Veterans to eligibility certifying personnel and VHA medical services. As part of this task, the project team recommended appropriate changes and follow-up procedures to improve collaboration between CHC staff and designated VISN 5 personnel located at VHA facilities. See page 45 for an overview of each task.

Deliverables for Task 3:

- Identify appropriate CHC points of contact, Rural Health Outreach Coordinators, and other Veteran services stakeholders
- Facilitate a meeting between participating CHCs, their respective Veteran services stakeholders, Community Based Outpatient Clinics (CBOCs), and VISN 5 representatives
- Establish communications channels between CHC pilot sites, Rural Health Outreach Coordinators, and VISN 5/VA Medical Center (VAMC) enrollment centers

- Develop recommendations for improving intake documentation process, follow up procedures, and other processes based on site visit reports
- Conduct three Veteran focus groups

**Task 4 Complete a Final Report and Presentations:** This final report documents the methodology and key findings from the completion of Tasks 1 through 3, as well as recommends approaches that VISN 5 and VHA could consider to expand collaborative efforts on a national level or in multiple VISN locations. In addition, the report contains lessons learned during the project that will improve the functionality of the project in the future. It is expected that presentations will be made at VISN 5 leadership meetings, as well as at the national level. The VHA Office of Rural Health will also be engaged.

Deliverables for Task 4:

- Draft final report
- Close-out meeting with the Contracting Officer's Technical Representative

## BACKGROUND AND RATIONALE

Veterans enrolled in the VA health care system (also known as VHA) receive a medical benefits package that includes a full list of available outpatient, inpatient, and pharmaceutical services.<sup>1</sup> However, a majority of Veterans are not enrolled to receive VHA services. According to the most recent data sources, there are 22.7 million Veterans alive as of September 30, 2010.<sup>2</sup> At the same time, there are only 8.2 million, or 36% of Veterans enrolled to receive VHA services. These numbers indicate that 14.5 million Veterans, or 64% of the total Veteran population, are not enrolled for VHA benefits.<sup>3</sup>

Although the majority of Veterans are not enrolled in the VA health care system, there is a strong assumption that these Veterans do not remain uninsured and without health care, and instead seek access to health care through both public and private non-VA and civilian health care systems. In addition, there are Veterans who use both VHA and non-VHA systems of care and others who receive occasional non-VHA care through VHA health provider referrals to a fee for service provider. Where to obtain health care is an extremely personal decision, and there are many reasons why Veterans use multiple systems of care, or are not enrolled in VHA. While Veterans may want to use VHA services, some Veterans do not meet VHA eligibility requirements due to income and period of service. Even enrolled Veterans may experience barriers to VHA services, including geography, travel distance, and health issues such as Post Traumatic Stress Disorder (PTSD). Other Veterans simply choose not to utilize VHA services and prefer to use other systems to meet their health care needs. However, because the rural CHC patient population is characteristically lower-income, we know that the population of Veterans who use CHCs may potentially be eligible for VHA services.

For the past 45 years, the Health Resources and Services Administration (HRSA) has administered the CHC program throughout the United States. CHCs are not-for-profit, private, or public entities that serve designated Medically Underserved Areas or Medically Underserved Populations by providing comprehensive, culturally competent, quality primary health care.<sup>4</sup>

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<sup>1</sup> Department of Veterans Affairs, Veterans Health Administration (2011). VA Health Eligibility Home. Retrieved from <http://www.va.gov/healtheligibility/>

<sup>2</sup> Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. (2008). VetPop 2007 [Data file]. Retrieved from [http://www.va.gov/vetdata/Veteran\\_Population.asp](http://www.va.gov/vetdata/Veteran_Population.asp)

<sup>3</sup> Department of Veterans Affairs, Veterans Health Administration, VHA Support Services Center. (2011). *Current Enrollment Cube* [Data file]. Retrieved from <http://vssc.med.va.gov>

<sup>4</sup> U.S. Department of Health and Human Services, Health Resources & Services Administration. *The Health Center Program: What is a Health Center?* Retrieved from <http://bphc.hrsa.gov/about/>

Community, migrant, homeless, and public housing health centers, which will be referred to as CHCs for the remainder of the report, are private, non-profit, community-directed health centers that serve low income and medically underserved communities and all patients regardless of ability to pay for care.<sup>5</sup> CHCs charge based on a sliding-fee scale assessed according to an individual patient's ability to pay. As of 2008, all CHCs are required to identify Veteran status among their patients. However, past project reports show that CHCs may not be counting all of their Veteran patients using their current methods (see **Appendix 2** for recommendations for data collection).

This project is a collaborative effort between VISN 5 and NACHC to increase VHA enrollment, improve access to care for rural Veterans, and improve care coordination for dual users of the VHA and CHCs. Because the CHC patient population is a 'captive' population for which income, Veteran status, and health care insurance coverage is known, it is highly useful to study this population and their potential eligibility for, and interest in learning about VHA benefits. Targeting rural CHCs for this collaborative work is also useful given the access barriers rural Veterans face, including geography and travel distances. To that end, this work is in keeping with VA's current focus on ways to improve access and quality of care for rural Veterans.

Using National Center for Veteran Analysis and Statistics data, this project finds that approximately 27% of Veterans currently residing in VISN 5 are enrolled in VHA.<sup>6</sup> This percentage is slightly lower than the national average of Veterans enrolled in VHA services, however because it is important to engage this pilot collaborative approach to get the CHC Veteran patient population is a predominantly low-income population, some of whom do not have third party health care insurance. According to the HRSA Bureau of Primary Health Care, 71% of CHC patients have family incomes at or below the Federal poverty level, and nearly all are below 200% of the poverty level. In addition, approximately 63% of CHC patients are members of racial or ethnic minority groups, 38% of patients are uninsured, and another 44% depend on Medicare and Medicaid for their insurance.<sup>7</sup> All these socio-demographic

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<sup>5</sup> National Association of Community Health Centers, Inc. (2010). *America's health centers, fact sheet, August 2010*. (NACHC Publication No. 0309).

<sup>6</sup> Department of Veteran Affairs, National Center for Veteran Analysis & Statistics. (2007). VetPop 2007 [Data File]. Retrieved from <http://www1.va.vetdata.gov>

<sup>7</sup> Probst, J. C., Laditka, J. N., & Laditka, S. B. (2009). Association between community health center and rural health clinic presence and county-level hospitalization rates for ambulatory care sensitive conditions: An analysis across eight US states. *BMC Health Service Research*, 9(134).

characteristics are associated with disparities in health outcomes.<sup>8</sup> Therefore, the CHC patient population contains a population of non-enrolled Veterans who are more likely to be eligible for VHA services than the general U.S. population.

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<sup>8</sup> U.S. Department of Health and Human Services, Agency for Health care Research and Quality. (2010). *2009 National Health care Disparities Report*. (ARHQ Publication No. 09-0002) Retrieved from <http://www.ahrq.gov/qual/qrd08.htm#toc>

## TASK 1. ANALYSIS OF CHC PATIENT POPULATION

The initial phase of the Collaboration with Rural Community Health Centers project involved building relationships with the CHC and VISN partners involved in the project. The success of this project relied heavily on personal contact and relationships built upon trust, collaboration as a team to solve problems, and the sharing of important information to complete a task. The importance of this initial relationship-building phase was compounded by the notion particular to rural patients and providers that personal presence communicates commitment and sincerity. Therefore, the first step to completing Task 1 was to conduct site visits with the individual CHC administrators and intake personnel to: 1) obtain input and build stakeholder buy-in into the process of data collection, 2) explain the rationale and goals behind the project, and 3) define the mutual expectations and roles of the various team members within the project. These site visits and follow up personal phone calls also communicated that the project team honored the essential role of the CHCs in the overall project and demonstrated respect for the values of their patients, the CHCs, and rural communities they serve. This level of contact and relationship building is essential for fostering 'project buy-in' by the CHCs and made the project a collaborative team effort rather than a top down project done to the CHCs in which they had no voice.

The project team identified a number of general criteria to select the most salient CHC systems and clinical sites for participation in this project. The first stage of the selection process involved gathering data from the HRSA Uniform Data System (UDS) and ranking each system according to the number of Veterans reported. Each location was then assessed against the following criteria:

- Demographic characteristics, such as gender and age, of the CHC's patient population reported to the UDS in 2009
- Rating on a scale of 1 to 5 of the willingness and interest of the CHC to participate in the data analysis and pilot program, as well as willingness to accept the level of compensation for this work
- Number of miles from the CHC site location to at least one CBOC and/or Vet Center
- Rating on a scale of 1 to 5 on how closely the geographic area served by the CHC represents the health care access challenges faced by rural Veterans
- Commentary on the availability of community-based organizations in the community served by the CHC that could potentially assist in educating Veterans and their families about the pilot program and VHA benefits

Based upon the results of the site selection criteria and the site visits, four CHC systems and 17 associated clinical sites were selected for participation in this project (see **Figures 1 and 2, Table 1 and Appendix 1**). Each site signed a Memorandum of Understanding, which clearly detailed the parameters of the project.

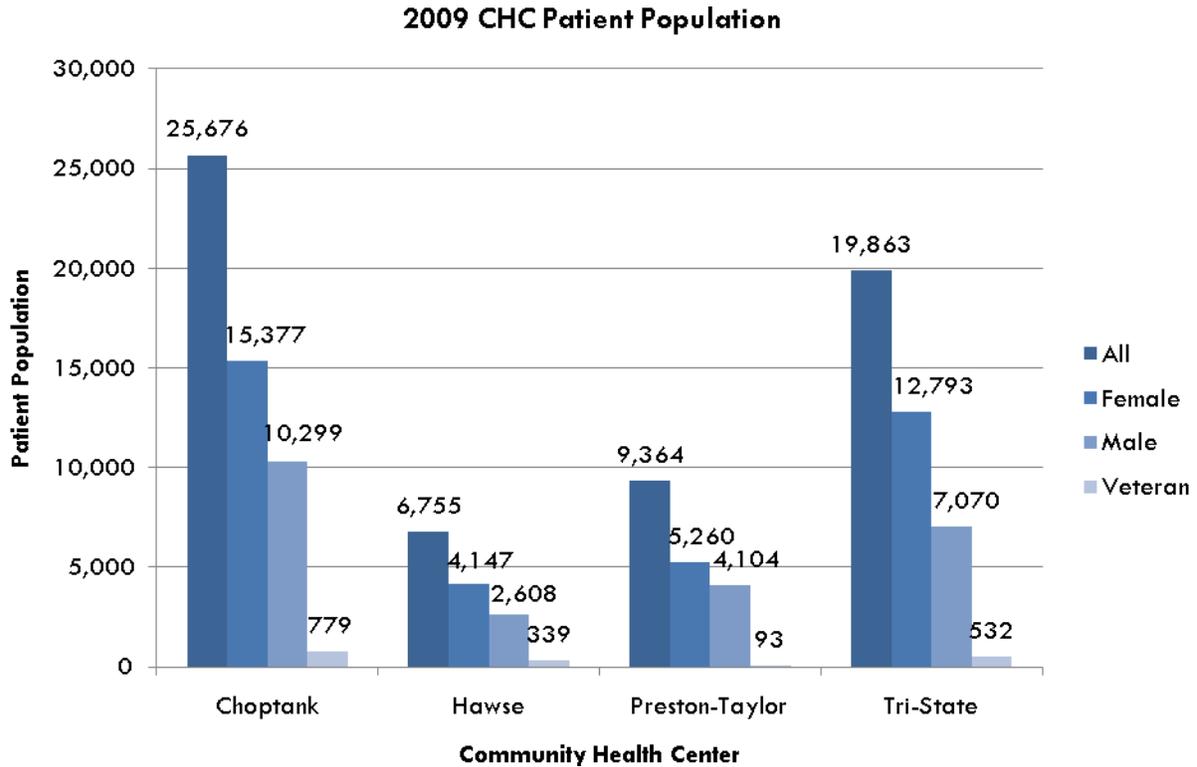
Once the participating sites were finalized, the team developed a baseline assessment that presented the findings of an analysis of the Veteran population within the catchment areas of the four rural CHC systems listed in **Figure 1**. The assessment examined the demographics of the Veteran population living in the rural counties served by the four CHC systems. Those systems include: Choptank Community Health System, Inc., E. A. Hawse Health Center, Inc., Preston-Taylor Community Health Centers, Inc., and Tri-State Community Health Center, Inc. Several demographic characteristics were considered, including market penetration, enrollment and utilization, gender, age, service connection and priority, and use of health services. The baseline assessment also included a literature review and discussion of CHCs and their role in rural health, quality of care, chronic disease management, mental health services, telehealth services, cost effectiveness, and care coordination. Finally, the baseline assessment included a review of other VA health care collaborations.

According to VHA enrollment data, an estimated 774,793 Veterans reside in VISN 5 as of 2010, approximately 27% (207,165) of whom are enrolled in VHA. Of those enrolled in VHA, an estimated 55% (113,607) have utilized VHA services in the past 12 months. VISN 5 Veterans are predominantly male. By contrast, each of the CHC systems in this assessment had more female than male patients (see **Figure 1**); however, it is important to note that the CHC data include adults as well as children, and not just Veterans. All four CHC systems had some self-reported Veteran patients, ranging from 93 Veterans at Preston-Taylor CHC to 779 at Choptank CHC. In every system, the number of self-reported Veteran patients comprised less than three percent of the overall patient population.<sup>9</sup>

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<sup>9</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. (2009). *2009 Uniform Data System Manual*. Retrieved from <http://www.hrsa.gov/data-statistics/health-center-data/reporting/index.html>

**Figure 1. 2009 CHC System Patient Population Demographics from UDS\***



\* Preston-Taylor CHC initially reported 600 Veterans for the project Baseline Assessment, but a later hand count of records at the Mt. Storm site showed a Veteran patient population of 93.

The VA National Center for Veteran Analysis and Statistics provides data on the number of potential Veterans living in a given market area served by the VHA. Such data is used to project service needs and develop programs in response to those needs. **Table 1** shows the projected total Veteran population in the counties served by each CHC system (hereafter “county catchment area”).<sup>10</sup>

**Table 1. Projected Veteran Population within CHC System Catchment Areas**

CHC System	Projected Veteran Populations by CHC System		
	All Veterans	Male Veterans	Female Veterans
Choptank	14,617	13,836	781
E. A. Hawse	9,684	9,351	333
Preston-Taylor	1,169	1,078	91
Tri-State	21,442	19,624	1,819

<sup>10</sup> Department of Veteran Affairs, National Center for Veteran Analysis & Statistics. (2007). VetPop 2007 [Data File]. Retrieved from <http://www1.va.vetdata.gov>

**Table 2** shows a comparison of market penetration between VA facilities and CHCs in their county catchment areas. The market penetration numbers below are an extrapolation based on the projected Veteran population shown in **Table 1**. In the VA column, **Table 2** shows the percent of total projected Veterans in the CHC county catchment areas who use VHA services. In the CHC column, **Table 2** shows that based upon current UDS numbers, CHCs serve between 2% -8% of the total projected Veterans within their catchment areas.

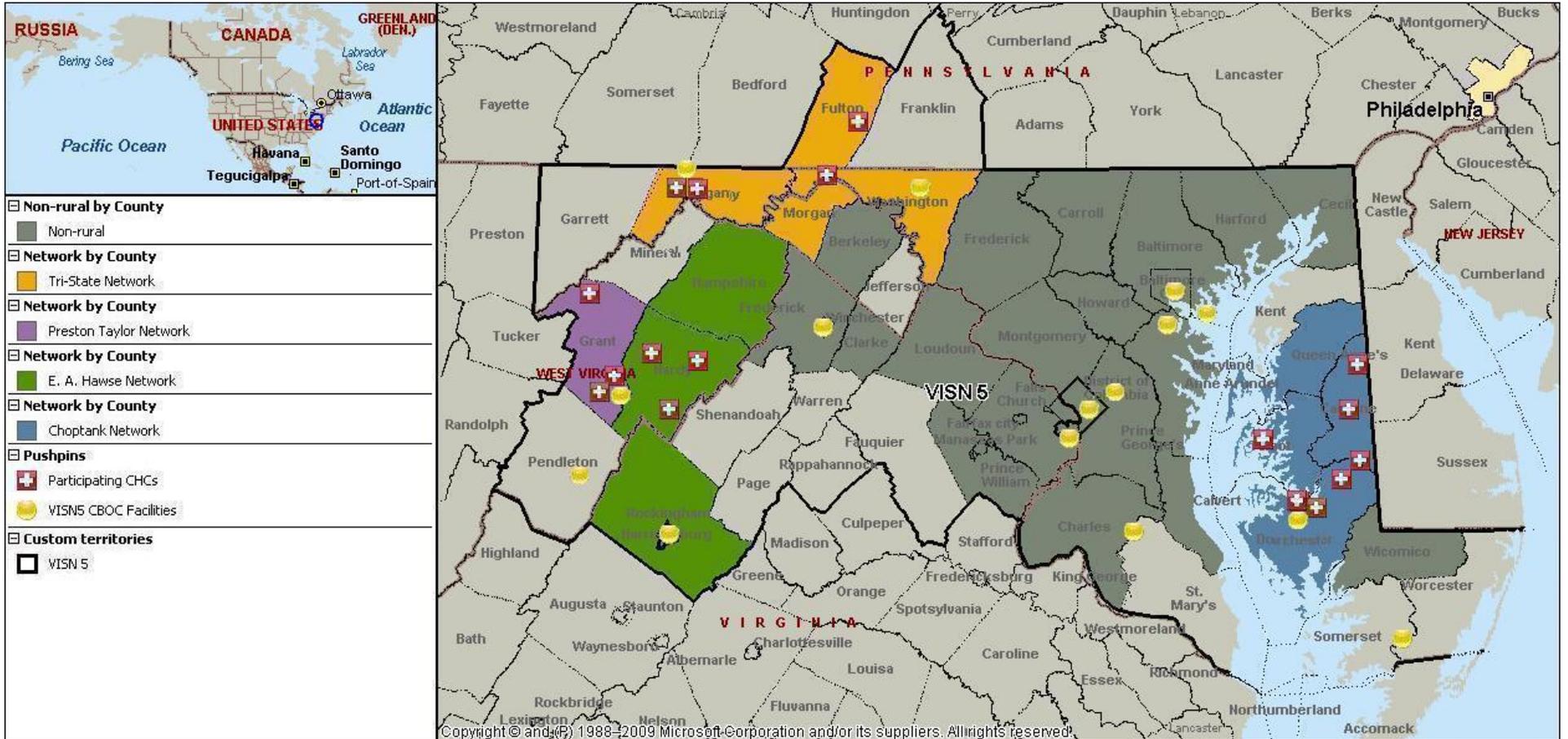
**Table 2. Comparison in Market Penetration between VA and CHC**

CHC System	Projected Market Penetration	
	VA	CHC
Choptank	18%	5%
E. A. Hawse	23%	4%
Preston-Taylor	33%	8%
Tri-State	27%	2 %

The intent of **Table 2** is to show compare market penetration between VA and CHC systems within each CHC catchment area. VA has higher market penetration, but CHCs have a significant market penetration in each area, particularly Preston-Taylor with an 8% market penetration.

As a part of Task 1, the project team also analyzed the processes used by CHCs to collect Veteran patient data and report it to the UDS. The project team developed a series of recommendations for more detailed and accurate Veteran patient data collection by CHCs. Specifically, the project team made recommendations for improvements in data collection and intake by CHCs, ways VHA and CHCs might collaborate around data collection, and the methods by which VA and HRSA could partner to revise the UDS and provide a more accurate picture of Veteran patients served by CHCs. The list of these recommendations can be found in **Appendix 2**.

Figure 2. Map of Selected CHC Sites and Systems



## Lessons Learned Regarding Project Implementation and Processes

The following lessons learned are specific to project logistics, implementation and processes and may provide a useful guide to those that wish to replicate, or tailor this project to their specific needs. Lessons learned will be placed throughout this report in their respective Task sections and are also collected at the end of this report in the Recommendations section.

- Several CHCs issued a press release to raise awareness regarding participation in the project. This press release generated interest in the project and resulted in multiple Veterans visiting their local CHC to ask about potential services available to Veterans. This press release was also a useful tool in recruiting Veteran participants for the focus groups.
- The project team created a PowerPoint presentation for the purpose of educating the CHC staff on the purpose, importance, and their specific roles in the execution of this project, found in **Appendix 3**. This provided opportunities for all participating staff to meet together with project team and discuss implementation strategies.

## TASK 2. INCREASE ENROLLMENT IN VHA

This task involves a pilot project designed to increase rural Veteran enrollment in VHA services. The first component of the pilot project was a telephone survey instrument designed to assess the demographic and utilization patterns of Veterans seeking care at participating CHCs (hereafter “Veteran Assessment”). The project team identified and assessed a sample of rural Veterans who may be enrolled in, or eligible for VHA services and sought care within a CHC in the previous 12-months. Concurrently, the project team implemented a four-month outreach and educational program within the four CHC systems. The project team developed and distributed information packets for intake personnel, enrolled Veterans, and non-enrolled Veterans as part of the outreach and educational program (hereafter “Pilot Packets”). The program was designed to facilitate enrollment in VHA, educate Veterans and CHC personnel on health care services available through the VHA, and improve access to and coordination of VHA services for those already enrolled.

### VETERAN ASSESSMENT

#### Methodology

The purpose of the Veteran Assessment was to gather information from a select sample of CHC Veteran patients regarding their demographic information and their use of VHA services. The assessment was administered to at least 10% of the number of Veterans reported to the HRSA UDS in 2009 for each CHC system. Therefore each CHC participating in the project saw a unique number of Veteran patients and had a different target number of Veterans to administer during the assessment. To better understand clinical characteristics of Veterans seeking care in CHCs, the project team also collected International Classification of Diseases, Ninth Edition (ICD-9) diagnosis codes for all Veteran patient visits in 2009. A count of these diagnosis codes can be found in **Appendix 4**.

In order to conduct the Veteran Assessment, the project team first developed an online questionnaire using a software tool called Zoomerang, which captures survey data electronically. The Zoomerang Veteran Assessment questionnaire can be found in **Appendix 5**. Concurrently, each CHC system developed a master contact sheet in Microsoft (MS) Excel containing information for each self-reported Veteran seen in 2009. The master contact sheet was stratified according to the CHC site, age, and gender, as well as randomized within each group/stratum. CHCs were instructed to oversample Veterans within each stratum to ensure: 1) the target sample size included 10% of the number of Veterans reported to UDS for each individual site; 2) at least one

third of Veterans sampled were between the ages of 20 and 40 years old; and 3) at least one fourth of Veterans sampled in any age group were women. A sample CHC master contact sheet can be found in **Appendix 6**.

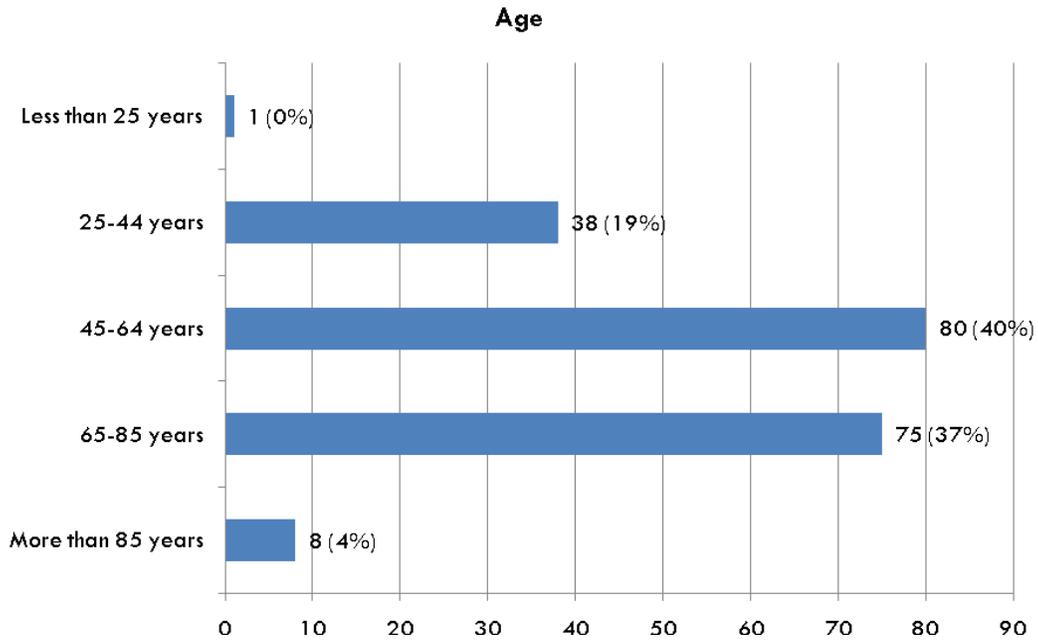
The project team trained each CHC system point of contact on how to conduct the Veteran Assessment using a Skype account to make the calls to the Veterans, a free online MP3 Skype recorder to record the calls, the master contact sheet, and the Zoomerang tool. The training packet used by project team members to train interviewers can be found in **Appendix 7**. Interviewers used the master contact sheet to call Veterans, and followed the script in the Zoomerang tool. With the Veteran's consent, all of the calls were recorded. The Veterans' responses to the Assessment questions were captured both in the Zoomerang tool, as well as by the free online MP3 Skype recorder. The CHC interviewers continued to contact Veterans until they reached their target number of interviewees. The completed interviews were transcribed, coded, and analyzed by the project team.

## Findings

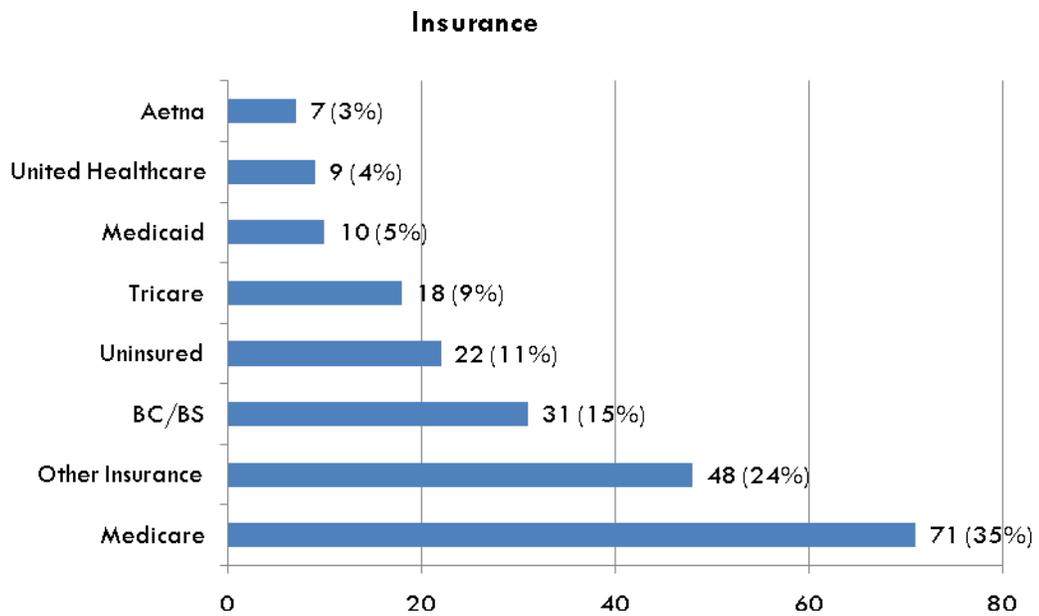
### ***Demographic Characteristics and Enrollment Status***

The project interviewed 202 total Veteran patients of participating pilot project CHCs. 182 Veterans (90%) were male and 20 Veterans (10%) were female. 189 Veterans (94%) were white, 10 Veterans (5%) were Black/African American, and 3 Veterans (1%) were White Hispanic. 80 Veterans (40%) were between the ages of 45 and 64 years old, 75 Veterans (37%) were between the ages of 65 and 85 years old, 38 Veterans (19%) were between the ages of 25 and 44 years old, 8 Veterans (4%) were more than 85 years old, and 1 Veteran (0%) was less than 25 years old. See **Figure 3** below. There was a wide variety of health insurance coverage for the Veteran respondents. It is interesting to note that 22 Veterans (11%) receiving care at CHCs are uninsured. See **Figure 4** for the breakdown of health insurance.

**Figure 3. Age of Veteran Respondents**



**Figure 4. Health Insurance Coverage of Veteran Respondents**



99 Veterans (49%) of the Veteran respondents previously served in the Army. The remaining respondents served in the following military branches: 46 Navy (23%), 43 Air Force (21%), 15 National Guard (7%), 11 Marine Corps (5%), and 4 Coast Guard (2%). No respondents served in

the Merchant Marine Corps or the U.S. Public Health Service. The average length of service for the respondents was 6.5 years; however, five respondents did not know their years of service. The Veteran respondents began their years of service during the following years:

- 1940 – 1954: 21 Veteran respondents
- 1955 – 1975: 103 Veteran respondents<sup>11</sup>
- 1976 – 1989: 52 Veteran respondents
- 1990 – present: 22 Veteran respondents

The overwhelming majority of respondents, 197 Veterans (98%) are no longer active in the Reserves and 5 Veterans (2%) are still active in the Reserves. 148 Veterans (73%) did not serve in a combat or war-zone. However, of the 54 Veterans (27%) who did serve in a combat or war-zone, 23 Veterans (43%) served in the Vietnam War, 18 Veterans (33%) served in the Gulf War (August 2, 1990 through present), 5 Veterans (9%) served in World War II, 5 Veterans (9%) served in the Korean War, and 3 Veterans (6%) served in other combat theatres.

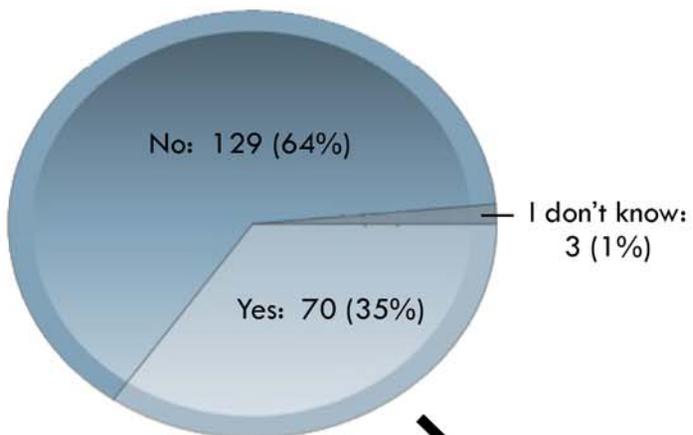
All respondents were asked if they were enrolled in VA to receive health care benefits and services. 129 Veterans (64%) were not enrolled, 70 Veterans (35%) were enrolled, and 3 Veterans (1%) did not know. Of the 70 Veteran respondents who are enrolled in VA to receive health care benefits and services, 59 Veterans (84%) have visited a VA facility for health care at any time in the past and 11 Veterans (16%) have not. Of the 59 respondents who are both enrolled in VA and have visited a VA facility for health care at any time in the past, 45 Veterans (76%) have visited a VA facility within the past 12-months and 14 Veterans (24%) have not visited a VA facility within the past 12-months for health care. **Figure 5** depicts these conditional results.

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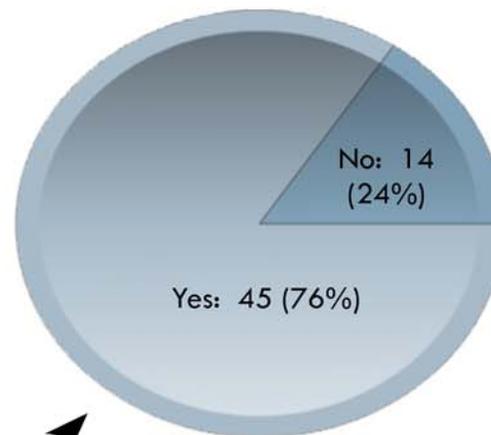
<sup>11</sup> One Veteran served twice, and is double counted in this figure.

**Figure 5. Enrollment in the VA and Utilization of VA Health Care Services by Veteran Respondents**

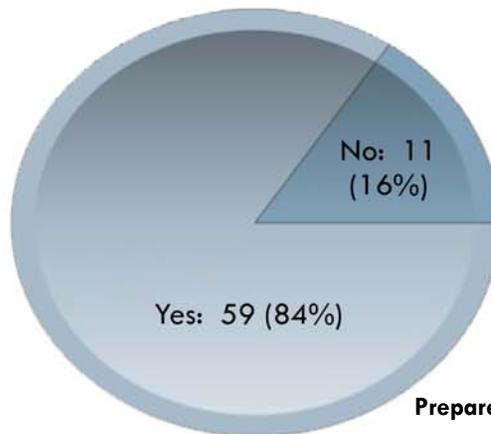
Are you enrolled in the VA to receive health care benefits and services?



Have you visited a VA facility for health care in the past 12 months?

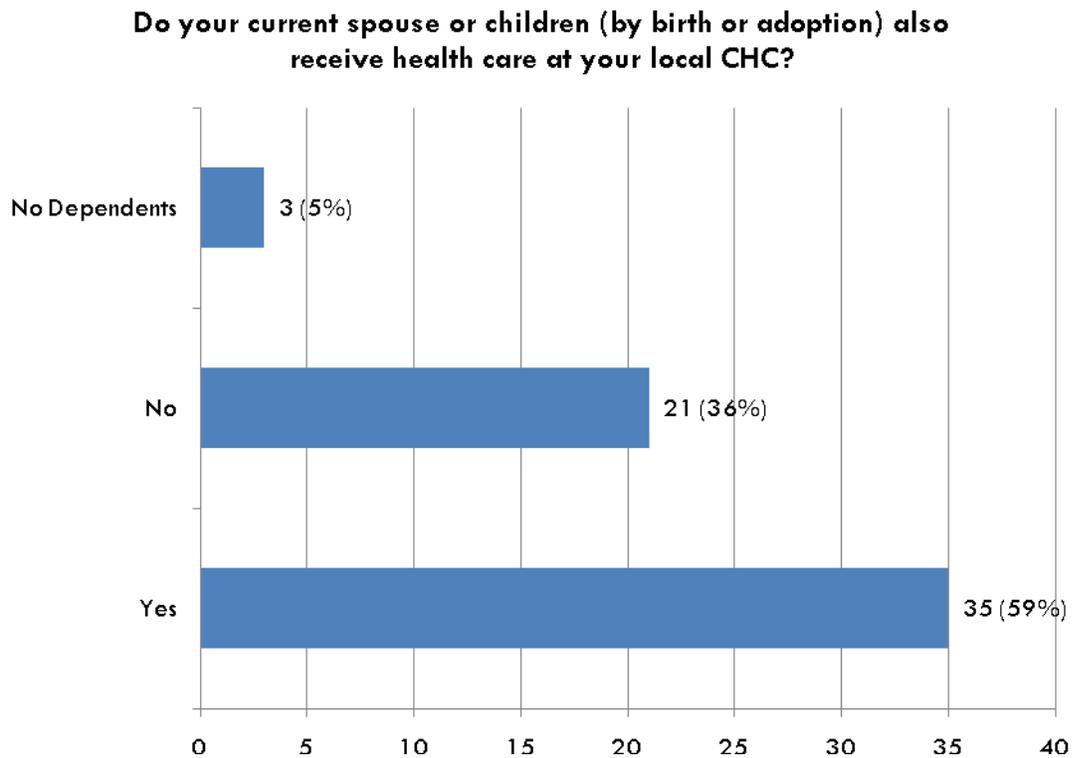


Have you visited a VA facility for health care at any time in the past?



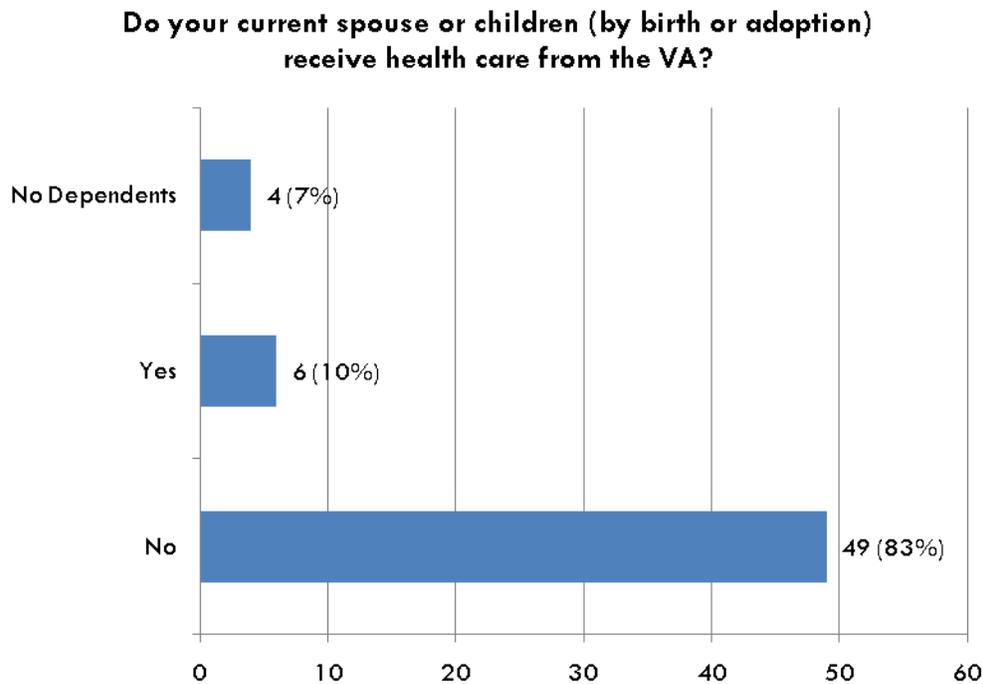
The 59 Veteran respondents who are both enrolled in VA and have visited a VA facility for health care at any time in the past were also asked if their current spouse or children, by birth or adoption, also receive health care at their CHC. 35 Veterans (59%) stated, yes, their current spouse or children also received health care at their CHC, while 21 Veterans (36%) stated no, their current spouse or children do not receive health care at their CHC, and 3 Veterans (5%) did not have any dependents. See **Figure 6** for these results.

**Figure 6. Percent of Veteran Respondents' Current Spouse or Children that Receive Health Care at their CHC**



These same 59 Veteran respondents were also asked if their current spouse or children, by birth or adoption, also receive health care from the VA. The overwhelming majority, 49 Veterans (83%) stated that their current spouse or children do not receive health care from the VA; 6 Veterans (10%) stated, yes, their current spouse or children do receive health care from the VA, and 4 Veterans\* (7%) stated that they do not have any dependents. See **Figure 7** for these results.

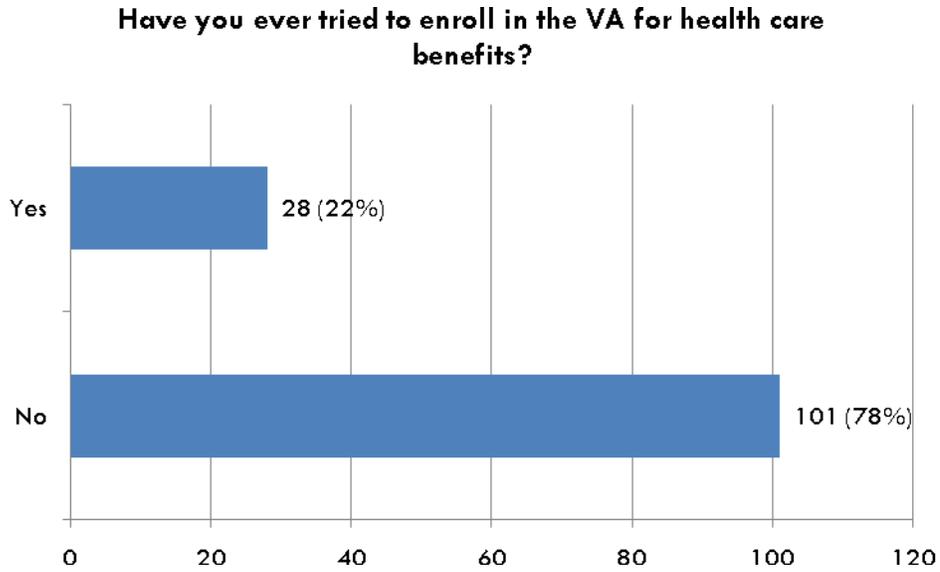
**Figure 7. Percent of Veteran Respondents' Current Spouse or Children that Receive Health Care from the VA**



\* Project staff recognize data inconsistencies in the number of Veterans responding that they have no dependents in **Figures 6 and 7**.

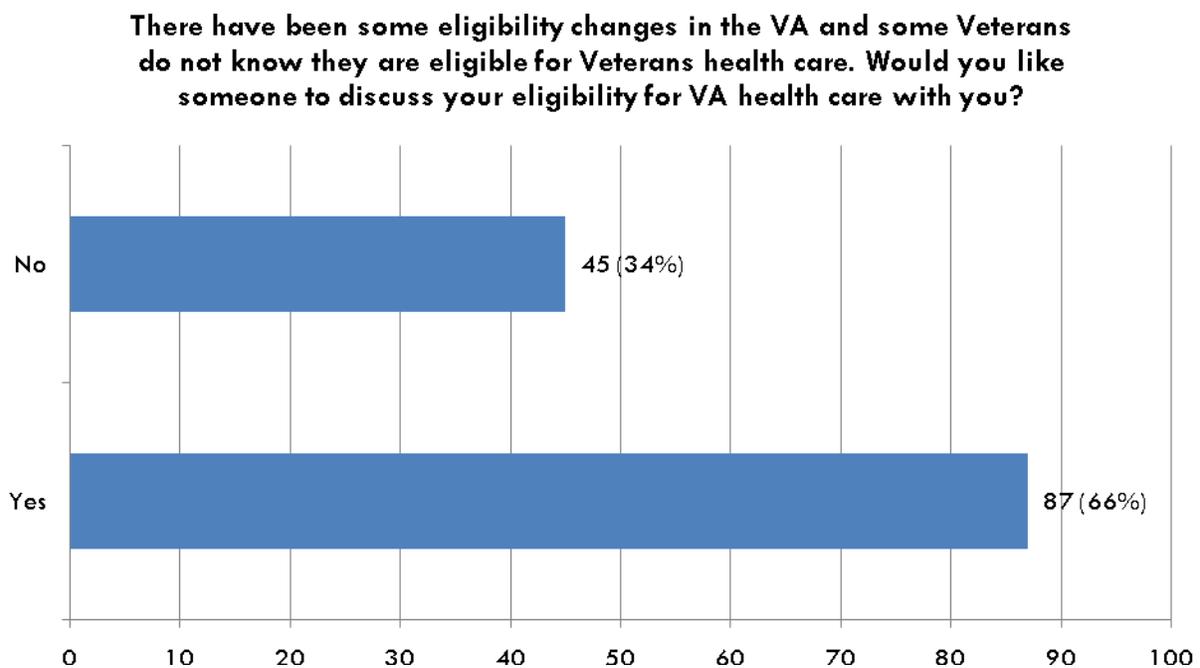
Those 129 Veteran respondents who are not enrolled in VA for health benefits or services were asked if they ever tried to enroll in VA. Of the 129 Veteran respondents not enrolled in VHA, 28 Veterans (22%) have tried to enroll in VA while 101 Veterans (78%) have not tried to enroll in VA for health benefits or services. See **Figure 8** for these results.

**Figure 8. Percent of Non-Enrolled Veteran Respondents Who Have Tried to Enroll in the VA for Health Care Benefits**



Finally, the 129 Veteran respondents not currently enrolled in VHA and the three Veteran respondents who did not know if they were enrolled in VHA were asked if they would like to discuss their eligibility for VA health care with a VHA representative. 87 Veterans (66%) stated that, yes, they would like someone to contact them regarding their eligibility for VA health care. These names were provided to the VISN 5 Rural Health Outreach Coordinators for follow up by VHA. The results of these contacts, including enrollments, are discussed later in the report in the section titled, “Comparison of Outreach Methodologies: Veteran Assessment and Pilot Packets”. 45 Veterans (34%) stated that no, they were not interested in being contacted regarding their eligibility. See **Figure 9** for these results.

**Figure 9. Percent of Veteran Respondents Interested in Receiving Further Information Regarding VHA Eligibility**



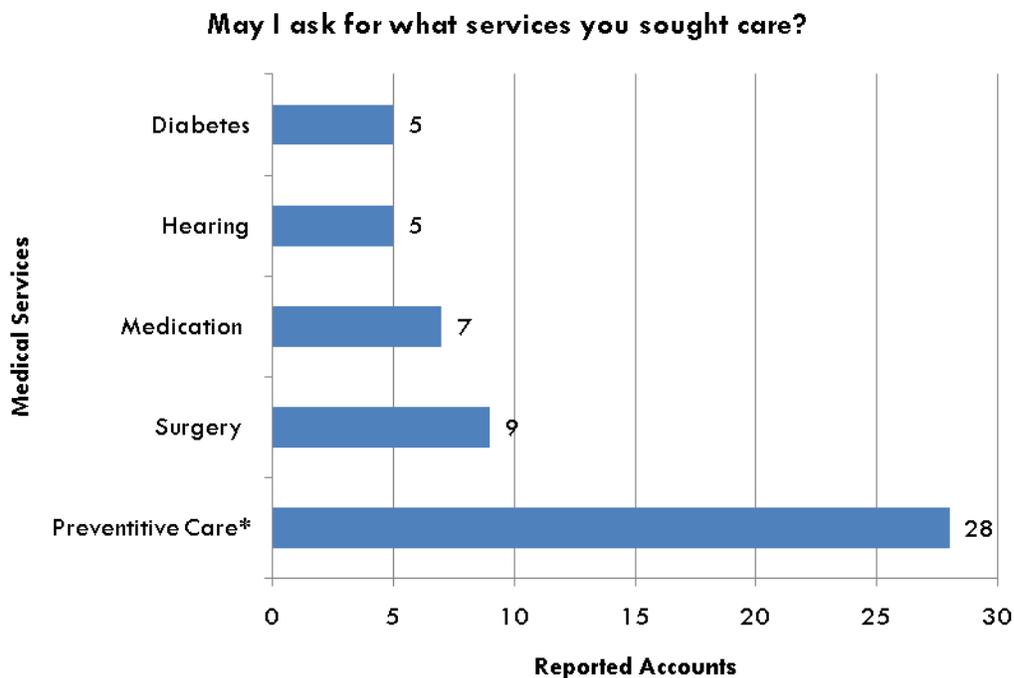
**Qualitative Findings: Utilization and Motivation for Care Patterns**

In addition to the quantitative questions asked as part of the Veteran Assessment, depending on whether or not a Veteran was enrolled or non-enrolled for VA health care, interviewers also asked five qualitative questions. Because Veterans may have given multiple responses for the open-ended questions, the counts reflect the number of responses, not necessarily number of Veterans. The five qualitative questions considered in this section include:

1. May I ask for what services you sought care?
2. What are some reasons you receive care from both [Name of Health Center] and the VA?
3. What are some reasons you do not use VA for health care?
4. What are the reasons you did not enroll?
5. Is there anything else you would like to tell me about your health care experiences as a Veteran?

When asked, “**May I ask for what services you sought care?**” enrolled Veterans offered a variety of responses for reasons why they had visited a VA facility. The primary reason given for seeking care at the VA was to complete routine physical exams and check ups for preventive care. Enrolled Veterans also sought services such as surgery (hip/knee replacements, hernia, back, cataracts) and to acquire medications cost effectively, obtain hearing aids, or receive treatment for diabetes. Responses also included back problems, arthritis, mental health, prostate problems, and heart trouble. The top five responses are displayed in **Figure 10**.

**Figure 10. Top Five Services for which Veterans Sought Care at VA Facilities**



\*Including: Physical exams, check ups, and lab work.

In response to the question, **“What are some reasons you receive care from both [Name of Health Center] and the VA?”** enrolled Veterans identified care for multiple conditions (some service-connected) and travel distance to the VA as being the primary reasons they use both the VA and their local CHC. **Figure 11** displays the five most common responses. Specific comments included the following:

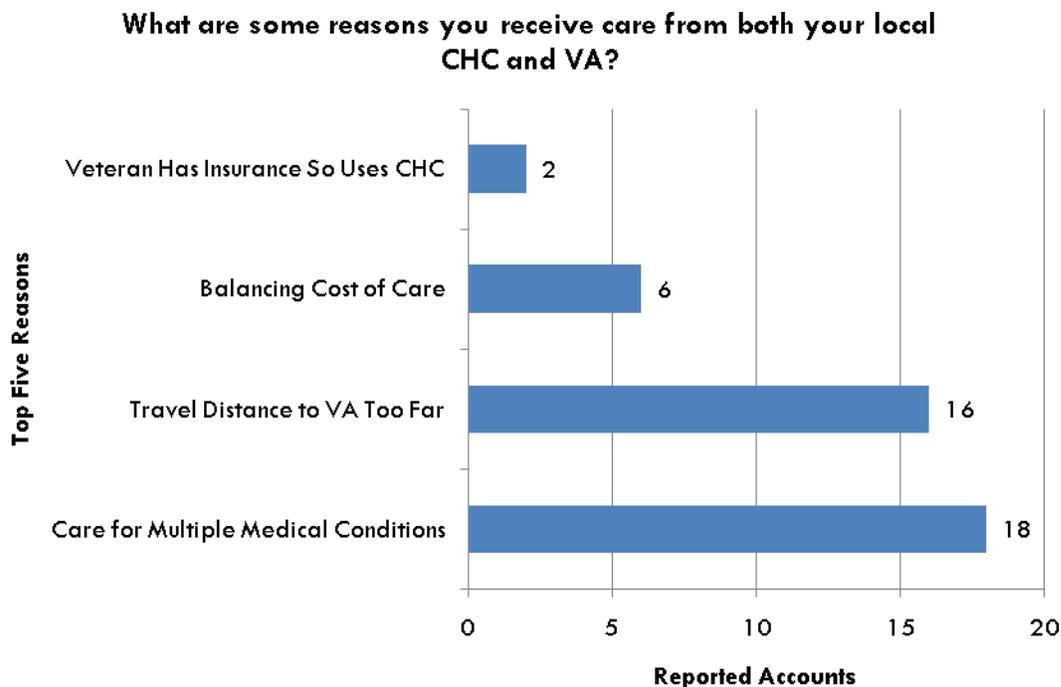
*“I received care from [the CHC] exclusively before I was disabled, and then when I was diagnosed with MS, the VA picked me up.”*

*“Normal things like convenience. I like the service out there. They have been pretty good. It’s so far to go to [VAMC]. That would be about 2.5 hours.”*

*“I was going to the [CHC] because I was not enrolled at the time with the VA. Plus, at the same time, you guys [CHC] were a lot closer to handle small, little things, so that is the reason why I was going to both.”*

*“The [CHC] is closer and if I get sick and need something the same day I can get in quick. [CBOC] is a long drive and you have a long wait. [CBOC] is a 40 mile drive.”*

**Figure 11. Reasons Veterans Sought Care from the local CHC and VA**



Given that only 11 of the enrolled Veterans indicated they had not used the VA in the past, there were few responses to the question, **“What are some reasons you do not use VA for health care?”** The primary reasons why they did not use the VA were that they had other health insurance and the travel distance to the VA was inconvenient for them. Specific comments included the following:

*“More or less convenience of location, because I don’t... Obviously we live in [location] so the closest one is in [city], so I don’t want to travel all the way there.”*

*“I have great coverage once I worked for [employer], so I never went back to the VA. Now I have Blue Cross plus I am on Medicaid. There is no need for me to go over there because I don’t think I would get the quality care I can get over there that I can get here at [CHC]. I only use dental at VA.”*

Only non-enrolled Veterans responded to the question, **“What are the reasons you did not enroll?”** In several cases, Veterans may have provided multiple reasons for why they did not enroll. Among the top reasons for not enrolling, Veterans responded most frequently with the fact they had other insurance, they believed they were not eligible or were told they were ineligible by the VA or a member of a Veteran Service Organization, the Veteran had forgotten to enroll or never got around to it, and the travel distance to the nearest VA facility was too far. The highest response given for either not believing they were eligible or being told they were ineligible for VA health care was that they had not served long enough on Active Duty to qualify. **Figure 12** depicts the top given reasons for not enrolling. Specific comments from the Veterans included the following:

*“I haven’t any idea where to go. I don’t have any transportation to get there. I don’t think I am even eligible for any VA benefits. I thought everything had to be military related to receive benefits.”*

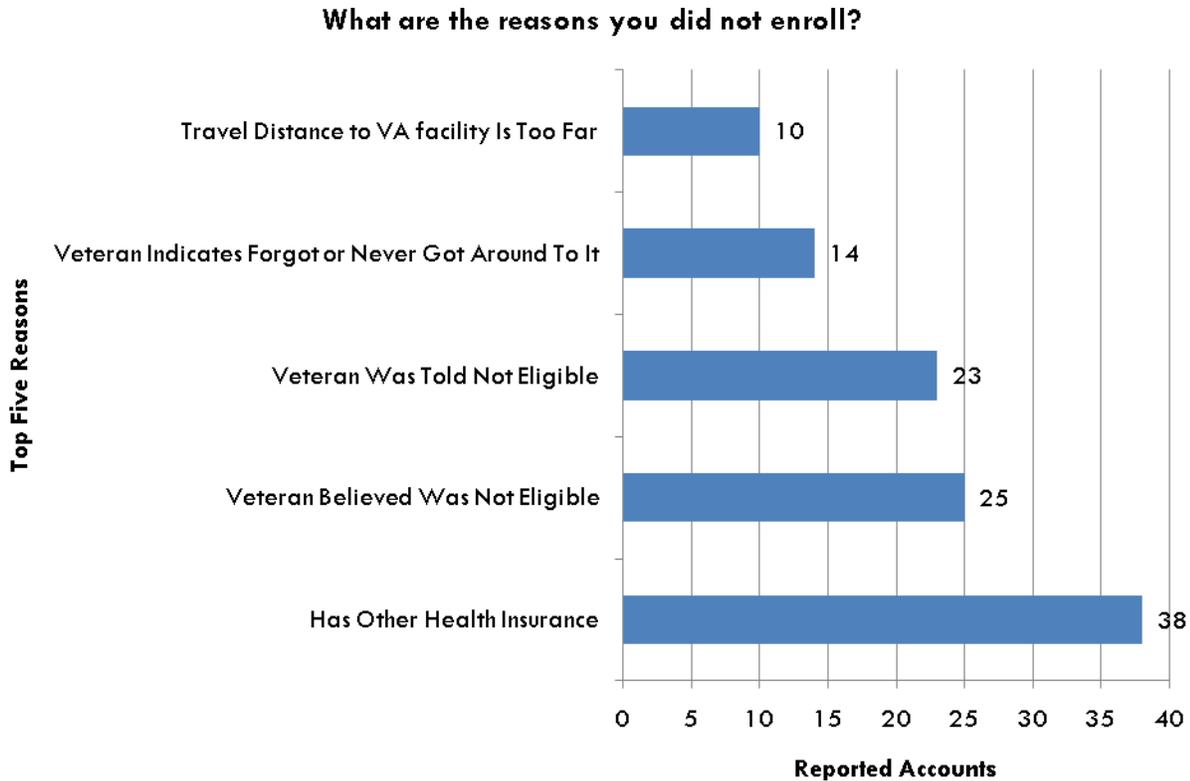
*“After retirement, worked for the state so all my medical benefits were covered by them. After that I had TRICARE and Medicare, but I really haven’t needed them.”*

*“... I am retired now, and I have very good health insurance, and I couldn’t see infringing on them when I had good health care...I don’t go through the VA because I have to go to [city]...I would rather pay \$215 supplemental than have to travel because I am 71 years old now.”*

*“I checked with army personnel 5 or 6 years ago, and they said that I was not eligible because of the National Guard, at that time I guess, not included in the army benefit thing, although I did serve 6 months active duty.”*

*“I figured I just wasn’t qualified. I didn’t consider the National Guard eligible. I didn’t think I could do it.”*

**Figure 12. Reasons Veterans Are Not Enrolled in VHA services**



Not all Veterans responded to the final question, **“Is there anything else you would like to tell me about your health care experiences as a Veteran?”** Of the responses provided, 30 were positive and 15 were either negative regarding travel distance to the VA or the lack of local VA facilities, or comments for improvement in the quality of care at the VA. Veterans’ responses included the following:

**Positive Comments:**

*“I would say very good. In fact, I am trying to have the two talk together now, so one knows that the other one is doing. What I’ll do is I have the COPD and I’ll get bronchitis, and*

*rather than travel all the way to [city] to the VA, I'll run over here to [CHC provider]. And then I can use my Medicare and Tricare for life also, so I am fortunate and blessed I guess that I have both. But anything [CHC provider] does, I make sure the VA knows. And anything [VA provider] does at the VA I make sure [CHC provider] knows."*

*"I think they [VA] do a real good job. Excellent care."*

*"My care is good at [CHC] with [CHC provider]."*

*"All my health care has been excellent."*

*"...Once I got to [VA Medical Center], they did an excellent job. It's just the travel was a little over an hour from my house and it wasn't...I mean they did an excellent job. "*

### **Improvement Comments:**

*"I've had cancer for the past year. It was misdiagnosed by my veterans' doctor. I went from October until March before...he thought it was an ear infection, and it was actually cancer of the throat."*

*"I feel like a number when I go into the VA—like I'm taking up the doctor's time. Nobody wants to deal with pain management."*

*"It's very far away though and it has been tough for me to go to a VA facility. If [PTSD] counseling was closer I would go to that. I wish it was local where I could participate."*

### **Discussion**

The Veteran Assessment revealed some interesting findings regarding the Veterans who are served by CHCs. Of those who responded, more than 80% of the Veterans receiving care through the CHCs were aged 45 and over. Less than one-third of the Veterans were actually in a combat or war zone, primarily in Vietnam (43%). 11 percent of the Veterans were uninsured and almost half of the Veterans had served in the Army.

Of the 70 Veterans enrolled in the VHA, most have visited a VA facility (CBOC or VAMC) and most are still using it. Overwhelmingly, the primary services typically sought are for preventive care, including annual physical exams, routine check-ups, and lab work. When asked why they use both the local CHC and the VA for health care, most identified that they use the VA for service-connected conditions and use the CHC for other conditions to include emergent needs such

as treating mild colds. The CHC is typically closer to the Veteran's home and more convenient to use than the nearest VA facility.

Almost two-thirds of the Veterans are not enrolled in the VHA and of these 78% have not even tried to enroll. The primary reason given for not enrolling is that many of these Veterans have other health insurance that covers their needs whether through TRICARE, their civilian employer, or their spouse. Still other Veterans believed they were not eligible mostly due to their time in service whether in the Guard or Reserves or receiving a medical discharge. For those who attempted to enroll but were unable, they were told they were ineligible primarily due to time in service or ineligibility due to income level by a VA representative or member of a local Veterans Service Organization. In some cases, the Veteran indicated they had forgotten or just never gotten around to enrolling or were in the process of doing so. Finally, for some, the travel distance to the nearest VA facility made enrolling not worth it.

With respect to their health care experience as Veterans, of those who responded, most commented favorably regarding the quality of care they received at both the CHC and the VA, even citing certain providers by name. For those who offered comments for improvement, VA quality of care and access to care, particularly long travel distances to VA facilities, were identified.

### **Lessons Learned Regarding Project Implementation and Processes**

- Use one form of technology that has been tested and works on all computer operating systems, such as Skype, to reduce the number of hours spent on technical related issues.
- Remove the responsibility of conducting the interviews from CHC employees, due to their limited amounts of time and difficulty managing project responsibilities while working to deliver patient care in remote locations. Trained project team members should instead conduct the Veteran Assessment to ensure continuity and interview quality.
- Assign a local telephone number to the interviewers for each Skype account created. This may incur an extra cost; however, this yields a higher response rate as a majority of interviewees have caller ID and are reluctant to pick up an unknown number.
- Recognize that numerous calls will have to be made to reach a given target for Veteran interviews. Veteran Assessment calls received a 10% response rate for completed interviews.

## VETERAN PILOT PACKETS

### Methodology

The project team implemented a four-month pilot project establishing outreach and educational programs at the four participating CHC systems. As a part of this pilot project, the project team developed and distributed information packets for CHC intake personnel, their Veteran patients who are already enrolled in the VA, and their Veteran patients who are not yet enrolled in the VA. Each CHC system received a set of packets tailored to its geographic region and designed to facilitate enrollment in VHA, educate Veterans and CHC personnel on health care services available through the VHA, and improve access to and coordination of VHA services for those already enrolled. **Table 3** provides a more detailed account of the respective components of each of the three types of pilot packets for intake personnel, enrolled and non-enrolled Veterans.

CHC intake personnel, who are the front line point of contact for all patients were required to ask whether or not a patient is a Veteran, and were tasked with distributing a pilot packet to each Veteran presenting in the CHC over a four-month period. Project team leaders provided an orientation for all participating staff members in order to emphasize the use and importance of the pilot packets. Intake personnel were offered the following script and depending on the answers to the posed questions, provided Veterans with the appropriate pilot packet for their needs:

1. *"Have you ever served Active Duty in the US Military?"* If **Yes**, then ask:
  2. *"Have you received health care services from VA within the last three years?"*
    - If **Yes**, share enrolled packet
    - If **No**, share non-enrolled packet

Each CHC site received enough packets for one-third of its reported Veteran population. Enrolled and non-enrolled packets were individually numbered so that the project team could track the number distributed at each facility. CHC pilot project training began on March 3, 2011 and pilot packets were distributed until June 26, 2011. Project team members called each facility to receive these reports on a bi-weekly basis starting from March 18, 2011 to June 24, 2011.

The pilot packets included instructions for CHC intake personnel on how to identify and refer eligible enrolled and non-enrolled Veterans to VHA for medical services. Importantly, non-enrolled Veteran packets also included the 1010EZ enrollment form for VHA health care services

and a pre-addressed envelope for returning the form to one of the VISN 5 Rural Health Outreach Coordinators.

The pilot project engaged two VISN 5 Rural Health Outreach Coordinators in strategic efforts to increase enrollment among rural Veterans, to provide informational services and guidance through the enrollment process, and to provide limited case management. Each pilot packet included contact information for the Rural Health Outreach Coordinator responsible for the CHC's particular region. This one-on-one contact with a VA representative proved invaluable to the project's enrollment and care coordination efforts. Each packet also included contact information for VISN 5 VAMC Women's Coordinators from each VISN 5 facility with specific knowledge of female Veteran health care issues.

Other important features of the information packets include a map of all VHA facilities in the surrounding area, as well as a list of local CBOCs with their locations, hours, and services provided. In many cases, the project team found that both Veterans and CHC personnel were not aware of VA clinics or services located as close as a few miles from the CHC clinical site. The informational packets were designed to illustrate the proximity of services for intake personnel, enrolled and non-enrolled Veterans. And, while the enrolled Veteran pilot packet does not assist in enrolling Veterans in VHA services, it does include valuable information for Veterans on resources of which they might not already be aware.

Finally, pilot packets included information intended to enhance personal health record coordination of VHA and CHC health care, such as the VHA medication formulary and information regarding the Blue Button function of the My HealtheVet online tool. The "Blue Button" provides an easy way for My HealtheVet users to input their personal health information in one location, making it possible for Veterans to view, print, or save their personal health information. Veterans can download a file to a location that they choose. The "Blue Button" is driven solely by the Veteran, who decides what information to include as the only person inputting information. With this function, Veterans can show any non-VA provider their personal health records, past and future VA appointments, and self-entered health care providers and health insurance information in a single and customizable file. The VHA medication formulary is a manual containing a list of medicines that are approved for prescription throughout the country, and indicating which products are interchangeable. During project site visits, CHC personnel specifically requested this item, stating that in the past they had prescribed medications that were subsequently filled through the VA and changed to match the formulary. CHC personnel expressed fear over the possibility of dangerous drug interactions when this information is not communicated back to the

CHC primary care provider. Similarly, the Blue Button function of the My HealtheVet online tool can retrieve all of a Veteran’s personal health records, including pharmacy prescriptions. Greater coordination of care is possible when a Veteran is able to print off his or her personal health record and present them to caregivers at a CHC. This way care, particularly pharmaceutical care, does not dangerously overlap.

**Table 3. Components of Informational Pilot Packets for Intake Personnel, Enrolled Veterans, and Non-Enrolled Packets**

	Intake Personnel	Enrolled	Non-enrolled
Definition of the term Veteran	X		
Steps for CHC intake personnel to assist in handing out packets	X		
Contact information for the VISN 5 Rural Health Outreach Coordinators	X		X
Contact information for VISN 5 VAMC women’s coordinators	X	X	X
Service map that shows all VA facilities in the surrounding area	X	X	X
Locations, hours, and services for all VA CBOCs in the surrounding area	X	X	X
Link to My HealtheVet and description of Blue Button function	X	X	X
Link to Online Veteran Eligibility Tool	X		X
1010EZs with pre-stamped envelopes for return			X
Link to VHA Medication Formulary	X		
Priority 7 Income Limits for surrounding counties	X		X

### Findings

The goals of the pilot project were to facilitate enrollment in VHA, educate Veterans and CHC personnel on health care services available through the VHA, and improve access to and coordination of VHA services for those already enrolled. Project outcomes were measured in terms of the number of packets distributed and, subsequently, the number of enrollments resulting from the returned 1010EZs. **Table 4** depicts the total number of packets distributed at each site and in total throughout the duration of the pilot project.

**Table 4. Total Number of Pilot Packets Distributed**

Enrolled Packets Distributed:		Non-enrolled Packets Distributed:	
Choptank	21	Choptank	45
E. A. Hawse	6	E. A. Hawse	19
Preston-Taylor	0	Preston-Taylor	4
Tri-State	29	Tri-State	73
Total	56	Total	141
<b>Total Packets Distributed: 197</b>			

The distribution of these pilot packets shows that the population of Veterans receiving care within the past 3 months at CHCs is demographically similar to those Veterans contacted during the Veteran Assessment. Of the 202 Veterans contacted for the Veteran Assessment, 129 Veterans (64%) were not enrolled, 70 Veterans (35%) were enrolled, and 3 Veterans (1%) did not know their enrollment status. Similarly, of the 197 packets distributed, 141 (72%) were non-enrolled packets and 56 (28%) were enrolled packets. These findings support the project hypothesis that a large percentage of non-enrolled Veterans in rural areas utilize CHCs, and reinforce the importance of providing education on potential benefits and services for eligible Veterans.

**Table 5** shows the enrollments accomplished through the distribution of pilot packets and through the efforts of the VA Rural Health Outreach Coordinators who contacted the Veterans and received and filed the distributed 1010EZs.

**Table 5. Enrollments through Non-Enrolled Pilot Packet Distribution**

	Packets Distributed	1010EZs Returned	Priority Groups Assigned*	Eligible for Health Care Services
Eastern Shore	45	2	2	2
Western Maryland	96	14	11	6
Total	141	16	13	8

## Discussion

As a result of the pilot packet distribution process, the Rural Health Outreach Coordinators succeeded in enrolling eight new Veterans into VHA. These eight Veterans represent 6% of the total number of non-enrolled Veteran contacts made through the pilot packets. It is important to note that informational packets distributed to Veterans at participating CHCs were only able to

\* All Veterans assigned priority groups are counted as enrolled, however Veterans assigned priority group 8g are not eligible to receive health care services.

reach those Veterans who received health care at the CHC within the four-month pilot project period. A total of 197 packets were distributed to Veterans at their local community health center. 141 (72%) packets were distributed to non-enrolled Veterans. 56 (28%) packets were distributed to enrolled Veterans. These percentages show that a large number of non-enrolled Veterans currently receive care from CHCs, but are also potentially eligible for VHA services. In addition, Rural Health Outreach Coordinators established ongoing communications channels that will enable them to continue to enroll Veterans at project sites beyond the duration of the project.

Also key to the level of success of the pilot packet distribution process is the fact that the current process is heavily dependent upon the knowledge, participation, and enthusiasm of CHC intake personnel who distribute the packets. After speaking with staff members at each CHC facility, the project team received a number of suggestions for improving the distribution process and informational packets. As CHC staff distributed the Veteran packets during the intake process, they were able to gauge the reactions and interest level of Veterans who received a packet. CHC staff reported that while many Veterans were interested in the packets, some Veterans refused them or were confused about the overall purpose of the information. In order to combat this confusion, CHC staff were often pulled away from their jobs to answer the Veterans' questions regarding the content of the packets. In addition, while the majority of CHC staff reported they felt they had been given enough information to answer basic questions, answering Veteran questions added to an already heavy workload. Another CHC respondent stated that the packets contained too much information and too many confusing charts. In addition to the 1010EZ enrollment form and Rural Health Outreach Coordinator contact information, the pilot packets included all of the components listed in **Table 3**, and in some cases were 13 pages long. In an effort to combat this issue, one staff member suggested shortening the packets into a single informational letter that would be distributed to interested Veterans, who could then contact a VA Rural Health Outreach Coordinator if they wished. It is paramount that CHC staff are knowledgeable about the purpose and contents of both the enrolled and non-enrolled informational packets, or else opportunities for reaching Veterans may be missed. Other suggestions made by CHC staff can be found in the Lessons Learned section below. These suggestions are important to consider during project replication due to the hands-on role that CHC staff play in the identification of Veterans and distribution of packets.

## Lessons Learned Regarding Project Implementation and Processes

### *Distribution Process*

- Advertise heavily to increase Veteran patient awareness of the project. Ensure that the advertising is eye-catching and appealing to the Veteran.
- Hang a small sign in the reception area of the CHCs stating that Veterans may inquire for additional information at the front desk and display VA material in the waiting rooms. This may reduce the added commitment of asking about Veteran status, as well as help reach as many Veterans as possible.
- Educate intake personnel about the importance of distributing the informational packets to enrolled Veterans. Follow-up frequently during start-up period to reinforce and ensure timely and appropriate distribution.
- Provide enough self-addressed envelopes or labels to cover the number of packets distributed to the CHCs.
- Provide VHA informational pamphlets on VHA services, such as behavioral health care, women's health care, pharmacy services, transportation etc., to CHCs for distribution to Veteran patients in addition to the informational packets.

#### ***Content of Informational Packets***

- Ensure that the information Veterans receive is clear and concise to minimize confusion about the purpose of the packets as well as ensure they are not overloaded with information.
- Provide more localized information inside the packets.
- Change the informational packets to be more appealing to the eye, patient friendly and less data oriented. Some patients were put off by how statistical and data oriented the packets were, and seem less inclined to go through the process.
- Include information on how Veterans can better coordinate their care between CHCs and VHA.
- Develop a simpler process for filling out the 1010EZ, beyond just including it in the packet. Include the "Enrolling for VA Health Care Online" brochure in the packet as an option for enrollment.

## **COMPARISON OF OUTREACH METHODOLOGIES: VETERAN ASSESSMENT AND PILOT PACKETS**

This project implemented two different strategies in an attempt to increase VHA enrollment. Question 17 of the Veteran Assessment asked the 129 Veteran respondents not currently enrolled in VHA and the 3 Veteran respondents who did not know if they were enrolled in VHA if they would like someone to discuss their eligibility for VHA health care with them. The names of the 87 Veterans (66%) who replied that, yes, they would like someone to contact them to discuss their eligibility for VHA health care were captured during the Veteran Assessment and compiled upon completion of the interviews. The list of interested Veterans was given to the VISN 5 Rural Health Outreach Coordinators, who then contacted all of the individual Veterans. The Rural Health Outreach Coordinators mailed 1010EZs with return envelopes to the eligible Veterans, assigned priority groups once the 1010EZs were returned, and finalized enrollment. The final outcomes of this approach can be found in **Table 6**, together with a comparison to the outcomes from the pilot packet methodology.

**Table 6. A Comparison of Project Methodologies for Enrollment**

	Veterans Reached	1010EZs distributed	1010EZs Returned	Priority Groups Assigned	Eligible for Health Care Services*
Veteran Assessment, Question 17					
Choptank	13	7	1	0	0
E. A. Hawse	20	14	5	4	2
Preston-Taylor	13	12	2	2	0
Tri-State	13	10	3	3	3
Total	59 <sup>†</sup>	43	11	9	5
Total as a percent of Veterans reached:	100%	73%	19%	15%	8%
Pilot Packets					
Eastern Shore	45	45	2	2	2
Western Maryland	96	96	14	11	6
Total	141	141	16	13	8
Total as a percent of Veterans reached:	100%	100%	11%	9%	6%

## Discussion

Because the two methods of outreach and enrollment – the Veteran Assessment and Pilot Packets – vary greatly in terms of ease of use, cost, outcomes and a number of other pros and cons detailed in **Table 7**, it may be a worthwhile exercise to compare and contrast the two methods for future project replications.

Overall, the Veteran Assessment was marginally more successful in enrolling Veterans than the Pilot Packets. As a result of the Veteran Assessment, 15% of the Veteran population reached was newly enrolled in VHA, while 9% of the Veteran population was newly enrolled in VHA as a result of the Pilot Packets. In addition, a significant percentage of Veterans who received 1010EZs from the Veteran Assessment and through the distribution of Pilot Packets returned their 1010EZ enrollment forms and were assigned a priority group. Again, the Veteran Assessment was more successful than the Pilot Packets in the percentage of 1010EZs returned and the

\* The column showing new enrollees includes Veterans who have been fully vested as well as those who are scheduled for the physical necessary to have before being fully vested. This column does not include those Veterans assigned priority group 8g as they are not eligible to receive health care services from VHA.

† While the Outreach Coordinators were able to contact 60 Veterans identified by Question 17 of the Veteran Assessment, some Veterans contacted were not sent 1010EZs. Some were already enrolled in VHA services, some were ineligible, and a few Veterans were only interested in dental services.

percentage of priority groups assigned. The outcomes of both enrollment methods can be found in **Table 6**.

The success of the Veteran Assessment in enrolling Veterans into VHA can largely be attributed to the fact that this enrollment approach is highly personalized. Specifically, Veterans were only contacted if they responded, yes, to Question 17, and they had a designated point of contact in the Rural Health Outreach Coordinators, who, as enrollment specialists, were best equipped to assist them during the enrollment process. While VA is generally thought of as a large, bureaucratic institution, this strategy was intimate and personal, and simplified a complex process. The Rural Health Outreach Coordinators not only aided the Veterans in the enrollment process, but were also available to assist the Veterans in understanding their benefits package. In addition, this process did not require Veterans to make multiple trips to a VA hospital because they were able to easily communicate over the phone with the Rural Health Outreach Coordinators. Furthermore, Question 17 of the Veteran Assessment increased Veteran awareness in ever-changing VHA eligibility requirements. It may be to the Veteran's benefit to stay informed and aware of VA eligibility guidelines because they may become eligible in the future for additional VA services. Finally, Question 17 of the Veteran Assessment allowed first interviewer and then Rural Health Outreach Coordinators to proactively contact and follow-up with the Veteran, whereas the pilot packets relied on the Veteran to complete and mail the 1010EZ form to the Rural Health Outreach Coordinator before the enrollment process could be initiated.

The Veteran Assessment only reached a small proportion of Veterans, so while the process was intimate, in order to maximize results it would need to be replicated on a larger scale. Furthermore, confusion sometimes arose when interviewers did not read Question 17 verbatim, causing Veterans to not understand the purpose of having the Rural Health Outreach Coordinators contact them. Therefore, it is important to train interviewers to read assessment questions verbatim as well as understand the entire process, so they can answer questions the Veterans may pose during the Veteran Assessment. In fact, the best scenario is to utilize the project team to administer the patient assessment.

In contrast, the Pilot Packets were slightly less personalized than the Veteran Assessment, because they were distributed by CHC personnel and were not accompanied by a telephone call from the Rural Health Outreach Coordinators. However, the Pilot Packets were custom made for the three target groups: enrolled Veterans, non-enrolled Veterans, and CHC intake personnel, and they did contain the contact information for the Rural Health Outreach Coordinators, allowing interested

Veterans to take proactive steps to receiving services. In addition, the packets included a great deal of valuable information that the target groups were able to review and process on their own. Survey participation was not required, unlike the Veterans who completed the Veteran Assessments, as the packets were distributed to Veterans during scheduled visits to their CHC.

Furthermore, the packets were invaluable as educational outreach tools. Information inside the packets increased the target groups' knowledge of VA benefits, services, locations, and hours. By including a breadth of information in the packets, they potentially answered questions that the Veterans and intake personnel did not realize they had. In addition, the packets potentially reached a greater number of Veterans while using fewer human resources than the Veteran Assessment, which only reached 10% of the Veteran population in each CHC system. However, the distribution of the packets did depend upon Veterans coming into the CHCs within the four-month trial period, so in order to maximize results the packets would need to be distributed on a continual basis.

While non-enrolled Veteran pilot packets were supposed to be distributed with a return envelope for 1010EZs, this did not always occur, which potentially diminished the return of 1010EZs to VA and thus limited further enrollment. Finally, the CHC intake personnel were confounding factors that greatly influenced the distribution of the packets. The intake personnel had to offer the packets to the Veterans, and if they did not, the Veterans would not know to ask for them. Therefore, it is vital to ensure that the intake personnel understand the importance of distributing the packets.

In conclusion, both methods reached a similar proportion of Veterans and each have a number of pros and cons to assess when designing future enrollment strategies. The project team's ability to replicate the Veteran Assessment using the set up in **Appendix 7** is simple, because all of the technology has been tested and proven to work, assuming the project team administers the patient assessment. In addition, many of the start up costs, such as the cost of headsets, disappear during replication. The online software has already proven to be useful and cost-effective. In contrast, the Pilot Packets would be more difficult to replicate, because while the packets have already been constructed, they would need to be tailored to new geographic regions and undergo revisions based upon the feedback received during the evaluation process. In addition, the new packets would need to be printed and delivered to the CHCs, where a project team member would need to train CHC staff on the content of the packets as well as the method of distribution. Overall, while both strategies have their strengths and weaknesses, both strategies have proved to be successful in improving rural Veteran enrollment in VA.

**Table 7. Pros and Cons of Enrollment Strategies**

Enrollment Strategy	Results	Pros	Cons
Question 17 Veteran Assessment	19% of 1010EZs returned	<ul style="list-style-type: none"> <li>• Personal and intimate process</li> <li>• Proactive ability for VA Rural Health Outreach Coordinators to contact Veterans</li> <li>• Increased Veteran awareness of changes in eligibility status</li> <li>• Opportunity to explain VA benefits package</li> <li>• Easily replicable given project findings</li> </ul>	<ul style="list-style-type: none"> <li>• Dependent on Veteran acceptance to participate in the Veteran Assessment survey</li> <li>• Limited reach to only 10% of Veteran population (exclusive to this project)</li> <li>• Dependent on skill of interviewers, e.g., they may not read Question 17 of the Veteran Assessment verbatim</li> </ul>
Pilot Packets	11% of 1010EZs returned	<ul style="list-style-type: none"> <li>• Simple process</li> <li>• Customized packets</li> <li>• Educational outreach tool</li> <li>• Increased awareness of VA benefits, services, hours, and locations</li> </ul>	<ul style="list-style-type: none"> <li>• Distribution depended upon Veterans coming to CHC</li> <li>• Distribution depended upon CHC intake personnel</li> <li>• Distribution of return envelopes with packets not uniform</li> </ul>

### TASK 3. IMPROVE COORDINATION OF CARE BETWEEN CHCS AND VHA

This initiative established ongoing communication channels between CHC staff, Rural Health Outreach Coordinators, and other VISN 5 staff. During the period of performance, the project team visited each CHC participating in the pilot project. Project team members performing these visits conducted interviews with appropriate CHC management to obtain all necessary background information and enlist the support of CHC staff. The project also engaged two VA Rural Health Outreach Coordinators to establish relationships that could enable CHCs and VISN 5 to improve coordination of care, as well as establish ongoing communication channels for referring Veterans to eligibility certifying personnel and VHA medical services.

As part of this task, the project team recommended appropriate changes and follow-up procedures to improve collaboration between CHC staff and designated VISN 5 personnel, including recommendations for improving the CHC intake documentation process. Through site visits and interviews with CHC personnel, the project team found that although CHCs are required to report the number of Veteran patients they serve to the UDS, at times the question as to

whether or not a patient is a Veteran is not asked or is not well understood by the patient. And, when intake personnel do receive accurate information regarding a patient's Veteran status, at times that information is not communicated to the primary care provider. Knowledge of Veteran status becomes especially important for Veteran patients suffering from post-traumatic stress disorder and other mental health conditions in which the VA has particular expertise, or when Veterans are using the two systems of care simultaneously.

Finally, the project team conducted three Veterans focus groups to better understand some of the reasons why and how individuals use both VHA and CHC systems of care.

## **ASSESSMENT OF CHC INTAKE PROCESS**

As a condition of funding, all CHCs are required by HRSA to report data on special populations, including migrant and seasonal agricultural workers, homeless patients, school-based health center patients, and Veterans. There is no standardized process in place to ensure Veteran patients served by CHCs are accurately identified, but it is expected that this data is collected during the patient information/intake process at each Center. Moreover, it is unclear who should ask patients about their Veteran status and at what point during the intake process this should occur. Furthermore, CHCs are asked to report only those individuals who affirmatively indicate they are Veterans, and persons who do not respond or who have no information are not counted, regardless of other indicators. Individuals asked about their Veteran status, particularly female or noncombat Veterans, may not recognize their own status and provide incorrect answers.

Many CHCs do not have electronic medical records (EMRs), and rely on paper and pencil methods to record patient information, thereby increasing the potential for errors and inconsistencies when collating the data at the end of year for reporting. CHCs also use different practice management systems with different report generating capabilities, which may create potential inconsistencies in the ways they collect Veteran data. There are many possible factors affecting the accuracy and reliability of the reported numbers of Veteran patients served by CHCs and it is suspected that Veterans are undercounted.

### **Methodology**

Project team members conducted site visits to each CHC system in order to evaluate the patient intake process, including identification of Veteran patients and communication of that information to CHC providers. The purpose of the assessment was to look for consistency and variation among the sites regarding the manner in which they gather specific information on Veteran status

at the time of first intake as well as during annual updates of patient records. Interviews were conducted with CHC administrators, case managers, and front desk personnel. The case managers who were interviewed work with low-income or uninsured CHC patients to ascertain their potential eligibility for other supported and entitlement programs. See **Appendix 8** for the list of questions used during the intake process interviews. These interviews were recorded and transcribed. After reviewing the transcriptions, the project team created recommendations, listed below, for intake procedures that will assist in the identification of Veterans who may potentially be eligible for benefits with VA.

## Findings

Each of the CHC systems is currently in the practice of asking new patients about their Veteran status, with varied success. One front desk worker interviewed stated that she and her team had been in the habit of asking each patient for Veteran status, but had gotten out of the habit due to a change in intake software that placed Veteran status on a page with sliding fee scale information, that isn't necessary for all patients. The respondent stated that this pilot project was beneficial as a reminder of something they should always be doing.

As expected, each CHC system stated that it identified Veterans by simply asking, "Are you a Veteran?" However, multiple interviewees described general uncertainty over the definition of Veteran. One interviewee stated, "We ask if they're a Veteran and a lot of times they don't know what qualifies to be a Veteran. [They say] 'I served but I was never in any wars.' So we actually do tell them 'yes, you qualify as a Veteran.'" Because CHC personnel have limited knowledge of the VA, they are often unable to clarify the question for potential Veteran patients. Also as expected, no CHC system reported asking identified Veterans follow-up questions, such as "are you enrolled for VHA benefits?" One interviewee suggested implementing a nearby computer interface or paper questionnaire, so that they could easily identify potentially eligible Veterans.

Currently, none of the CHC systems report annotating Veteran status on a medical chart; however, there were multiple suggestions for ways of communicating Veteran status from intake personnel to CHC providers. Those CHC systems still primarily using paper records currently use stickers on each patient chart to signify allergies or reactions to medications, and there was general support for another sticker which would identify Veterans. Conversely, one respondent expressed concern over placing too many stickers on a chart and making a patient feel "labeled." Those CHC systems using electronic medical records also had suggestions. Staff suggested the use of their electronic pop-up notifications. Another front desk interviewee described the use of their

electronic alert system, which is functional across the front desk, clinicians, and billing, as a way to create an alert pertaining to a patient's Veteran status.

All respondents agreed that regularly identifying Veterans, asking additional questions, and passing out information about Veterans would not add an overwhelming amount of work to front desk and other intake personnel. All respondents also stated that these processes could be easily implemented. Some systems reported current practices that may already assist in identifying Veterans. A respondent detailed a process where each afternoon one front desk staff member goes through the charts of patients scheduled for the following day and attaches a preprinted, color coded, and laminated card to each patient chart requiring verification or updating of patient information. These color-coded cards also have the needed information printed on the card. The card to alert the front-desk staff to ask about Veteran status is red with Veteran status clearly printed on the card. This system saves time, as the front desk receptionist does not have to leaf through the chart looking for missing information when the patient comes in. Another respondent stated that their staff make a note card with a list of things to review for each patient chart, which does not currently, but could later include Veteran status.

Furthermore, one CHC has case managers and another has patient services coordinators that work one-on-one with patients of low-income and limited or no insurance to assist them in finding programs to help cover their medical costs. CHC administrators described these programs as helpful and successful and a possible way to assist identified low-income Veterans. With the potential for participation across staff members, multiple respondents also noted the importance of further meetings for all participating CHC staff for educational purposes as well as to make the process of identifying and passing information out to Veterans more cohesive. An interviewee stated that, "If there's like more people involved in it and there are multiple steps, then there's a chance it's being overlooked." One respondent also stated that, "money talks" and would be helpful in increasing CHC participation. Finally, a respondent noted the dedication of CHC staff to Veterans and patients in saying, "they've been our patients on the other side of the window caught in a vicious insurance cycle or caught up in something they didn't have any help with so [CHC staff are] more willing to help."

## VETERAN FOCUS GROUPS

To augment the information gathered in the Individual Veteran Patient Assessments, Rural Veteran Focus Groups were held in three of the CHC systems in the pilot.

### Methodology

These Focus Groups were held one each at the Mt. Storm Health Center (Preston-Taylor CHC), Baker Health Center (E. A. Hawse CHC), and the Denton Administrative Site (Choptank CHC). The purpose of these focus groups was to examine the way Veterans make decisions about their health care and navigate their health care options by exploring their responses in three areas: awareness, accessing and utilizing health care, and satisfaction with current services. These focus groups were structured under a standard protocol process in which the same questions were asked of all groups and all members, responses digitally recorded, and participants remained anonymous in the transcription and final report. Project staff drafted and explained to participants ground rules for participation, and each focus group question was written on a flip chart that could be seen by all participants. Focus group participants responded to each question according to a round robin technique and each participant was asked to state his/her name each time he/she responded to allow the transcriber to become familiar with the participants' voices. Upon transcription, all respondents were made anonymous and this process was explained to the participants. A seating diagram was made for each focus group session and the same facilitator ran all three groups. The list of focus group questions and a demographic card used to collect basic participant information can be found in **Appendix 9**. These focus groups were recorded and transcribed for coding and analysis.

A variety of methods were used to recruit participants for the three Focus Groups, and to encourage a diverse group of all ages and both genders to attend. The Veteran Assessment telephone interviews included a question about the Veteran's interest in attending a focus group (this question was asked only of those Veterans who were served by one of the clinic sites where focus groups were to be held), and formally invited through a mailed invitation from a Health Center System Administrator. Focus group flyers were also placed around the community in an attempt to broaden the pool of potential Focus Group participants. Six participants were recruited by this method and these veterans were enrolled in the VHA and used this system of care exclusively. Veteran participants were given a \$100 stipend as an incentive for their participation and to defray their gasoline costs or missed work hours. Mailed registration forms were sent to the Focus Group Facilitator, others were registered by phone or by face to face contact at the CHC site; others responded to the flyers by calling the Focus Group Facilitator whose name and cell number was listed on the flyer. This same contact number was included in

the invitation letter and form mailed to the Veterans on the CHC's contact list. Two days prior to the scheduled focus group, the facilitator called each registrant to give them more information about the purpose of the focus group, respond to any questions about the process, reconfirm the time and location of the session, and to give them driving directions to the location if needed.

Upon their arrival at the focus group location, Veterans were asked to fill out an anonymous demographic card and sign an informed consent form required by NACHC as contractor, stating that they are aware that their commentary was being recorded and that their statements might be anonymously used in the final report. This form was signed by the Focus Group Facilitator, the NACHC project lead, and the Veteran participant and was used as the primary documentation and confirmation that the Veteran received the \$100 stipend.

## Findings

The Focus Groups recordings were transcribed, coded, and analyzed for themes. Veterans who wanted to make individual statements at the end of the Focus Group were allowed to do so and these personal statements were transcribed and analyzed as well. There were a total of 36 Veteran participants and three spouses in attendance at all three Focus Groups. **Table 8** details the demographic information collected on all participants at the beginning of each Focus Group session.

**Table 8. Focus Group Demographics**

	Total participants	Gender		Year of Birth			Enrollment Status			Ethnicity/Race	
		M	F	Prior to 1945	1946-1955	1956-1975	Enrolled	Non-enrolled	White	Black/African-American	
Choptank	12	12	0	5	3	4	4	8	6	6	
E. A. Hawse	17	14	3	4	7	6	7	10	17	0	
Preston-Taylor	7	5	2	3	3	1	1	6	7	0	
Totals	36	31	5	12	13	11	12	24	30	6	
Percentages	N/A						33%	67%	83%	17%	

All three Focus Groups identified similar themes and no differences among the issues were revealed among the three groups. The themes and trends found in the Veteran Assessments were confirmed in the Focus Groups. The project team has concluded the following as the major themes and trends for the rural Veterans in the Focus Groups:

1. There is considerable confusion over personal eligibility for VA and VHA Benefits. The most common misperception about eligibility is that, to be eligible for benefits, the service member had to have served in a war. Among women Veterans, there was a misperception that they were not eligible because of their gender.
2. There is also considerable confusion over where to get the most accurate information on eligibility for VA and VHA benefits. Some Veterans reported getting information from local Veterans Service Organizations and the local Veteran Representative of the State Department of Veterans Affairs. Others reported that word of mouth by family members and others in their rural communities was the best vehicle for increasing awareness regarding the best ways to contact the VA and the types of services available.
3. Most Veterans reported that their primary access issue with VHA services was the distance and time it took to get to these facilities for primary care services. The travel distances to the closest VAMC for all these participants was between 1.5 to 3.5 hours and to the closest CBOC was between 45 minutes to 2 hours. All participants lived in mountainous terrain and on secondary or unpaved roads.
4. Some Veterans reported that the driving time and the waiting time to be seen by their caregiver and then return home was a deterrent to their use of the VHA, especially if they had to take time off from work to keep these appointments. Also the lack of consistent mental health services (especially reported by one woman veteran who reported Military Sexual Trauma (MST) while on active duty ) was a frustration and deterrent to accessing VHA services.
5. When asked about utilization of services, those Veterans who use both systems of care reported that they did so in order to obtain primary care services close to their home, lab work, and/or dental care, or other services not offered by the VHA. Those who were disabled or who used the VHA regularly preferred to get their specialty care at the VA Medical Center (VAMC) or through a fee for service contract to VA referred providers and get their primary care at the CHC. Others used the VHA for their pharmacy benefit and the CHC for their primary care.

6. Those Veterans who used VHA exclusively used the VAMC and the CBOCs for all levels of care, as well as those providers to whom they were referred by their VHA physician under a fee for service contract. The six Veterans who reported this utilization were recruited to the focus groups as a result of flyers around the community or brought along by other Veterans.
7. Most Veterans reported a high level of satisfaction with both systems of care. This was reported regardless of whether the Veteran used both systems of care or one system to care exclusively. Their satisfaction reports were most closely associated to their relationship with their provider regardless of the challenges they felt with the bureaucracies or wait times within either system of care.
8. The Veterans and family members who attended the groups were positive about their experience with the Focus Group, the awareness they gained from the project members, and especially the mutual support and learning from each other.

### **Representative Responses to Focus Group Questions**

Comments below are perceptions, not statements of fact. During the focus group, some misconceptions were corrected and veterans were given information on proper VHA resources.

#### **1. How do you learn about the services of the VA in general?**

Respondents stated that they learned about VA services through other family members, friends, and community members who are Veterans, providers and other medical staff, and CBOC open houses. Veterans also received information from Veterans Service Organizations like VFW and American Legion which publish informative magazines.

Specific comments include:

*"I found out a lot of information through the local VFW. There's a good chain link of information going on, a good network of information, so that's where I get it from, and now through the VFW and the American Legion, as a matter of fact through the magazines."*

*"I speak also to [CHC provider] and I obtain other information from your various magazines at the VFW and American Legion."*

*"Like [name of Veteran removed] I went down to [city] to the Open House that day and I filled out the papers and I sent them in."*

*“I learned about it through other family members, people in Korea, a brother in Vietnam.”*

*“I have a brother-in-law who is retired Army and if there’s any changes he gets like Army Times or something like that and he’ll call me and tell me, “Hey, did you know this was happening?”*

## **2. Do you know if you are eligible for VA benefits?**

The majority of Veterans were not aware of their individual eligibility for benefits. A number of Veterans attempted to enroll for VA benefits, but were told they were ineligible due to income.

Specific comments include:

*“Yes I do know I’m eligible for them right now and the paperwork’s in to sign up. Also I have a claim because I came down with what is it – myocardial ischemia.”*

*“I got out on a general discharge, but they told me when they released me that I could go to the Red Cross after I think a year or something and get it upgraded to an Honorable Discharge and all the benefits but I never checked into it.”*

## **3. Have you ever attempted to apply for VA benefits? If so, where? What was the outcome?**

A large portion of respondents have previously attempted to apply for VA benefits but multiple Veterans were told they were ineligible due to income. A few Veterans had not made any attempt to enroll.

Specific comments include:

*“I never applied because I didn’t think I was eligible.”*

*“I applied three times. I applied through the [CBOC] and was denied because of my income. I applied through [a different CBOC] about a year later, was denied again because of my income and applied about a year later through [CBOC] again and was denied because of my income.”*

*“I applied twice at [CBOC]. They denied me and they really didn’t give me a reason until I went to [city] and had some lady out there at the VA Hospital tell me that I made too much money.”*

## **4. What is your preferred health center where you receive most of your care?**

A large number of Veterans preferred their local community health care center, however respondents show mixed preference for VA CBOC/VAMCs and health centers.

Specific comments include:

*"I like the [CBOC]. That's where I do most of my health care. I just go twice a year every six months for check-ups, and then in between if I get sick I come to [CHC provider] here at the [CHC]."*

*"I receive most of my health care from the [CBOC]. That's my primary care and I felt that I've had excellent care there."*

*"This is my primary with [CHC provider] and [CHC provider]. I don't know what we're going to do if [CHC provider] ever decides to retire or whatever. We're all going to be hurting I guess. He's a very good physician. He's easy to talk to and everything."*

**5. If you are enrolled in the VA do you use both the VA and the Community Health Center?  
Can you tell us more about that?**

Of those enrolled, most use their local CHC, however a small number go to the VA to fill expensive prescriptions. Rationale for using both includes travel distance to VA, ease of getting appointments, being able to "walk-in" at the CHC, lack of gender-specific services, access to medical equipment, and the provision of dental services (offered through CHC).

Specific comments include:

*"I'm enrolled in the VA. I only use [CHC]. Once again I always thought the VA was pretty much for people who were in very bad condition monetarily-wise and physically. I thought it was combat-related."*

*"If you go to [CHC] they give you a prescription and if you're under any kind of disability the VA will pay for your prescriptions like \$8. "*

*"If I get sick and I don't want to drive to [CBOC] as a walk-in I come up here to see [CHC provider]."*

*"If you wanted to go to [VAMC] on the van...my husband done that a couple of times. Well we live in [city]. He had to get up at 3 o'clock in the morning to get to [city] by 6 to catch the van out and then he was gone all day long and then he didn't get home until around 7 or 8 o'clock at night. That makes it rough, especially if you have health problems."*

**6. Do you experience any challenges or barriers in accessing health care? If so, what challenges or barriers do you or have you experienced in getting care from the VA? From this health center?**

A large number of Veterans identified no barriers to care, and multiple respondents mentioned financial concerns regarding medical expenses incurred. Barriers to care at VA identified during the focus groups include travel distance to VA, perceived lack of women's health services and equipment, loss of VA health records, access to dental care, lack of female counselors for MST.

Specific comments include:

*"...They didn't file this with the Medicare and Blue Cross and they wouldn't honor it. [I] not only didn't get my \$2,000, but they had a very severe fine they took out of Social Security. What I'm trying today is if you go in and you do have private care like I did and they do take care of you, you want to get a receipt and follow through to make sure that your own private medicine is taken care of."*

*"My barrier is that the insurance I've got stopped paying for blood work and the blood work I get done runs around \$500 almost \$600 and the insurance wouldn't pay anything."*

*"Well the only thing I have is the distance that we have to travel, and if we could have it here it would be a lot easier on us to get our care."*

*"I just wanted to say that I wish the VA had women psychologist or whatever... and its hard to talk to a man doctor so I always cancel my appointments." [Statement of a female veteran who reported experiencing military sexual trauma (MST) while on active duty].*

**7. What have you heard from other Veterans in the community about their experiences in accessing and using VA services? What are the perceptions among Veterans and their families about who can use the VA?**

Most comments about VA health care have been positive. Suggestions for improvements were with respect to travel distance to facilities and potential access issues for Guard/Reserves. Many Veterans also have the perception that all Veterans should be eligible for VA health care even if they have to pay a co-pay based on income level.

Specific comments include:

*"I know a lot of Veterans here [location] and most of them don't go to the VA to try to get help because it's too far for them to drive or whatever."*

*"...Most people I've talked to and have experience with are World War II Veterans, family members, Vietnam and Korea, everybody is happy if you take the time to go down and follow through with things."*

*"There's a lot of vets where I work at and I talk to them and a lot of them that's been in the regular service they can get benefits, but it seems like the ones that were in the National Guard and Reserves it's kind of hard trying to get medical and stuff."*

*"I have a brother older than I am and he uses the Veterans also. He's always had good words to say about them and he gets his hearing aids from them and his medications. And then I had a brother that served in Vietnam and he died when he was 47 from Agent Orange and they took care of him most of the time."*

*"I think most people...non-Veterans have the perception that the Veterans receive all benefits...And that probably should be publicized more than it is to let everybody know and in some Veterans' eyes we don't think we're being treated fairly."*

*"My thinking always was that it should have been available to everyone and even though your income may have exceeded the limitations that they had set that by a copay you should be able as a Veteran to still go there and pay a copay even though your income is exceeding what they determine... When you're a Veteran you're disappointed that you're kind of blocked out."*

*"I'm sitting here with two friends and I'm in the health care system. [Focus group participant] and I work for the same company and make very similar money yet I'm in because I got in early...Now I come out later friends here are not accepted and it's kind of disheartening to know this. To me it's discrimination in one way form or another."*

**8. Within the past three years, have you been seen by a physician or other provider at the VA and if so, for what services?**

Veterans who attended the focus groups, received care at a VHA facility for blood work, heart health, sleep test, diabetes care, routine check-ups, knee replacements, medication, hearing, sleep apnea, gastritis, psychiatric care, and radiation after diagnosis of Hodgkin's Lymphoma.

Specific comments include:

*"I go down there for blood work every six weeks and I take blood thinners because I've got clots in my arms and legs and I go down there for a blood test and for my heart about every three months."*

*“I’ve had two knee replacements and I’ve been to my primary care provider for my normal meds. I’m a diabetic and believe it or not I’ve got gastritis and had to visit the emergency room in [city].”*

**9. What are the reasons you seek care both at the VA and the health center? Do you know other Veterans who get some of their care at the VA and some at the health center? If yes, do you know why?**

Reasons given for using both systems of care include the convenience of using local CHC, travel time/distance to VA, the fact that the whole family receives care through CHC, access to dental services and pain management services not available at VA, and need to have lower health costs by using VA.

Specific comments include:

*“I don’t use both systems. I use strictly the VA. The reason why is if I come to the clinic out here and I need another test run it may be the next day or so before they can get the orders in and stuff to have that test run. When I go to the VA as a walk-in or emergency or even as primary care they send you right up to the lab or they send you right up to the X-ray.”*

*“There’s a lot of times my wife and myself both deal with [CHC provider] and [CHC provider].”*

**10. Please describe how satisfied you are with the health care services you receive at the health center. Please describe how satisfied you are with the health care services you receive at the VA.**

All Veterans expressed satisfaction with their local CHC, while satisfaction with VHA facilities varied. In many cases, family members also use the CHC and are satisfied as well. Many Veterans had limited experience with VA as they don’t use it. Opportunities were also identified for improvements in the VA, including access to more female MST counselors and quality of care. Two Veterans reported that without post-op care and attention from their wives, they believe they may have died in the VA hospital.

Specific comments include:

*“No services at the VA, haven’t used it yet, but with the [CHC] I’ve had very good service over there. They’ll pretty prompt and responsive.”*

*"[CHC] is very adequate, friendly service. I really enjoy going there. The VA doesn't apply to me."*

*"I'm very pleased with the service I get at the VA plus the service that I get here at the Community Health Center. I never have any trouble getting an appointment when I call."*

*"At the VA Clinic in [city] I feel that I get excellent care. The people are friendly, courteous. I get in on time and sometimes I'm even out before my appointment is due if I'm lucky, but they're so nice down there and they seem to care."*

**11. Please describe how satisfied you are with the health center's ability to accommodate your family members and to involve them in your care. Please describe how satisfied you are with the VA's ability to accommodate your family members and to involve them in your care. Do your family members receive their care from the health center or clinic?**

Veterans with family members expressed satisfaction with the CHC and comments were positive regarding the VA's and CHC's involvement of family into the care of the Veteran.

Specific comments include:

*"I come here of course and so do my son and his family and we receive appropriate care and so we're completely satisfied."*

*"My wife and I we're very satisfied with [CHC provider] and [CHC provider]... I even have a daughter in [city] and she even comes up and sees [CHC provider]. She's not happy with the doctors in that area so she's very happy with her care of up here."*

**12. Are there other members of your family who are veterans? Do they receive care from the health center or VA or both?**

Most respondents have family members who are Veterans including parents, children, in-laws, grandchildren, and siblings. Some receive VA care.

Specific comments include:

*"My father and my oldest son and my father-in-law are all veterans and my father-in-law and father we're trying to get them in the VA system and everyone keeps rejecting them..."*

*"I've got two grand-children that go to the VA."*

*"My wife has two brothers that were career Army and they both of course use the VA."*

*“My son was in the Marine Corps but he’s not enrolled in the VA. I don’t know that he actually tried, although income would be a factor with him too.”*

## Discussion

The focus groups were conducted in such a way as to allow Veterans to express their thoughts and concerns in an open setting with the support of their peers. For example, during the focus groups Veterans reported confusion over whether or not they were personally eligible for VA and VHA benefits and expressed their frustration in attempting to locate the eligibility information and reported impatience with the bureaucracy when attempting to enroll. The project team recognizes that access barriers can cause frustration, especially when coupled with other personal or social issues such as Vietnam Veterans’ lingering anger over having been drafted to serve in an unpopular war. The Veteran Assessment was not structured in a way to obtain this information however, the freer form of the focus group allowed Veterans with these feelings to express them during and after the sessions. In all three focus groups, there was a considerable amount of learning across the generations of Veterans, and between the enrolled and non-enrolled Veterans. At the end of one session, one Vietnam Veteran who has been using VHA for some time, shared with other non-enrolled Veterans that he, too, had these same frustrations, but fortunately he was able to resolve them and get the necessary help by “not letting that attitude stand in my way.”

Women Veterans attending the focus groups were active participants and shared a number of personal experiences with their fellow Veterans. After the focus group, upon being approached by project members, women Veterans also engaged in lengthy discussions regarding their concerns rather than bringing these personal issues up during the focus group session. This could be related to their low numbers as well as the content of the issues they shared. In addition, wives of multiple Veterans attended the focus group and participated in the discussion, but also tended to share more freely with the project staff following the sessions than during the sessions. These wives reported frustration and concern for their husbands due to their lack of knowledge about the system and not knowing exactly how best to help.

During the focus groups, the project team learned that a number of rural Veterans, who had not previously explored their eligibility, did so due to a number of misconceptions about VHA services. Some believed that there were other Veterans in greater need and they were concerned that they might take services away from more needy Veterans, while others believed that VHA health care was reserved solely for Veterans with service related injuries. While this was not a specific question in the Veteran Assessment or the focus groups, it did come up in the

barriers to care discussion during the focus groups. It is also an issue that may merit further exploration.

During the focus groups and Veteran Assessment, time and distance were consistent access barrier themes reported by rural Veterans who use VHA services or decided not to enroll. The majority of employed Veterans reported that they found it necessary to take off a full day or two from work when utilizing VHA services due to the travel distance and time receive care. Likewise, Veterans who are retired or otherwise not working and receiving disability compensation from a service related condition, face the same distance and time barriers, and reported that receiving care from VHA can feel like “a full time job.”

The majority of Veterans however, reported high levels of satisfaction with the care they receive from both the CHC and the VHA regardless of how they use these systems of care. Those who use both the VHA and CHC, most often use the CHC for their primary care and the VHA for their subspecialty care. Some use the CHC for dental care and the VHA for pharmacy benefits. The Veteran’s positive relationships with their providers often made the most difference in terms of what system they use and what barriers they are willing to overcome to receive health care. The Veterans who had a positive relationship with their provider reported the highest level of satisfaction with their care, in either the CHC, VHA, or both. Finally, the attending Veterans and family members were positive about their experience with the focus group, the awareness they gained from the project members, and especially the mutual support and learning from each other.

### **Lessons Learned Regarding Project Implementation and Processes**

- Encourage focus group participants to arrive 15 minutes early in order to fill out the necessary paperwork. This will allow focus group administrators to ensure all paperwork is turned in and that the focus group can start on time.
- Encourage Veterans to bring their wives or caretaker with them to the focus group if they so choose. This proved very helpful for older Veterans with hearing impairments or memory challenges.
- Focus groups should be conducted by trained facilitators, digitally recorded, and transcribed. All recording equipment should be checked multiple times and facilitators should be prepared with back-up systems and extra batteries.

- Conduct personal phone calls to follow-up on mailed invitations, increase the comfort level of the Veteran and increase the number of participants. Some registered Veterans asked if they could bring other Veterans. This was allowed as long as the Focus Group size did not exceed 18 participants.

## RECOMMENDATIONS

The following section recommends approaches that VISN 5 and VHA might consider to expand collaborative efforts with CHCs. The section is organized according to the project's goals of increasing VHA enrollment, improving data collections by CHCs, improving outreach and education, establishing communications channels, and developing a framework for clinical collaboration. An underlying theme throughout the recommendations is the importance of building and maintaining personal working relationships amongst CHC and VISN partners. Personal interaction is valued in rural communities and is seen as representative of sincerity and commitment. When this value is respected, both rural patients and rural health providers are more likely to engage in collaboration and to take steps toward some mutual goal. Site visits and personal follow-up phone calls by the Rural Health Outreach Coordinators produced enrollments that may not have been possible through the use of impersonal methods such as the internet, direct mail, or other forms of public communication. This section highlights ways for VHA to build relationships of trust with CHCs and generally improve the project upon replication.

### **INCREASE ENROLLMENT**

- Due to the findings of this project that Veterans, particularly non-enrolled Veterans, are a captive audience at CHCs, the project should be replicated on a larger scale using personal site visits with CHC administration and providers, telephone interviews, and the informational packets to provide information and increase enrollment.
- Prepare and distribute guidebooks, tailored by region, to CHCs to provide information on where and how CHCs can refer Veterans potentially eligible for VHA services to VHA.
- Provide CHCs with 1010EZs and envelopes addressed to the Rural Health Outreach Coordinator and encourage the Outreach Coordinators to accompany the delivery of 1010EZs and envelopes with a site visit to the CHCs.
- Encourage CHCs to rubber stamp 1010EZ forms with the name of the CHC and always return completed 1010EZs to the same Outreach Coordinator so the project can more easily track outcomes.
- Train CHC case managers on how to properly fill out 1010EZ enrollment forms.
- Provide CHC case managers with a one-page cheat sheet regarding basics of the enrollment process and filling out the 1010EZ. This should be accompanied by contact

information for a VA Rural Health Outreach Coordinator to whom the case managers could refer the Veterans and/or send the completed 1010EZ.

- Encourage CHC intake personnel to ask the question, “Are you enrolled in VA for health care?” as part of the intake process. CHC intake personnel may also utilize the script provided in the informational packets for intake personnel (see page 31).

## **IMPROVE DATA COLLECTION**

- Develop a new definition of the term Veteran for the 2012 UDS Manual that is consistent with the eligibility requirements for relevant VHA services. Include up-to-date information about the National Guard and Reserve in the new definition.
- Ensure the new definition of the term Veteran is thoroughly explained in UDS trainings to limit confusion over the term.
- Add the following question to all CHC patient information/intake forms nationwide: “Have you ever served in the U.S. Armed Forces?”
- If the patient responds “yes” to the question, “Have you ever served in the U.S. Armed Forces,” encourage CHCs to collect secondary information pertinent to Veteran status, such as VHA enrollment status.
- Explore the use of the My HealtheVet Blue Button as a preliminary method of data sharing initiated by the patient in the exam room or other clinic area.
- Develop a VA-HHS Memorandum of Understanding (MOU) encouraging VA collaboration with HRSA and CHCs that would foster increased VHA enrollment, data sharing, and collaboration and coordination of care for Veterans. Presently, there exists a VA-HHS MOU encouraging VA collaboration with Indian Health Service on Veterans' care.
- Improve the CHC intake process by:
  - Using stickers on each patient chart to flag Veterans for their CHC providers. This recommendation could be implemented for those CHC systems still primarily using paper records.
  - Developing electronic pop-up notifications or creating “alerts” in the electronic health record system, to notify front desk, clinicians, and billing personnel that the patient is a Veteran.

- Assigning a staff member to review the following day's patient charts and note items for front desk personnel to update or review, to include Veteran status.
- Providing education on VHA health care benefits to case managers and patient services coordinators who work one-on-one with low-income and limited or no insurance patients.

## **IMPROVE OUTREACH AND EDUCATION**

- Utilize VA Rural Health Outreach Coordinators or other VHA staff to maintain direct contact with CHC personnel and provide information on eligibility and assistance in enrollment of Veterans into VHA.
- Collaborate with CHC to identify outreach opportunities, such as fairs or local events, and coordinate to attend them together.
- Distribute lists containing contact information, hours, locations, and available services at local CBOCs and distribute to nearby CHCs. Receive and distribute a similar list from CHCs for distribution to CBOCs and other VHA facilities.
- Develop maps detailing both CHC and VHA systems of care on them and distribute them to VA facilities, CHCs and Veterans.
- Encourage CHCs to include VHA and community Veteran Service Organizations in demographic and community-needs scans.
- Encourage CHCs, VHA, and local Veterans groups to reach out to each other to better understand each other's services

## **ESTABLISH COMMUNICATIONS CHANNELS**

- Establish strong, open communication channels between CHC case managers and VA Rural Health Outreach Coordinators.
- Connect individual CBOC and CHC staff, especially health care providers, through site visits with each other's facilities in order to learn more about the two systems of care.
- Identify CHC networks, state primary care associations, and national associations to facilitate communications with CHCs, and design projects inclusive of CHC systems, rather than implementing projects at the individual CHC level.

## **DEVELOP A FRAMEWORK FOR CLINICAL COLLABORATION**

- Collaborate to create provider training modules for rural CHCs' providers on the needs and issues experienced by Veterans with a focus on Post-Deployment Health, PTSD, and MST. This could be done under the terms of the existing MOU between HRSA and VA (EES) on health professions training resources.
- Develop an educational system for VHA and CHCs to learn more about each other's systems and quality of care as a precursor to clinical collaboration.
- Consider offering CHC providers the continuing education opportunities provided on-site at VHA facilities.
- Increase and facilitate VHA provider to CHC provider interaction through the sharing of contact information and knowledge of shared patients until interoperability of medical records is feasible.
- Develop telehealth linkages in CHCs to VHA mental health providers using CHC video equipment.
- Explore the utility of My HealtheVet for interoperability between CHCs and VHA facilities.
- Educate Veteran patients on the My HealtheVet Blue Button and increase visibility of its functions that help to better coordinate care. For example, at a CHC, a Veteran can pull up their My HealtheVet homepage and allow their CHC provider to review their current medications, read and input information as one means of "sharing" patient records.
- Provide CHC workers cell phones with Google Android or Apple iOS technology that are preloaded with the My HealtheVet Blue Button application, VA-214, and teach CHC personnel its use and function.
- Investigate successful models for prescription coordination among CHC and VHA providers, such as increasing interactions with Prescription Management personnel at CHCs and honoring CHC prescriptions at VHA pharmacies and vice-versa.
- Consider contracting with CHCs on a fee for service basis or to act as CBOCs in rural areas where VHA would not consider building a clinic due to relatively small Veteran populations, or where workforce and travel distance make it necessary for one entity to act as both.

- Develop a pilot project to test a capitated payment system for Veterans who utilize CHCs, whereby VHA pays CHCs a set monthly amount for each enrolled Veteran assigned to that CHC.
  - The pilot could be lead by an team of VHA and CHC clinicians and case managers to determine the scope of care as well as facilitate communications between the systems of care.
  - Quality indicators, clinical reminders, and other metrics must be shared across the two systems to enable both the VHA and CHCs to collect data and track Veterans utilizing both systems of care. This level of sharing health information is necessary so that both VHA and CHC providers have knowledge of the care the Veteran is receiving in both systems of care to maintain quality and continuity of care.
- Investigate how the CHCs could play a support role in the eligibility determination process through assistance with VHA's History and Physical exams. CHC doctors could be trained by VHA and complete the VHA forms.
- Form a VA and HRSA working group or task force to identify unique health needs or disparities among Veterans and develop strategies for working collaboratively to create a more seamless system for Veterans who are served both by the VHA and CHCs.
- Consider a pilot project whereby CHCs with a significant number of Veterans establish a dedicated Veteran case manager with a background in social work or nursing who could assure care coordination and advocate for the provision of appropriate services. This case manager could work with a counterpart in VHA to develop an individualized care plan and a method for assuring information is shared between the CHC and VHA providers. A small working group composed of Veterans, CHC and VHA clinicians, and administrators could provide oversight and recommendations based upon the findings of the pilot program. In addition, this group could provide oversight and input into both the development and evaluation of such a program.

## LESSONS LEARNED

This section compiles the lessons learned throughout the life of the project that could improve the implementation and processes of the project, should the project be replicated in the future. While the lessons learned are embedded throughout the report in their respective sections, they are placed in the section below for easy readability and convenience. They remain separated by task number.

### **TASK 1. ANALYSIS OF CHC PATIENT POPULATION**

- Several CHCs issued a press release to raise awareness regarding participation in the project. This press release generated interest in the project and resulted in multiple Veterans visiting their local CHC to ask about potential services available to Veterans. This press release was also a useful tool in recruiting Veteran participants for the focus groups.
- The project team created a PowerPoint presentation for the purpose of educating the CHC staff on the purpose, importance, and their specific roles in the execution of this project. This provided opportunities for all participating staff to meet together with project team and discuss implementation strategies.

### **TASK 2. INCREASE ENROLLMENT IN VHA**

#### **Veteran Assessment**

- Use one form of technology that has been tested and works on all computer operating systems, such as Skype, to reduce the number of hours spent on technical related issues.
- Remove the responsibility of conducting the telephone interviews from CHC employees, due to their limited amounts of time and difficulty managing project responsibilities while working to deliver patient care in remote locations. Trained project team members should instead conduct the Veteran Assessment to ensure continuity and interview quality.
- Assign a local telephone number to the interviewers for each Skype account created. This may incur an extra cost; however, this yields a higher response rate as a majority of interviewees have caller ID and are reluctant to pick up an unknown number.
- Recognize that numerous calls will have to be made to reach a given target for Veteran interviews. Veteran Assessment calls received a 10% response rate for completed interviews.

## Veteran Pilot Packets

### ***Distribution Process***

- Advertise heavily to increase Veteran patient awareness of the project. Ensure that the advertising is eye-catching and appealing to the Veteran.
- Hang a small sign in the reception area of the CHCs stating that Veterans may inquire for additional information at the front desk and display VA material in the waiting rooms. This may reduce the added commitment of asking about Veteran status, as well as help reach as many Veterans as possible.
- Educate intake personnel about the importance of distributing the informational packets to enrolled Veterans. Follow-up frequently during start-up period to reinforce and ensure timely and appropriate distribution.
- Provide enough self-addressed envelopes or labels to cover the number of packets distributed to the CHCs.
- Provide VHA informational pamphlets on VHA services, such as behavioral health care, women's health care, pharmacy services, transportation etc., to CHCs for distribution to Veteran patients in addition to the informational packets.

### ***Content of Informational Packets***

- Ensure that the information Veterans receive is clear and concise to minimize confusion about the purpose of the packets as well as ensure they are not overloaded with information.
- Provide more localized information inside the packets.
- Change the informational packets to be more appealing to the eye, patient friendly and less data oriented. Some patients were put off by how statistical and data oriented the packets were, and seem less inclined to go through the process.
- Include information on how Veterans can better coordinate their care between CHCs and VHA.

- Develop a simpler process for filling out the 1010EZ, beyond just including it in the packet. Include the “Enrolling for VA Health Care Online” brochure in the packet as an option to enrollment.

### **TASK 3. IMPROVE COORDINATION OF CARE BETWEEN CHCS AND VHA**

#### **Veteran Focus Groups**

- Encourage focus group participants to arrive 15 minutes early in order to fill out the necessary paperwork. This will allow focus group administrators to ensure all paperwork is turned in and that the focus group can start on time.
- Encourage Veterans to bring their wives or caretaker with them to the focus group if they so choose. This proved very helpful for older Veterans with hearing impairments or memory challenges.
- Focus groups should be conducted by trained facilitators, digitally recorded, and transcribed. All recording equipment should be checked multiple times and facilitators should be prepared with back-up systems and extra batteries.
- Conduct personal phone calls to follow-up on mailed invitations, increase the comfort level of the Veteran and increase the number of participants. Some registered Veterans asked if they could bring other Veterans. This was allowed as long as the Focus Group size did not exceed 18 participants.

## CONCLUSION

This project provides strong evidence that collaboration between the VHA and CHCs in a defined rural area is productive given the willingness of VHA and CHC leaders to engage in the process. Building relationships at the point of delivery of patient care as well as throughout the hierarchy of both systems of care based on communications, trust, and psychological buy-in is an essential first step for success of the collaboration. The collaboration can take many forms, however, the more focused the goals and objectives the greater the likelihood for success. This project focused upon building relationships and communication around increasing enrollment of eligible rural Veterans, identifying the rural Veteran population who were dual users of both systems of care, determining why such Veterans use both systems and increasing rural Veterans' awareness of services and eligibility in the VHA and the CHC systems.

The project resulted in increased mutual understanding by the staff working in both systems of care and this understanding increased the motivation of the respective staff to improve the rural Veteran's awareness of VHA benefits. This understanding also increased the competence of the staff in guiding Veterans to reliable sources of information concerning eligibility and problem solving around access issues. The project further proved how vital the respective roles of case manager in the CHC and Rural Health Outreach Coordinator in the VHA are to reaching rural Veterans and assisting them in navigating both systems of care. The project also provided a voice for Veterans, especially within the Focus Groups, and, importantly, a forum for providers in both systems of care to express their dedication to Veterans and willingness to overcome challenges and barriers to solve the individual rural Veteran's problems.

APPENDIX 1. LIST OF PARTICIPATING CHC SYSTEMS AND SITES

Center Name	County, State
<b>Choptank Community Health System, Inc.</b>	
Veterans served: 779	
Goldsboro Medical Center	Goldsboro, MD
Denton Medical Center	Denton, MD
Federalburg Medical Center	Federalburg, MD
Fassett-Magee Health Center	Cambridge, MD
Bay Hundred Health Center	St. Michaels, MD
Hurlock Medical Center	Hurlock, MD
Women’s Health Center	Cambridge, MD
<b>E. A. Hawse Health Center, Inc.</b>	
Veterans served: 339	
E. A. Hawse Health Center, Baker Site	Baker, WV
E. A. Hawse Health Center, Mathias Site	Mathias, WV
Potomac Valley Family Medical	Moorefield, WV
Grant Pediatrics & Internal Medicine	Petersburg, WV
Potomac Valley Family Dentistry	Petersburg, WV
<b>Tri-State Community Health Center, Inc.</b>	
Veterans served: 532	
Tri-State Community Health Center, Hancock Site	Hancock, MD
Tri-State Women’s Health Center	Cumberland, MD
Tri-State Community Health Center, Cumberland Site	Cumberland, MD
Tri-State Community Health Center, McConnellsburg Site	McConnellsburg, PA
<b>Preston Taylor Community Health Centers, Inc.</b>	
Veterans Served: 93	
Mt. Storm Health Center	Mt. Storm, WV

## APPENDIX 2. RECOMMENDATIONS FOR DATA COLLECTION

The project team analyzed the processes used by CHCs to collect Veteran patient data. **Table 9** shows the multiple inconsistencies in the collection of data on Veteran patients. The project team, including content experts from the NACHC, developed a series of recommendations for more detailed and accurate Veteran patient data collection by CHCs. Specifically, the project team made recommendations for improvements in data collection and intake by CHCs, ways VHA and CHCs might collaborate around data collection; and the methods by which VA and HRSA can partner to revise the UDS to provide a more accurate picture of Veteran patients served by CHCs. The list of recommendations can be found below.

**Table 9. UDS Data on Veteran Patients Served in 2008 and 2009**

ID	CHC System	UDS Data		Change between 2009 and 2008	Percent Change between 2009 and 2008
		2008	2009		
1	Alexandria Neighborhood Health Services	1	40	39	3900%
2	Baltimore City Health Department	0	0	0	0%
3	Baltimore Medical System, Inc	749	845	96	13%
4	Chase Brexton Health Services	0	0	0	0%
5	Choptank Community Health System, Inc.	785	779	6	1%
6	Columbia Road Health Services	27	36	9	33%
7	Community Clinic, Inc.	37	49	12	32%
8	Community of Hope	0	6	6	0%
9	E. A. Hawse Health Center, Inc	243	339	96	40%
10	Family Health Centers of Baltimore, Inc	0	1	1	0%
11	Greater Baden Medical Services	59	35	24	41%
12	Health Care for the Homeless	172	204	32	19%
13	Keystone Rural Health Center	1486	0	1486	100%
14	La Clinica del Pueblo	0	0	0	0%
15	Mary's Center for Maternal & Child Care, Inc	0	14	14	0%
16	Parkwest Health Systems	0	80	80	0%

ID	CHC System	UDS Data		Change between 2009 and 2008	Percent Change between 2009 and 2008
		2008	2009		
17	Pendleton Community Care	304	380	76	25%
18	People's Community Health Center	624	672	48	8%
19	Preston-Taylor CHC, Inc	546	177 <sup>2</sup>	369	68%
20	Shenandoah Valley Medical Systems, Inc	60	433	373	622%
21	Three Lower Counties Community Services, Inc	287	297	10	3%
22	Total Health Care, Inc	0	461	461	0%
23	Tri-State CHC	429	532	103	24%
24	Unity Health Care, Inc	6103	908	5,195	85%
25	Walnut Street CHC	35	146	111	317%
26	West Cecil Health Center, Inc	31	28	3	10%
27	Western Maryland Health Care Corporation	9	61	52	578%

**List of Recommendations from Data Recommendations Deliverable:**

**HRSA AND NACHC**

- Develop a new definition of the term Veteran for the 2012 UDS Manual that is consistent with the eligibility requirements for relevant VHA services. Include up-to-date information about the National Guard and Reserve in the new definition.
- Assess the processes used by the four CHC's participating in the VISN 5 pilot project for assembling patient data, collecting patient intake forms, and documenting the entire patient data process.
- Determine if electronic reporting processes contribute to higher Veteran patient reporting.
- Develop a nationally standardized process for collecting information on Veteran status using information collected from the analysis of VISN 5's pilot project.
- Add the following question to all CHC patient information/intake forms nationwide: "Have you ever served in the United States (U.S) Armed Forces?"
- If the patient responds yes to the question, "Have you ever served in the U.S. Armed Forces," encourage CHCs to collect secondary information pertinent to Veteran status, such

as homeless status, VA enrollee status, discharge status, etc., but ensure these secondary questions are voluntary

- Require all CHCs nationwide to ask the question above to newly enrolled CHC patients.
- If CHCs collect patient information electronically, encourage CHCs to develop a hard stop, or a feature that prevents the user from moving forward until he/she performs a required action, in their practice analytics software, to assist CHCs in gathering this information.
- Develop a nationally standardized process for reporting the secondary information with the other UDS data requirements.
- Encourage CHCs to explore the utility of My HealthVet for interoperability between CHCs and VHA facilities. For example, at a CHC, a Veteran can pull up their My HealthVet homepage and allow their CHC provider to input information as one means of “sharing” patient records.
- Explore the use of the Blue Button as a preliminary method of data sharing which is initiated by the patient in the exam room or other clinic area.
- Encourage new CHC site grantees to include VA and community Veteran organizations in demographic and community-needs scans before developing new service sites, and once service sites are operational.
- Encourage CHCs, as they expand, to reach out to VA and local Veterans groups to better understand each other’s services

## **VA**

- Prepare and distribute guidebooks, tailored by region, to CHCs to provide information on where and how CHCs can refer Veterans eligible for VHA services to VHA.
- Explore an interagency relationship with HRSA to access Veteran patient data at the grantee level.
- Encourage VHA facilities to work directly with CHCs to deliver seamless care to Veterans.

## **HRSA AND VA**

- Collaborate to create provider training modules for rural CHCs providers on the needs and issues experienced by veterans.
- Better publicize the current Memoranda of Understanding (MOU) in place between HRSA and VA on health professions training resources.
- Encourage data exchange between VA and CHCs.
- Make UDS data publicly available at state and regional level.
- Brainstorm options to disseminate CHC best practices in reporting Veteran patients.

## APPENDIX 3. PROJECT ORIENTATION FOR CHCS



### VA Collaboration with Rural Community Health Centers Project Orientation for CHCs

### Efforts to address Rural Veteran Issues

- 40 to 44% of Veterans are rural
- 38% of enrolled Veterans are rural
- 2008 median household income of rural Veterans was \$19,632 and 4% lower than urban Veterans
- Roughly 2/3 of Veterans are served by civilian health care system or not served
- Largest number of Veterans are over 55. This year average age of Vietnam Vet is 65.

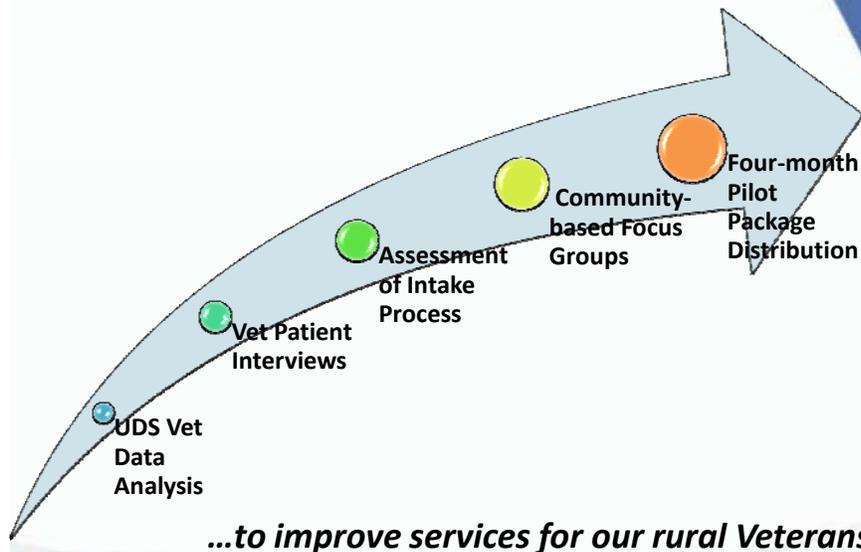
  

## VA Collaboration with Rural Community Health Centers

- One of VISN 5 VA Capitol Area Health Care Rural Health Initiatives
- 17 CHC sites (MD, VA, WV) selected to participate
  - Highest numbers reported on UDS
  - Willingness to participate
  - Proximity to CBOC or Vet Center
  - Access issues for all rural populations present in communities served by CHCs
  - Availability of and shared mission for health education and outreach



## VA Collaboration with Rural Community Health Centers



## UDS Veteran Data Analysis

- 2008-2009 data reported on CHC UDS
- Number of Veterans reported by each site
- Total among all CHC sites 2,225
- Why obtain and analyze this data?
  - Assess number of Veterans seen at CHCs
  - Obtain names and contacts for individual Vet Assessments
  - Diagnoses compare to VA use data



## Veteran Patient Interviews

- Telephone interviews of 10% of numbers reported on UDS for each site
- Over sample of women and younger Veterans
- Interviews recorded online and digital recording for transcribing to simplify data collection
- Calls in evenings and weekends net best results
- Get volunteers for Focus Groups (Mt. Storm, Baker, eastern shore Maryland)



## Assessment of Intake Process

- 15 questions to assess how intake works at each participating site
- Intake personnel are most knowledgeable on what works and what does not work
- Assessment needed to make easiest and most efficient recommendations to determine how to identify Veterans for providers and share information on VA enrollment



## Community-Based Focus Groups

- Three sites selected for focus groups
- 1.5 hours in the evening and at local site
- Invite a minimum of 21 to 25 Veterans
- Oversample younger and women Veterans
- Goal is to have 10 to 12 per focus group
- Veterans will be paid \$100 for participating
- Looking for Veterans who are enrolled and not enrolled and using CHC and/or VHA



## Four-month Pilot Package Program Sharing VA Enrollment Information

Ask of all adults 18 and over:

1. *“Have you ever served Active Duty in the US Military?”* If **Yes**, then ask:
2. *“Have you received health care services from VA within the last three years?”*
  - **Yes**, share enrolled packet
  - **No**, share non-enrolled packet
  - Both packets include Women’s Health information for all women Veterans



## Four-month Pilot Package Program Sharing VA Enrollment Information

- Label 1010-EZ with CHC site name so CHC gets credit for information sharing
- Encourage Vet to return 1010-EZ in pre-addressed envelope
- Number packets of each category. Report number of packets distributed when Atlas staff calls each two weeks
- VA Rural Health Outreach Coordinator can supply forms, envelopes, brochures



## Anticipated Outcomes and Results

- Hope to inform VA of CHC services, quality of care and vice versa
- Hope to increase VHA enrollment
- Hope to lead to a full clinical pilot of coordinated care for rural Veterans
- Hope to replicate in other VISNs with other CHC systems and sites



## Rural Health Outreach Coordinator Baltimore/Perry Point VAMC

- **Steven G. Leaphart**
- 410-691-7304 Office
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## APPENDIX 4. ANALYSIS OF VETERAN DIAGNOSES

International Classification of Diseases, Ninth Edition (ICD-9) codes for Veteran visits to CHCs in 2009 were collected for all facilities in the Choptank Community Health System, Inc. (CCHS) and the E.A. Hawse Community Health System. The listed ICD-9 codes show the diagnoses Veteran patients received treatment and were billed for during all visits in 2009.

### Choptank

Diagnostic and demographic data were collected on CCHS Veterans from the Denton and Hurlock Medical Centers; the Goldsboro and Federalsburg Medical & Dental Centers; the Bay Hundred and Fassett Magee Health Centers; and the Cambridge Dental Center. **Table 10** shows the top 10 ICD-9 codes for the entire Choptank CHC system as well as the proportion of the Veteran patient population with the diagnosis.

**Table 10. Top Ten ICD-9 Codes: Choptank Community Health System, Inc.**

ICD-9 Description	Number of Veteran patients (609 total patients)	Proportion of Veteran patient population with diagnosis
Flu vaccine	191	31%
Benign essential hypertension	136	22%
Diabetes II	107	18%
Dental exam	51	8%
Routine medical exam	47	8%
Mixed hyperlipidemia	45	7%
Diabetes, unspecified type with complications	35	6%
Pre-operative exam	25	4%
Acute bronchitis	24	4%
Chronic airway obstruction	18	3%

### E. A. Hawse

Diagnostic data were collected on E.A. Hawse Veterans from the E.A. Hawse Baker and Mathias facilities, Grant Pediatrics & Internal Medicine, Potomac Valley Family Medicine, and Potomac Valley Family Dentistry. **Table 11** shows the top 10 ICD-9 codes for the entire E. A. Hawse system as well as the proportion of the Veteran patient population with the diagnosis.

**Table 11. Top 10 ICD-9 Codes: E.A. Hawse Health Center**

ICD-9 Description	Number of Veteran patients (884 total patients)	Proportion of Veteran patient population with diagnosis
Unspecified essential hypertension	260	29%
Dental exam	131	15%
Other unspecified hyperlipidemia	86	10%
Diabetes	83	9%
Routine medical exam	75	8%
Flu vaccine	66	7%
Acute sinusitis	49	6%
Acute bronchitis	46	5%
Acute upper respiratory infection unspecified	37	4%
Benign essential hypertension	35	4%

## APPENDIX 5. ONLINE DATA CAPTURE WITH ZOOMERANG



Page 1 - Heading

### Veteran Assessment Form

#### Instructions

*Items written in italics are instructions.*

Items written in **bold** should be read aloud to the Veteran.

Page 1 - Heading

### Patient Assessment Form

#### Instructions

Items written in italics are instructions.

Items written in bold should be read aloud to the Veteran.

Please check your responses before hitting the "Submit" button on each page as you will not be able to use your browser back button to scroll back to a previous page in this assessment to make any corrections.

Page 1 - Heading

#### Introduction

Upon contacting the Veteran, please begin the assessment by reading the following text.  
Hello. My name is [Your First Name] and I'm calling from [Name of Health Center]. May I please speak with [Name of Veteran]?

Our registration information indicates that you are a Veteran. [Name of Health Center] is conducting a short, 10-minute assessment to learn more about our Veteran patients and their health care. We are working jointly with the Department of Veteran Affairs to better coordinate services and improve overall care for Veterans. Your input is very important, and if you choose to participate, your responses to these questions will be recorded and will remain confidential and anonymous. Your participation in this assessment will in no way negatively affect your care at [Name of Health Center].

Would you be willing to participate in this assessment?

If answer is "No", thank the Veteran for his or her time and do not complete or submit this assessment form.

If Veteran answers "Yes", ask: Is this a good time to talk to you and get your ideas?

If Veteran indicates "Yes", but not convenient now, ask: If this is not a convenient time for you, when is a good time to call you back?

Record the time to call back on the contact log but do not submit this assessment form. You will only complete this form when you actually interview a Veteran.

Page 1 - Heading

### Assessment Questions

Page 1 - Question 1 - Open Ended - One Line

[Mandatory]

I am turning on the recorder now. This is Veteran [say alphanumeric code out loud], and I will begin the questions now.

Please enter the alphanumeric code into the comment box below and ensure to update the contact log with this code.

Page 1 - Question 2 - Choice - Multiple Answers (Bullets)

[Mandatory]

In which branch of service did you serve? Check all that apply

- Army
- Air Force
- Navy
- Marine Corps
- Coast Guard
- Merchant Marine
- US Public Health Service
- National Guard

Page 1 - Question 3 - Yes or No

[Mandatory]

Are you still in the Reserves?

- Yes
- No

Page 1 - Question 4 - Open Ended - One or More Lines with Prompt

What are your dates of active duty service including time in the Guard and Reserves?  
Please enter 4 digit year only in each block as instructed.

- Year Service Began \_\_\_\_\_
- Year Service Ended \_\_\_\_\_
- Year 2nd Period of Service Began (if applicable) \_\_\_\_\_
- Year 2nd Period of Service Ended (if applicable) \_\_\_\_\_

Page 1 - Question 5 - Yes or No

[Mandatory]

Were you in combat or a war zone?

- Yes
- No

Page 1 - Question 6 - Choice - One Answer (Bullets)

If "yes", Which war(s)?

- World War II
  - Korean War
  - Vietnam War
  - Gulf War (August 2, 1990 through present)
  - Other
- 

Page 1 - Question 7 - Choice - One Answer (Bullets)

[Mandatory]

Are you enrolled in the VA to receive health care benefits and services?

- Yes [Skip to 2]
- No [Skip to 5]
- I Don't Know [Skip to 6]

Page 2 - Question 8 - Yes or No

[Mandatory]

Have you visited a VA facility for health care at any time in the past?

- Yes [Skip to 3]
- No [Skip to 4]

[Skip Unconditionally to 7]

Page 3 - Question 9 - Yes or No

[Mandatory]

Have you visited a VA facility for health care in the past 12 months?

- Yes
- No

Page 3 - Question 10 - Open Ended - Comments Box

May I ask for what services you sought care?

---

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Page 3 - Question 11 - Open Ended - Comments Box

What are some reasons you receive care from both [Name of Health Center] and the VA?

---

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Page 3 - Question 12 - Choice - One Answer (Bullets)

Do your current spouse or children (by birth or adoption) also receive health care at [Name of Health Center]?

- Yes
- No
- No Dependents

Page 3 - Question 13 - Choice - One Answer (Bullets)

Do your current spouse or children (by birth or adoption) receive health care from the VA?

- Yes
- No
- No Dependents

[Skip Unconditionally to 7]

Page 4 - Question 14 - Open Ended - Comments Box

What are some reasons you do not use the VA for health care?

---

---

---

---

[Skip Unconditionally to 7]

Page 5 - Question 15 - Yes or No

[Mandatory]

Have you ever tried to enroll in the VA for health care benefits?

- Yes
- No

Page 5 - Question 16 - Open Ended - Comments Box

What are the reasons you did not enroll?

---

---

---

---

[Skip Unconditionally to 6]

Page 6 - Question 17 - Yes or No

[Mandatory]

We are working with the VA to increase health care enrollment. There have been some eligibility changes in the VA and some Veterans do not know they are eligible for Veterans health care. Would you like someone to discuss your eligibility for VA health care with you? If Veteran says "Yes", then annotate the "Yes for more eligibility information" on the contact log next to the Veteran's name

- Yes
- No

[Skip Unconditionally to 7]

Page 7 - Question 18 - Yes or No

[Mandatory]

The [Name of Health Center] will be holding a Veterans Forum in the near future to talk about health care for Veterans. We want to hear your ideas on ways to improve Veteran's health care in our community. We expect to hold this Forum in the evening and will serve food and beverages.

Would you be interested in participating in this Forum?

If Veteran says "Yes", then annotate the "Yes for participation in the forum" on the contact log next to the Veteran's name and say: Thank you. We hope to recruit at least 15 Veterans to participate in this Forum so someone may call you again with more information. Depending on the number of interested Veterans we may not call everyone that expresses interest; however, thank you sincerely for your interest.

- Yes
- No

Page 7 - Question 19 - Open Ended - Comments Box

Is there anything else you would like to tell me about your health care experiences as a Veteran?

---

---

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---

Page 7 - Heading

This concludes our assessment. Thank you for your time in answering these questions, and thank you for your service to our nation.

[Skip Unconditionally to 8]

Page 8 - Heading

Demographic Information

Please record the following demographic information for each Veteran who is administered this assessment. Do NOT ask for this information during the call. Instead, please pull this information from the patient record.

Page 8 - Question 20 - Choice - One Answer (Bullets)

[Mandatory]

Age

- Less than 25 years
- 25-44 years
- 45-64 years
- 65-85 years
- More than 85 years

Page 8 - Question 21 - Choice - One Answer (Drop Down)

[Mandatory]

Gender

- Male
- Female

Page 8 - Question 22 - Choice - Multiple Answers (Bullets)

[Mandatory]

Race/Ethnicity

- White Non-Hispanic
- White Hispanic
- Black/African American
- Black/Hispanic
- American Indian/Alaska Native
- Asian
- Native Hawaiian/Other Pacific Islander
- Some Other Race
- Multiracial
- Unknown

Page 8 - Question 23 - Open Ended - One Line

[Mandatory]

Zip code of home address  
(Please verify only five characters are entered)

Page 8 - Question 24 - Choice - Multiple Answers (Bullets)

[Mandatory]

Insurance (check all that apply)

- Medicare
- Medicaid
- Tricare
- BC/BS
- Aetna
- United Healthcare
- Migrant Health Coverage
- Uninsured
- Other Insurance, please specify

Page 8 - Heading

Briefly check your responses on this page to ensure that you have completed the demographic section accurately and then click on the "Submit" button. If you exit out of the assessment before clicking the "Submit" button, the assessment will NOT be saved for analysis. Once you click "Submit" you will NOT be able to access this same assessment again. Thank you!

Thank You Page

(Kiosk - Send survey taker to introduction)

Screen Out Page

(Kiosk - Send survey taker to introduction)

Over Quota Page

(Kiosk - Send survey taker to introduction)

Survey Closed Page

Standard

## APPENDIX 6. SAMPLE CHC MASTER CONTACT SHEET

Guidelines and Instructions_Attachment A [Read-Only] - Microsoft Excel															
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	VA Collaboration with Rural Community Health Centers														
2															
3	ID	RAND	Alpha Numeric Code	Last Name	First Name	Phone Number	Age	Gender	Race/Ethnicity	Zip Code of Home Address	Insurance or Other 3rd Party Coverage	Outcome of Call	Reschedule Date/Time	Focus Group (Y/N)	Enrollment Specialist (Y/N)
4	1	0.23	CC1	Doe	John	202.445.0588	30	M	White Non-Hispanic	20011	Uninsured				
5	2	0.75													
6	3	0.27													
7	4	0.12													
8	5	0.51													
9	6	0.87													
10	7	0.63													
11	8	0.64													
12	9	0.2													
13	10	0.14													
14	11	0.57													
15	12	0.51													
16	13	0.3													
17	14	0.92													
18	15	0.03													
19	16	0.75													
20	17	0.13													
21	18	0.2													

## APPENDIX 7. ASSESSMENT INSTRUMENT GUIDELINES AND INSTRUCTIONS

### **Assessment Instrument for Individual Veteran Patients Guidelines and Instructions**

#### **Purpose**

The purpose of the Veteran Assessment is to gather information from a select sample of Community Health Center (CHC) Veteran patients regarding their demographic information and their use of Veterans Health Administration services. The Veteran Assessment is a critical component of the Department of Veterans Affairs (VA) Collaboration with Rural Community Health Centers Project, of which your CHC is a part. The goal of this project is to improve collaboration between CHCs and the Veterans Health Administration by better understanding the CHC Veteran patient population, their needs and why they might use CHC in addition to, or instead of the Veterans Health Administration for care.

This document is divided into following sections:

1. Guidelines for CHC System Administrators
2. Guidelines for Interviewers, and

In the Overview of the Guidelines for Interviewers section, interviewers will find detailed instructions regarding the interview process as well as answers to a number questions they might be asked by the Veteran. The Guidelines for CHC System Administrators section provides information on the sampling methodology and the Veteran contact roster CHCs must develop for their designated interviewers.

#### **Guidelines for CHC System Administrators**

##### **Sampling Methodology**

Target Sample Size: This assessment should be administered to a number of Veterans equal to at least 10% of the number of Veterans reported to the Health Resources and Services Administrating (HRSA) Uniform Data System (UDS) in 2009. For example, a CHC that reported 200 Veterans to the UDS in 2009 would complete interviews with 20 Veterans. Because each CHC participating in this project sees a unique number of Veteran patients, each CHC will have a unique target for the number of Veterans to which it will administer the assessment.

Among all the sites selected for this project there are 2,250 Veterans reported on the UDS. The project goal is to interview 225 Veterans. The number of completed interviews for each individual CHC site should represent as closely as possible 10% of the number of Veterans reported for the site on the 2009 UDS.

Contact Roster and Randomization: Each CHC Grantee (System) should develop a master contact sheet in Excel containing information for each self-reported Veteran seen in 2009 (Example in **Appendix A**). Title fields on this contact roster should, at minimum, include:

#### Pre-Populated Fields:

- ID
- RAND (Excel random number generator function)
- CHC Site Visited
- Last Name
- First Name
- Phone Number
- Age
- Gender
- Race/Ethnicity
- Zip Code of Home Address
- Insurance or Other Third Party Coverage

#### Blank Fields to be filled in by the Interviewer:

- Alpha Numeric Code
- Outcome of Call
- Reschedule Date/Time
- Focus Group
- Enrollment Specialist

The master contact list should be grouped or stratified according to CHC site, then according to age, and, finally, according to gender. The contact list should be randomized within each group/stratum.

CHCs should oversample within each stratum to ensure 1) the target sample size includes 10% of the number of Veterans reported to UDS for each individual site; 2) at least one third of Veterans sampled are between the ages of 20 and 40 years old; and 3) at least one fourth of Veterans sampled in any age group are women.

Since there are many factors that influence the proportion of individuals contacted by the interviewee that actually complete the interviewing process, interviewers should plan to contact more Veterans than the target number of Veteran interviewees (10% of those reported on UDS). These factors could include wrong phone numbers, Veterans who refuse to be interviewed, or Veterans who cannot be interviewed for whatever reason. CHCs should plan a randomized, stratified list of all the Veterans seen by the CHC system in 2009 and should maintain this list until the target number of interviewees is reached.

### **Guidelines for Interviewers**

These instructions describe the hardware, software and associated instructions needed to interview Veterans for the VA Collaboration with Rural Community Health Centers Project. Interviews will be conducted using a three-step capture process. First, interviewers will download and use the Skype function to call Veterans on their computers. Interviewers will use the free Skype recorder to digitally record the conversation between the interviewer and the respondent. Finally, the interviewers will input the Veteran's responses into the online Zoomerang assessment tool.

## **Software and Hardware Needs**

- Computer with high-speed Internet connection
- Microsoft Excel software
- Zoomerang assessment link
- Skype software
- Free MP3 Skype Recorder
- Headset with a microphone

### **1. Making Phone Calls with Skype**

#### **1.1. Instructions: Create a new account**

1. Go to [www.skype.com](http://www.skype.com) in any web browser.
2. Click on the *Join Skype* button in the upper right hand corner of the page
3. Complete the “Create an account” form as follows:

First name:	Your First Name
Last name:	Your Last Name
Your email address:	Your email address
Birthday	Select your birthday from the dropdowns
Gender	Select your gender from the dropdown
Country	Select United States from the dropdown
City	Your City
How do you intend to use Skype?	Select <i>Mostly Business Conversations</i> from the dropdown
Skype Name	XXX (just pick something easy)
Choose a password:	Make sure your password has at least 6 characters Password strength indicator should be <b>Strong</b>
Re-enter password:	*Re-enter your password
Mobile Phone Number	Enter your mobile phone number

*Note: you can choose to uncheck the receive updates via SMS and email if you would like.*

4. Enter the text in the word puzzle and click the *I agree – Continue* button.  
Your account has been successfully created; you will receive an email confirming and be logged in.

#### **Instructions: Downloading Skype Software**

1. Click the *Get Skype* tab when logged in to Skype on the Web.



## Welcome, Brian Barclay

This is your account. You can view, manage and activate products and features.

 **\$0.00**

This is your Skype Credit balance.

[Buy Skype Credit](#)

2. Click on the green *Get Skype* button in the middle of the page
3. This will direct you to a page with all the versions you can download. Click on the appropriate Operating System. If you are a Windows user, click on the *Windows* icon at the top; if you are a Mac user, select *Mac OS X*.
4. In the middle, click the green *Download Now* button.
5. You will be taken to what looks like the sign-up page again. This time, click *Sign In*, and sign in using the account information you set up.
6. Now the download will start. You will be prompted for your language.
7. Click *Install*. Once installed, log in with your account information and you will be ready to start.

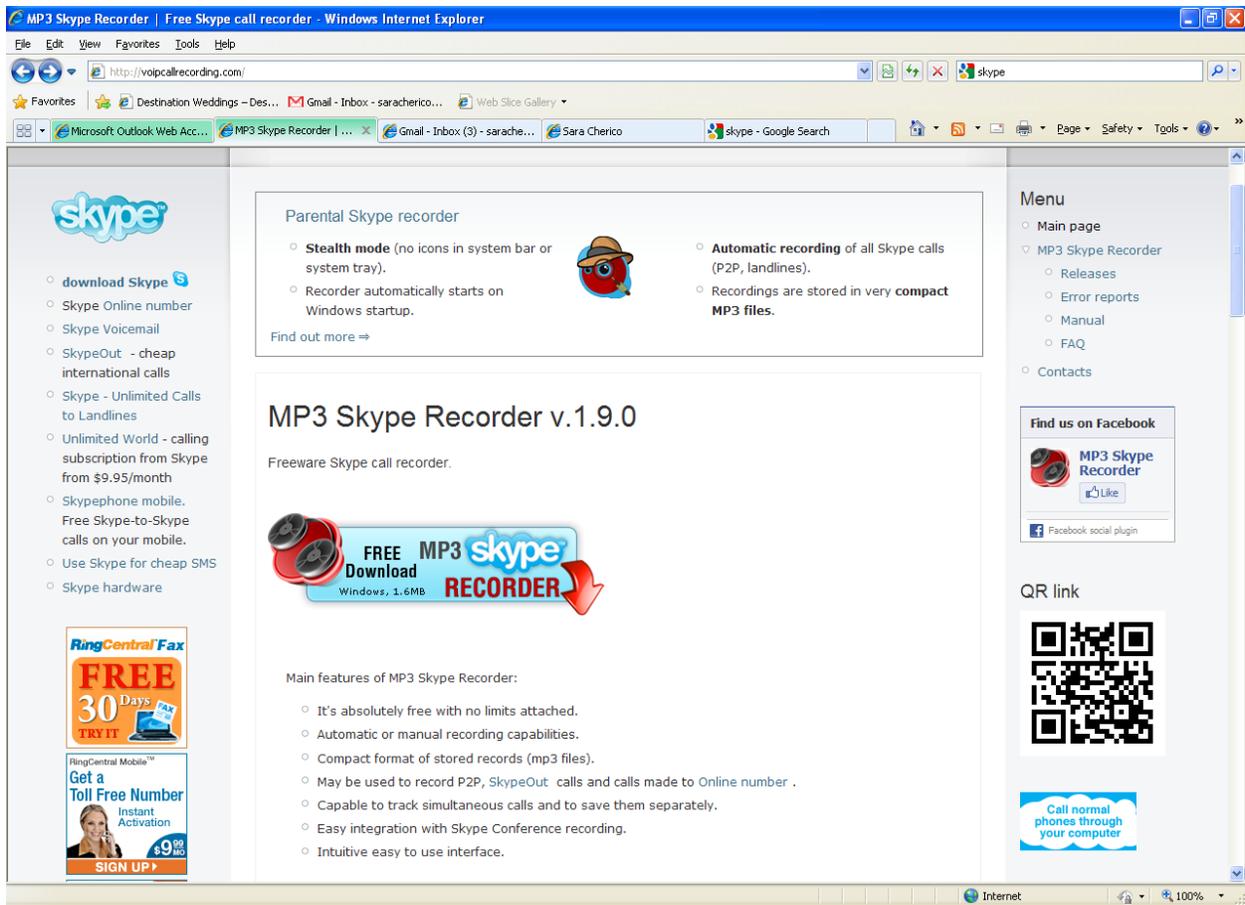
### 1.2. Instructions: To Add Contacts

1. Go into the *Contacts* tab and click *Search for Skype Users*.
2. Search for people by their user names.
3. You will add your interviewers Skype account to test the Skype software

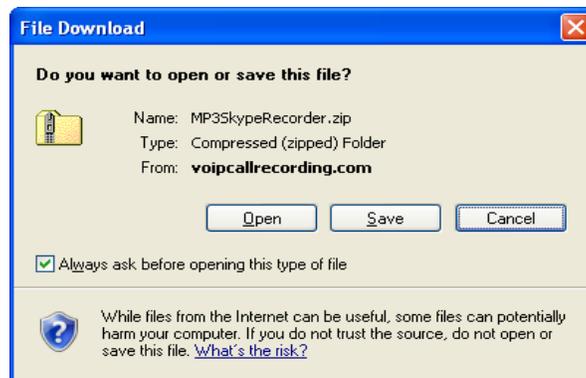
**After training, you will receive an email to join a Skype account with credit on it. You will create your own password for this account and use it to call Veterans.**

### Recording Skype Calls

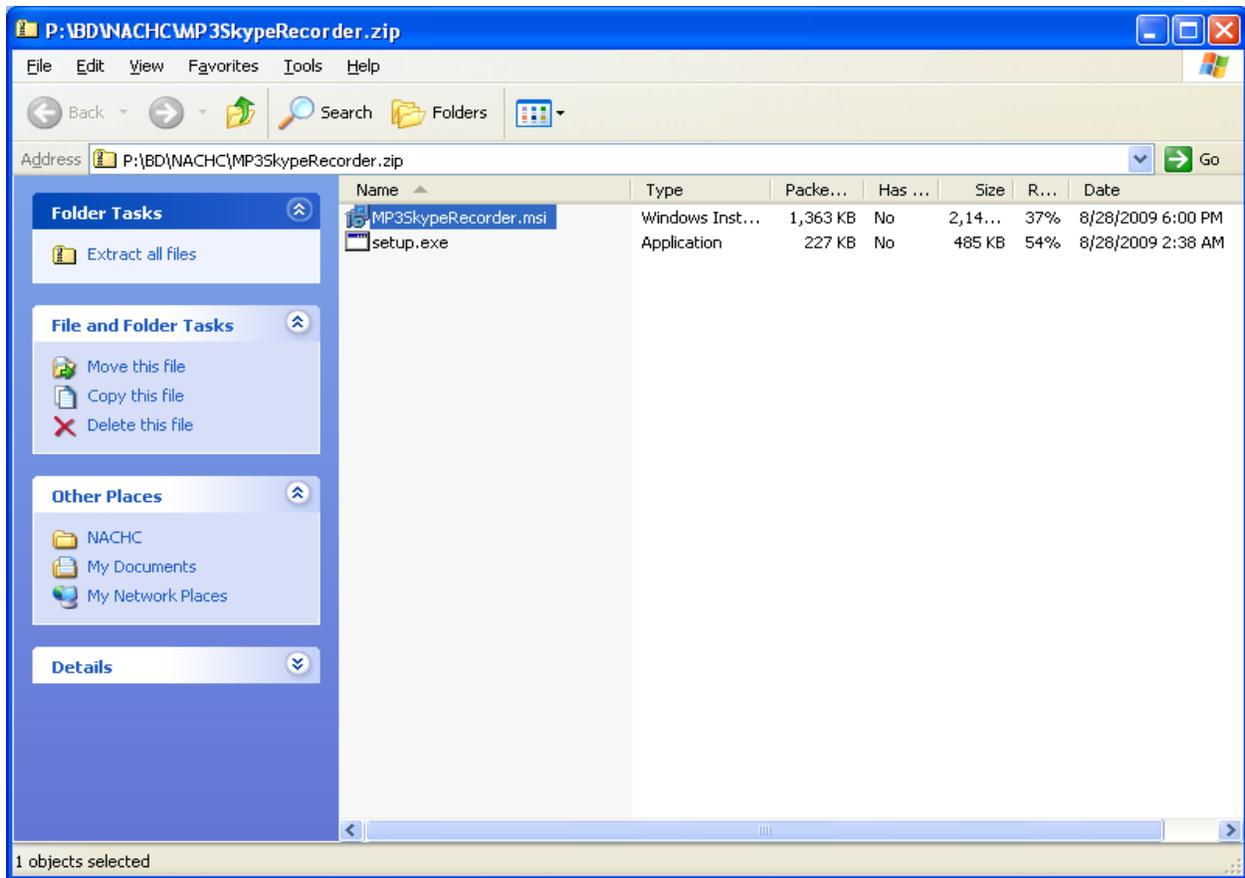
1. Go to the Free Recorder website by clicking on the following link:  
<http://voipcallrecording.com/>
2. Click the Free Download icon as shown below:



3. A File Download popup should appear, click on save, and save the file.



4. After saving, you should see the following:

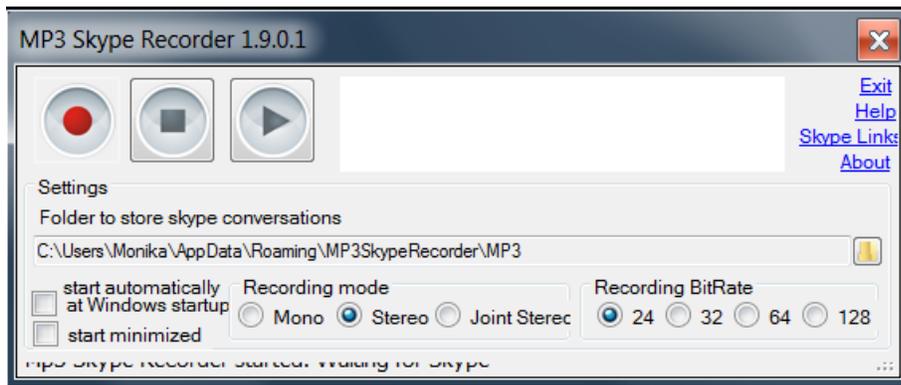


Double click on the MP3SkypeRecorder.msi

5. Follow the instructions to install the MP3 Skype Recorder onto your computer.



6. Open MP3 Skype Recorder. It should look similar to this:



### **Veteran Assessment Interview Instructions**

When you are ready to begin your interview, use the following steps:

1. Open the contact log Excel spreadsheet, which will be email to you separately.
2. Open the Zoomerang online assessment using the link, which will be emailed to you separately.
3. Open Skype.
4. Open MP3 Skype Recorder.
5. Dial the Veteran's phone number.
6. Read the Veteran the introductory paragraph on Zoomerang.
7. When a Veteran agrees to be interviewed, start recording your conversation by clicking the **Red Record** button in the Skype window. You should see the digital interpretation of your interview (the blue lines that move with the timelines) on the Audacity screen.
8. When prompted by Zoomerang to end the assessment, click on the **Stop** button to stop recording.
9. Hang up your Skype call by clicking on the red **End Call** button in the active call window.
10. Finally, save your recording as an MP3. Save each recording to a designated folder in the MP3 Skype Recorder on your computer using the same file name as the alphanumeric code used at the beginning of the interview.
11. Complete the Demographics portion of the Zoomerang tool using the information on the Excel spreadsheet. When you are finished be sure to hit **Submit** on the Zoomerang tool and you will be returned to the original page so that you can complete another interview.
12. Record the outcome of each call by filling out each field on the contact log. Please be sure to fill in the alphanumeric code for each Veteran interviewed. This code ties together the Excel spreadsheet, the recorded MP3 of the interview and the Zoomerang online responses.

## Return the MP3 files to NACHC and Atlas Research

In order to securely transfer you interviews back to NACHC and Atlas Research we have created a shared folder for you to save the MP3s to. Please do not email the MP3 files at any point in the interview process as this could compromise the security and confidentiality of the Veteran's responses.

**On a PC, from Internet Explorer** go to:

- URL: <ftp://ftp.atlasresearch.us>
- On the right side of the browser window, click on the **Page** menu and select **Open FTP site in Windows Explorer** and you will be prompted for credentials
- Username:
- Password:
- You should now have access to the **NACHC** folder
- To save MP3s from you computer to this folder,
  1. Open both the folder on your computer that contains the MP3s and the NACHC FTP folder on your desktop.
  2. Highlight all the MP3 files on your computer
  3. Drag and drop the MP3 files from the folder on your computer into the NACHC FTP folder

**On a Mac:**

- Download CyberDuck FTP conversion software by copying the following link into your browser: <http://wsidecar.apple.com/cgi-bin/nph-reg3rdpty2.pl/product=02966&cat=11&platform=osx&method=sa>
- Open the CyberDuck application from your applications folder
- Click on **Open Connection**
- Type <ftp://ftp.atlasresearch.us> into the **Server** field and the following credentials into the **Username** and **Password** fields:
  - Username:
  - Password:
- Select the **NACHC** folder
- Click on the **Action** button and select **Upload**
- Navigate to the MP3s you have saved on your computer and upload them to the FTP folder by selecting **Upload**

## APPENDIX 8. INTAKE PROCESS ASSESSMENT QUESTIONNAIRE

### Assessment of CHC Intake Process (Regarding Veterans)

*Interviewer instructions: These questions are worded for a face-to-face brief interview. If the interview is to be done over the phone, the wording of a number of questions will need to be modified.*

*After introductions, please use this statement as an explanation of this assessment: “As part of the VA Collaboration with Rural CHCs project in which your clinic is participating, we are assessing the clinic’s patient intake process. Our hope is to make recommendations in this process to identify Veterans who may be eligible for benefits with the VA. As the intake specialist, you are vital to this assessment. I would like to ask you a few questions about your intake procedures and process. Is this a good time for you?”*

1. Does the clinic use an electronic medical record system, and if so, is the intake process part of this system? (If not, please skip to number 3)
2. Who is the vendor of your EMR system? Can you make modifications to the system or can you ask the vendor to make these modifications to your system without additional costs?
3. Please describe the steps of your intake process.
4. Can you give me blank paper copies of forms you use for this process or print blank screens of the electronic system you use?
5. Once the intake is completed, do you have a system to flag the EMR or paper patient record for certain status of the patient, such as Medicare, Medicaid, or a specific known medical condition?
6. If you do flag these records, how is this done? Can you show me?
7. Do you ask each new patient whether he or she is a Veteran? If so, how do you ask this question? What is the specific language that you use?
8. Have you encountered patients that are confused by the question? If so, could you please describe?
9. If a patient is a Veteran do you ask if they have applied for or are receiving VA benefits?

10. For your established patients, do you have a routine system to update their patient records with the same basic information you get during the initial intake?
11. Do you ask the established patient about any changes in their address or insurance with each visit?
12. How difficult would it be to ask an established patient over the age of 18 whether he or she is Veteran at the time that you verify their address and insurance coverage?
13. If the Veteran status of an established patient is unknown to the clinic, how could you best get this information?
14. If we recommend that changes be made to your intake process to gather more information on Veteran status, what do you think would be the easiest and most efficient way to introduce these changes?
15. If we recommend that changes be made to your intake process to flag Veteran status for the health care provider, what do you think would be the easiest and most efficient way to introduce these changes?
16. Do you have any other recommendations about getting the Veteran status information from your patients?

## APPENDIX 9. FOCUS GROUP QUESTIONS

### Focus Group Guide for Rural Veterans

#### NACHC VA Collaboration with Rural CHC

(1.5 hours maximum)

Date of Focus Group: \_\_\_\_\_ Location: \_\_\_\_\_

*(Moderator Opening Comments to Group— explains Consent Form and Demographic cards. Further explains that this is a semi-structured group session and while we have a list of questions used to guide the conversation, additional questions may be asked to clarify responses and information contributed by group members. Moderator asks the group members to please note “Health Center” will be used to refer to the Center site where the Veteran receives his/her care and VA will be used for VAMC, CBOC or other VA facilities):*

Thank you for your interest in participating in this focus group. The Center along with the Veteran’s Health Administration has asked us to conduct this focus group with you to determine how the Health Center and the VA can better serve the health care needs of rural Veterans and their families. This focus group will be recorded to ensure its accuracy; however, your individual feedback will be kept strictly confidential and only shared anonymously with Center or the VA. We will ask you to complete a demographics card to gain some information about each of you and then we will discuss your health care experiences and improvements you would like to see. As we are discussing these topics, we would ask you to observe the following posted guidelines:

- Respect confidentiality—what is said in the group stays in the group
- No rank used
- Respect one another
- Be as open and frank as you feel comfortable, but we ask that your feedback be honest.
- Listen fully for understanding
- Be open-minded and non-judgmental
- Speak one at a time

Do you have any questions before we begin? Let’s begin.

**A. Demographic Card (Distribute a card to each participant to obtain this information quickly. See page 2 for demographic questions.)**

*(Note to Moderator: This section should only take 5 minutes)*

*(Moderator Comments to Group):*

We would like to collect some general information about you in the next 5 minutes. This information will remain confidential. Please only provide information that you feel comfortable giving – you may decline to answer any or all of the questions.

**B. Awareness:**

13. How do you learn about the services of the VA in general?

14. Do you know if you are eligible for VA benefits?

15. Have you ever attempted to apply for VA benefits? If so, where? What was the outcome?

**C. Accessing and Utilizing Health Care:**

16. What is your preferred health center where you receive most of your care?

17. If you are enrolled in the VA do you use both the VA and the Community Health Center?  
Can you tell us more about that?

18. Do you experience any challenges or barriers in accessing health care? If so, what challenges or barriers do you or have you experienced in getting care from the VA?  
From this health center?

*(Note to Moderator: this could be personal barriers such as needing transportation or family care, or barriers specific to the facility or staff such as lack of privacy or sensitivity to unique needs, waiting time for appointments, and other challenges due to perceptions about who the health center or VA is meant to serve, etc.)*

19. What have you heard from other Veterans in the community about their experiences in accessing and using VA services? What are the perceptions among Veterans and their families about who can use the VA?

20. Within the past three years, have you been seen by a physician or other provider at the VA and if so, for what services?

**21.** What are the reasons you seek care both at the VA and the health center? Do you know other Veterans who get some of their care at the VA and some at the health center? If yes, do you know why?

**D. Satisfaction with Current Services:**

**22.** Please describe how satisfied you are with the health care services you receive at the health center. Please describe how satisfied you are with the health care services you receive at the VA.

**23.** Please describe how satisfied you are with the health center's ability to accommodate your family members and to involve them in your care. Please describe how satisfied you are with the VA's ability to accommodate your family members and to involve them in your care. Do your family members receive their care from the health center or clinic?

**24.** Are there other members of your family who are veterans? Do they receive care from the health center or VA or both?

*(Moderator Closing Comments to Group: Thank you for sharing your experiences with us today.)*