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Identification of Military Veterans Upon Implementation of a Standardized Screening Process in a Federally Qualified Health Center

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Abstract
The identification of veterans receiving care in community-based settings is important and has implications for healthcare delivery and workforce training and development. As part of a larger collaboration regarding the delivery of behavioral health services, this project partnered a Midwest Veterans Affairs Medical Center with a state primary care association and large federally qualified health center (FQHC) to standardize the method in which veteran status is captured in clinic. Before adapting the screening item and implementing it as a required field in the electronic medical record, the number of veterans reported was 56, or 0.32% of total patients. After implementation, that number increased to 506, or 3.01% of total patients. This suggests there is a need to standardize the method in which veteran status is collected, which has implications for awareness of conditions likely to impact veterans and may inform opportunities for providers to engage in veteran-centric education and training.

Keywords Veterans · Federally qualified health center · Community care

Introduction

Many veterans face barriers to care including living long distances to both primary and specialty care services [1]. As such, delivering care where veterans reside has become an increasing focus of the Veterans Health Administration (VHA) over the past several years. Whether via expansion of telehealth programs (e.g., Advancing Telehealth through Local Access Stations [Atlas]) or through legislative acts including the Veterans Choice Act or the recently implemented Mission Act [2–4], VHA continues to partner with community-based healthcare organizations to deliver care for veterans meeting certain criteria (e.g., distance, wait times) and values such partners as part of a "high performing network" of care [3]. In addition, it is widely known that veterans often choose to receive care in community-based settings, many times in conjunction with VHA services [5]. Taken together, the identification of veteran patients receiving community-based care is important and has implications for healthcare access and delivery as well as workforce training and development.

Federally Qualified Health Centers (FQHCs) represent one of those community-based options which veterans may

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utilize [6]; in 2018, over 385,000 veterans were seen in these clinics [7]. Indeed, the Health Resources and Services Administration (HRSA) requires FQHCs to report annually via the Uniform Data System (UDS) the number of veteran patients seen who have been discharged from uniformed service. While the UDS specifies that a question regarding veteran status "be included in the patient information/intake form," it does not mandate the question be asked in a specific way (i.e., with prescribed language). Rather, there are exclusionary guidelines which specify who may be counted as a veteran [8]. It is unknown the extent to which this may lead to underreporting of veteran status but suggests that there may exist issues surrounding its collection—in part due to lack of standardization of the question format—and opportunities to improve the process of capturing this information. A close examination of the existing process revealed to us an opportunity to make two changes: (1) introduce a standardized question format and (2) embed the question in the existing clinical electronic medical record (EMR).

Methods

In 2016, the Veterans Affairs Medical Center in Iowa City, IA partnered with the Iowa Primary Care Association and a large rural-serving FQHC without nearby VHA facilities. This FQHC—the Community Health Centers of Southeastern Iowa located in West Burlington, IA—served approximately 18,000 unique patients as of 2018 [9]. The overarching goal of this collaboration is to improve behavioral health screening for veterans and connect interested, eligible veterans to VHA behavioral health services. As a necessary first step of this project, we explored the primary issue described herein: how are veterans being identified in this FQHC?

Previously, the FQHC asked this question as follows: "Are you a veteran?" (yes/no). While commonly used in practice, this question fails to account for the complexity in responding which may be associated with whether an individual chooses to identify as a veteran. Research suggests that veterans may not identify as such for several reasons, including perceived stigma against military veterans, lack of deployment, belief that National Guard or Reserve active duty doesn't "count," limited understanding of the eligible length of time in the service, and/or limited understanding of VHA eligibility benefits, some of which may impact utilization [10, 11]. This makes asking the question in this manner potentially problematic as certain assumptions are made about the patient's perception of veteran status which may not be true. Moreover, what it means to be a veteran for the purposes of VHA benefits may be somewhat different than what it means to be a veteran more broadly, including social/cultural implications and military-related sequelae. Oftentimes, these two concepts are conflated.

Consequently, we implemented a systematic method of screening for military veteran status which focused on two main elements: (1) research- and VHA-supported, prescribed wording; and (2) implementing a required field or "hard stop" into the EMR upon a patient intake episode of care. The veteran status screening item was adapted as follows: "Have you served in the United States military or armed forces? This includes: Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves." (yes/no). Follow-up discussion was conducted as appropriate to ensure guidelines for veteran status reporting as detailed in UDS were met (e.g., not considering those still in active service). This item has been deemed to be more inclusive than traditional methods and contains the necessary elements as recommended by VHA [12].

Of note, UDS specifically requests information about "uniformed services" which also technically includes the US Public Health Service (PHS) and National Oceanic & Atmospheric Association (NOAA); by federal definition, service in either confers veteran status [13]. Although the present manuscript describes our initial focus solely on military veterans, an adapted version of our screening item is under consideration for nationwide expansion at the Health Resources & Services Administration (HRSA) to include all uniformed services, aligning with UDS requirements and fully meeting the federal definition of "veteran." Not explicitly naming PHS and NOAA in our initial item revision may have resulted in a slight underreporting of the total number of veterans reported here.

Results

As Table 1 shows, these changes dramatically increased the number of veterans identified as compared to the previous method. Pre-implementation rates are anchored to 2015 which was before the VHA-FQHC collaboration began. The FQHC reported identifying 56 unique veteran patients in 2015, representing 0.32% of the total patient population. Subsequently, in 2016, that number rose to 229 (1.41%). This year is important because there was an increased awareness among clinic staff of capturing veteran status as the project began, but the changes described above regarding screening language and EMR inclusion had not yet been fully implemented. In early 2017, changes to the screening item and EMR were fully implemented, resulting in identification of 506 (3.01%) unique veteran patients during that calendar year. Finally, most recent data for 2018 show 527 unique veteran patients, representing a nearly ten-fold increase from before implementation. Limiting the analyses to only adults (i.e., > 18 years old; see Table 1), the rate of veterans seen in this FQHC approaches one in twenty unique patients.

Table 1 Patients identified as veterans at FQHC

Reporting year	Number of unique patients (less children under age 18)	Number of veterans identified	Percentage of total patients (%)	Percentage of adult patients (%)
2015	17,459 (11,937)	56	.32	.46
2016	16,221 (11,306)	229	1.41	2.02
2017	16,827 (11,370)	506	3.01	4.45
2018	17,976 (12,182)	527	2.93	4.33

Source HRSA Uniform Data System

Discussion

The above results demonstrate a clear increase in the number of veterans identified receiving care in this FQHC. Although the general healthcare climate regarding increasing access and care to veterans may explain some of this increase, it is unlikely that it explains the majority. Moreover, this increase is a not necessarily a function of increased patient volume; note that the total number of veteran patients identified has increased year over year, yet the total patient volume has vacillated slightly over time. Given that some may also choose not to identify as veterans due to stigma [10], it is likely that these numbers remain an underreport of the actual.

Identification of veterans, regardless of VHA eligibility, will continue to be important considering recent VHA efforts to improve access to care for veterans using community-based healthcare services [2–4]. While a key aim of our current VHA-FQHC collaboration is to connect interested and eligible veterans to VHA behavioral healthcare, a number of veterans that we encounter won't be eligible for VHA care for various reasons. Knowledge of this particular patient characteristic, however, has enormous implications for screening and care (coordination), including awareness of conditions more likely to impact veterans such as PTSD, and may inform increased opportunities for providers to engage in veteran-centric education and training, in-service opportunities, and a general awareness of global veterans' issues [14].

Further education around veterans' issues, including military-related sequelae, may be especially helpful to providers not used to treating veteran patients regularly, as some evidence suggests [15–19]. For example, previous surveys of community-based providers have indicated that 84% reported no direct military experience [15] and only 13% reported a basic level of military cultural competence [16]. Another found that community-based providers of various walks (e.g., primary/specialty care, internal medicine) felt uncomfortable addressing routine issues related to the veteran experience [18]. In another study of a regional sample of community-based primary care providers, it was reported that many failed to ask about veteran status, were unsure of conditions and stressors most likely to impact veterans and had little knowledge regarding support services available to veterans [19]. The latter study also reported that providers wanted training in a variety of areas, including military culture, family issues, PTSD, mental health, and substance abuse.

In conclusion, this report supports the need for a standardized method of capturing veteran status within FQHC and other community-based clinic settings. Simply asking "are you a veteran?" is likely not enough. While these results are interesting and potentially important, it must be noted that the changes described above were implemented in only one FQHC in the Midwest and may not represent other clinics were similar changes to be implemented. In addition, it is possible that policy changes within VHA during the same time period contributed to an increased awareness of veterans being served through community care, thus contributing somewhat to the increased numbers of veterans we identified here. This experience does, however, suggest that standardizing the veteran screening process in FQHCs shows promise for identifying the true number of veterans in a clinic catchment area. This information may facilitate additional screening and care opportunities for veterans, help connect veterans to vital support services within the community, and engage providers in veteran-centric training opportunities, all of which are avenues for future research.

Disclaimer The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

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