Emily DeMent (00:00:02):

All righty. Hello everyone and welcome to today's webinar, standardized screening for military veteran status. My name is Emily DeMent, program associate in the training and technical assistance department here at NACHC. And I'm pleased to bring you this webinar along with my colleagues Dick Bohrer, consultant for network relations, and Gina Capra, Vice President of the training and technical assistance department, who you'll get to hear from in a few moments.

Dick Bohrer (00:00:26):

Thank you, Emily and thank you everybody who's joined in for this. I think you're going to find it really interesting presentation of a unique partnership and project that took place in Iowa, and that is already having implications across the country. If you want to switch it Emily.

Dick Bohrer (00:00:56):

National Association of Community Health Centers has been focusing for the last, oh golly, at least five or six years on improving the work that health centers can do in serving and reaching out to serve even more veterans in their respective communities. This is just just the right thing to do and very important to many of you. If you can switch Emily on. To that end, there are resources that I hope you are aware of, that we try to keep posted and up to date.

Dick Bohrer (00:01:38):

And I hope that all of you are becoming familiar with one of the newest ways in which you access NACHC resources, which is the health center resource clearinghouse. You see this on the screen, it will also be the last slide that we show today as part of this presentation. You want to switch it Emily please? We're fortunate to have four people joining us today who will share again a great example of partnerships that impact at the local and national level.

Dick Bohrer (00:02:20):

Bryant Howren, okay, well, when he began, was based in Iowa as part of veteran administration work in the research area in the research space. As you can see from the picture on the screen, along the way, Bryant changed locations, but he's doing a lot of the same sort of work but based in Florida. Aaron Todd is the CEO of the Iowa Primary Care Association. And I guess it'll be fair also to say when Aaron got involved in this project, he was in a different role with the association.

Dick Bohrer (00:03:04):

Ted Bosun, who I hope is on the call today, Ted was one of the inspirations of the idea behind it. Aaron will be sharing the PCA perspective. Ronald Kemp is the CEO of Community Health Centers of Southeastern Iowa, the health center that wanted to be a part of trying to do a better job of understanding people when they came to the center, whether they had been service veterans or not.

Dick Bohrer (00:03:41):

And then Patrick, but we're going to call him Mac. Mac Schoen is from the Bureau of Primary Health Care. He works okay in the quality part of the bureau and spend fine with the uniform data system and will share again some of the impact hat this pilot project had. You want to change Emily for the next slide? So, why is it important to have this conversation?

Dick Bohrer (00:04:13):

I have been interested in the first point for a number of years. I've always felt that we have understated the role, the work, the impact that health centers nationally have in serving veterans. My hope has been key that we will be able to accurately collect information about veterans, and then be able to roll that information up and present it to people.

Dick Bohrer (00:04:44):

But as I learned in working with folks on the webinar today, beyond that interest of just having it right, it also has a tremendous okay impact and importance for your clinical teams. A provider and in your local settings knowing that someone is a veteran that may prove to be very, very effective important information. So that practitioner patient relationship in dealing with a problem or an issue that the person presents with.

Dick Bohrer (00:05:27):

And then finally what was important about this pilot was the act of involvement of representatives from the Veterans Administration because they made a commitment. When the screening took place and if a person was identified as a veteran, a commitment to try to make sure that veterans were aware of and able to take full advantage of benefits that they were eligible for.

Dick Bohrer (00:06:01):

So if you want to know more about what we're going to talk about this afternoon, there was an article that was published about the pilot. You can see a way to get to that, but with that as your context, let's let the folks now who really did the heavy lifting share with you. So Aaron Todd's going to be the first of the Iowa team to present and then Mac will back clean up and pick up after the team from Iowa talk. He'll talk about the Bureau of Primary Health Care and how they're using it. So next slide, Emily. And you're on Aaron.

Aaron Todd (00:06:48):

All right, good afternoon everyone. And this is a photo of the Community Health Centers of Southeastern Iowa in West Burlington So, Ronald Kemp, the CEO of that health center will speak in just a moment but we can move on to the next slide. As with any good project, you first start with data.

Aaron Todd (00:07:05):

And so that is the first thing that we did, was to look at the data on veterans in the south eastern portion of Iowa to understand what is known about both the number of veterans who live in the area, some information about their demographics and access to care, and to overlay that against the surface areas for the VA.

Aaron Todd (00:07:26):

So we know you can't read this slide very well. We're just trying to give you a quick illustration of what we saw. And what you can see is that the darker the blue collar, the higher the density of veterans in southeastern Iowa service area. The area's not within the brown circles are outside of the VA direct service area. And so this essentially represents the highest likelihood of veterans who may not be receiving care, that being the blue colors outside of the brown areas.

Aaron Todd (00:07:55):

You can see here, that must be the areas serviced by the community health centers of South Eastern Iowa does not fall within the VA service areas. We mapped additional variables that included poverty, employment status, access to care and VA facilities. And then we map that against the various health care facilities in the region.

Aaron Todd (00:08:18):

We also geo coded veterans touched by the project to date and use the data to target outreach to additional veterans in the area. So the bottom line is we know we're working in an area of high need, in an area that likely is not anywhere near meeting the need of the veterans in this area.We can move on to the next, thanks.

Bryant Howren (00:08:43):

Thanks Aaron. This is Bryant Howren. Regarding goals and timeline, the four project goals have remained essentially the same throughout, so I'll read these very briefly. The first goal was to screen all patients presenting for care at the Community Health Centers of Southeast Iowa for veterans status using a standardized methodology. And we're going to go into that here a little bit more in a slide or two.

Bryant Howren (00:09:06):

Our second aim was to screen all adult patients to identify mental and behavioral health issues and these include depression, anxiety, substance use disorder and post traumatic stress disorder. The third aim was to, once veterans were identified, assist those who were interested and eligible with accessing VA care enrollment services.

Bryant Howren (00:09:30):

And the last one, we wanted to make sure that veteran patients who screen positive for behavioral health issues receive timely behavioral health care whether that was at a VA facility or where they were presently getting care at the FQHC. In terms of our timeline, this started several years ago. It took a bit longer than I think anyone had hoped, but once we got rolling, we started stacking successes as some might say.

Bryant Howren (00:09:58):

Back in 2014 and 2015 we really began having discussions between the VA's Office of Rural Health Resource Center in Iowa City and the Iowa Primary Care Association. When we started, we actually didn't immediately focus on mental and behavioral health. I think that was something that came out a bit later. Initially, we just wanted to partner around issues related to veterans in the state of Iowa and surrounding areas.

Bryant Howren (00:10:23):

Around 2016, we were able to secure funding for project management and a portion of effort from an RN care coordinator through the VA's office of rural health. In 2017, we finalized our veteran status screening item and the process surrounding that incorporating it a hard stop and the community health center electronic medical record.

Bryant Howren (00:10:48):

In 2018, we were able to add additional nurse care support and these are the two nurses that we actually have who are actively care managing veterans right now. And then finally, more recently, our focus has been on collecting data to be able to describe this group of individuals that get care at the CHC, also access VA services.

Bryant Howren (00:11:11):

Just be better able to describe their needs, also document the processes. We're actively working in the toolkit right now and then looking toward expansion in the near future. Next slide, please. And before I turn this part over to Ron, I'm going to make a quick comment about the item that you see in the lower left hand corner of the slide.

Bryant Howren (00:11:33):

So this is the item that we use to identify veterans now. The wording is really important here because we're not simply asking, are you a veteran? It doesn't capture all veterans who either may not think themselves to be a veteran. And this can be for one of many different reasons. Sometimes it's things like, well, I wasn't deployed, so I'm not a veteran. Well, that's not exactly true, or I'm not eligible for VA care or other services.

Bryant Howren (00:12:00):

And that doesn't make any veteran and those two things actually are conflated quite a lot. So what we did here was try and streamline the process, capture as many people as we possibly could. And then I'll let Ron take it from here.

Ronald Kemp (00:12:17):

Thank you Bryant.When this first was presented by the primary care staff, Ted Bose at the time, I was excited personally as a CEO, we always are looking for new challenges. But I was worried about our response from our staff. Is this just one more task we're going to have to do?

Ronald Kemp (00:12:38):

As soon as it was discussed with our team, I was pleasantly surprised by the response. The response was, yes, let's get going. What I learned was the number of staff who were veterans themselves or their family members were and the goodwill was already present. People want to get going because there was a common sense of, although we didn't have data to support, a common sense that the vets in our area were underserved for lots of different reasons.

Ronald Kemp (00:13:05):

But you had to make it work. So that's why we said, we have the right question and thank you to the VA. Because one of the things we learned early on, we really needed to listen to the VA staff in terms of the communication, what works in communicating with a vet. So shaping the question was one but we had to set the question up. So it was a hard stop because we looked at data and found we weren't finding very many vets.

Ronald Kemp (00:13:33):

Prior to us setting up the screening being a hard stop, the question being a hard step, we were less than 50 vets being identified a year. And now we're 10 times that on an annual basis. So it was very significant. This was the tool that got us to the door, that got the names of the individual vets then became context for the RN care manager. So it was the beginning and it had get done.

Ronald Kemp (00:13:56):

We thought it was going to be very complex, very difficult to get set up because we ARE part of a network of community health centers with a common software called Heartland. But it actually was very easy to get set up and the staff were eager to get it moving. In fact, they were complaining, why aren't we moving ahead? So that was a barrier that we were really concerned about both the cost and the practicality because there's 1015 members in that network member centers.

Ronald Kemp (00:14:24):

We thought we'd have to get all them to agree to it. And we were able to move ahead and make the modifications just within our individual software. And it worked. We start to see data change dramatically as soon as the heart stop and the education with the staff was completed.

Ronald Kemp (00:14:42):

So it sounds like a small issue, but it was the entree to get any contacts that we needed, because that was the base for how the care actually was connected to both providers, and then to the RN care managers who are eventually hired. And I'll leave Aaron at this point, to the next slide. Aaron, I think we're going to have you cover this slide?

Aaron Todd (00:15:20):

Yeah. So this data, this slide here shows the data of patients that were captured through the screening question. And you can see the powerful impact of that. 2015 was the base here where you can see there were 56 veterans that were identified. In 2016, that number naturally grew as a result of awareness of all staff about the project, even though formal changes had not yet been implemented at that point.

Aaron Todd (00:15:52):

In 2017, then the EMR change was incorporated in February of that year. And you can see that big increases two, or 3% of the total population served a patient. In 2018 and 19, you do see a leveling off of the growth. And it makes sense that there would be a huge increase when the change is made as the health center ramped up efforts to catch up on this data point with all adult patients.

Aaron Todd (00:16:19):

And then once everyone has been asked, or the majority have been asked, then it becomes a function of asking the question of new patients presenting for care. So even with a significant and very gratifying growth in the number of veterans identified, we know based on the data presented earlier that there are so many more veterans to reach to ensure they are engaged in care.

Aaron Todd (00:16:40):

So in short, the number of identified veterans in 2017 is actually nearly 10 times as many veterans were identified in 2018. I'll turn it over to Bryant.

Bryant Howren (00:16:55):

Thank you Aaron. Next slide, please. So this is a glimpse of where we are now. And while the purpose of this webinar is to share our success in identifying veterans, this project is a lot broader than that. So as I mentioned in a previous slide, we're actively care managing veterans with VA right now and substantial numbers.

Bryant Howren (00:17:19):

Currently our two nurse care managers that are at the FCC can not only view but also document in the VA electronic medical record that they are actively care managing veterans and help connect the community back to various services, some of which are mental health. And then there are also other services that veterans are taking advantage of.

Bryant Howren (00:17:42):

So we're also looking to actively expand this project in the next federal fiscal year. We've already secured more funding from the VA Office of Rural Health to do that, and we'll be looking within the Iowa region and also since I've recently relocated to Florida, we'll be doing the same thing in this area as well. Turning to the nurse care managers and what they're doing very practically speaking, they're getting, as I mentioned, many veterans connected to services.

Bryant Howren (00:18:15):

Some cases are uncovering needs that we didn't know existed. And so I think that's one of the pleasant surprises of this project. It's not just that we're assisting with mental health but also finding additional needs that veterans may have and that we can help or supplement with the VA services as we move through the project. I think now to turn it over to Ron.

Ronald Kemp (00:18:50):

How you up this is how we in committee health center level and working in close coordination with the regional VA services have really started to get services to vets who frequently were not aware of, not utilizing, not adequately utilizing. And the key piece of that was the care managers, because they develop relationships.

Ronald Kemp (00:19:17):

It wasn't infrequent that identifying a vet and having a VA nurse care manager talk to the vet on the phone, that they weren't immediately ready to get service or even to identify what issues. But it was very clear that that relationship was real critical after just a couple of stories. We could go on for stories for a long time, but they'll ruin my conversation, so I'm going to try to go through these fairly quickly. I picked out a couple.

Ronald Kemp (00:19:44):

One is how were the care management working with the VA Health System, how are they assisting in terms of eligibility? So case one, and he's elderly vet, he's a Vietnam vet. He presented to the community health center with a complaint of ongoing fears and recalling trauma. So that sound like it had been part of his personality, his life experiences for some time.

Ronald Kemp (00:20:07):

At the time that he was presenting and the case was reviewed with the our care manager, they could not locate his discharge. So technically he wasn't eligible for services at the VA. At the time of this story, we still haven't determined if that discharge has been resolved. But we arranged for him to be able to get the behavioral health services from one of our therapists and he had been not receiving care.

Ronald Kemp (00:20:32):

He had not sought care. He had come into our office not just because of these complaints, but it came up in a conversation because he was identified a vet, was referred to the VA nurse case manager. A second case was a world war two vet, moved from Ohio to Iowa. He had been getting services at the VA in Iowa city, but he started as he was aging, he started developing problems driving or actually even riding to Iowa City.

Ronald Kemp (00:20:59):

So we were able to arrange him to get benefits to the VA community care network, the community care program. And some of that service was being provided by the community health center. So again, somebody who was in the VA system was qualified for VA health care services, but had to transition just because of his health status to predominantly be receiving care of the community at the Community Health Center.

Ronald Kemp (00:21:24):

Another one was just the the power of care coordination. Case of a young female that who showed up at our office. She was seen by the VA care manager. Her presenting problem that she discussed with the care managers that she was sexually assaulted or raped in basic training when she was in the National Guard. She was not eligible for VA health care, because she, and I'm not an expert of this but apparently because she had not served in a federal capacity.

Ronald Kemp (00:21:56):

She was a resident of Illinois and had been receiving behavioral therapy services through the Illinois Medicaid program. That therapists dropped serving Medicaid, Iowa Medicaid, and she ended up showing up at our office. But working with the VA staff in Iowa city with Dr. Abrams, he was able to find assistance for Illinois through one of the veteran's service organization in Illinois.

Ronald Kemp (00:22:20):

And same time, she continued to receive some psychotherapy at the Committee Health Center. But the VA also because of her case, was able to eventually qualify for benefits at 30% level and was having their psychotropic medications paid for. So she went for several years and struggled with this and just think of the complications of trying to get that arrangement. It was especially the relationship between the VA staff, Dr. Abrams and our primary care managers that really made that connection.

Ronald Kemp (00:22:55):

And the last one I'll go through was, it was a gentleman came in with his wife. He was elderly, had a number of health conditions, was declining in health. He did qualify for VA benefits but was not utilizing them at the time. He was a VA, excuse me, a Vietnam veteran. He had had exposure to Agent Orange and Blue Water, spent quite a bit of time talking with our own care manager.

Ronald Kemp (00:23:18):

Finally agreed to go to the Quincy, Illinois VA and began getting additional services, especially services, but again became too sick and and was transferred back to the community, and got most of the services at the community level. But the VA RN care coordinator on our staff continued to provide services after he passed away in April of 2020 to his spouse, because she still was a beneficiary of the services.

Ronald Kemp (00:23:49):

So again, it's kind of a continuum of coordinated services that I doubt would have existed if that individual just came and saw one of our primary care providers in our system. So, again, very quick stories about the value of those RN care managers. We would not have those RN care managers if it wasn't for the financial support from the VA project.

Ronald Kemp (00:24:16):

But when asked before the staff said, you can't, if we don't continue to have funding for the VA. We have to have these RN's that are working specifically with the vets and so we are committed to that.

Bryant Howren (00:24:38):

So I think now we're going to briefly talk about some next steps related to the project and I'm supposed to kick that piece a little bit by talking about what VA has an interest in here. I think as VA continues to expand its cure network into community based clinics, there is going to be a continued interest in identifying veterans and being able to serve them.

Bryant Howren (00:25:00):

And one of the things that I can point out is that this is a little bit different from whether or not they're specifically eligible for VA care. And that's a huge piece of interest there, but VA would also say that they have an interest in serving veterans where they are and making sure they get care even for those who may not be eligible for VA services.

Bryant Howren (00:25:23):

Another quick point I want to make is regarding publications. So earlier, Dick had pointed out one that we were able to write up and get published not too long ago. And this is a powerful tool to get our message out there. And we're currently working proactively with Iowa primary care and with the FQHC to get some aggregate data and start to describe these veterans and some of their needs.

Bryant Howren (00:25:46):

I think I'd mentioned this a little bit earlier, and write up a paper around that, that demonstrates who these individuals are and what they need from the community and perhaps from the VA side as well. So that's something that's in process and we'll continue to write things like that, which can get our message out there. Those are my two main points. And I think I'm going to flip it back to Ron and let him talk about some of his perspectives on next.

Ronald Kemp (00:26:12):

Sure. Over a year ago, we did a presentation at a NACHC meeting. And one of the participants came up and she said, well, this is population health management. Yes, it is. So if you think of all the

transformation we as community health centers have gone through in terms of our clinical processes to improve the outcomes in the lives of our patients.

Ronald Kemp (00:26:35):

It's just another group has some unique needs, and some unique communication that is necessary to work success with vet. But we also want to standardize how we document what is being provided to the vets and part because of our effort to look at ourselves, and are we doing well? Are we having success in some of these efforts with vets but also to provide that information To the VA, and we're starting to look at more detailed data sharing between organizations to accomplish that.

Ronald Kemp (00:27:07):

The other piece to look at is, if you recall back on the slide where Aaron was reviewing, looking at the data, that is a next step, because we know who we're touching right now at this point is the person coming in the door or the vets family coming in the door. We need to do more outreach in our geographic areas to encourage more of the individual vets who are not taking care any place to use us as an entree so that we can connect them to the services that are both available at the community level and the regional hospital systems and outpatient clinics systems.

Ronald Kemp (00:27:42):

The other piece is the next steps is refining that relationship between the organizations. We keep learning from each other. And when Bryant talked about our staff being able to enter information into the VA health records and be able to review it, we're also looking at what other kind of data we can be sharing with a VA that's going to be helping them at their level, their specialty clinics or their inpatient programs.

Ronald Kemp (00:28:11):

So that the service is actually being refined to meet the needs as we come to really learn more and more about the needs for that. Aaron?

Aaron Todd (00:28:22):

Thanks, Ron. So the Iowa PCA views projects like this with an eye toward replication and how we can utilize what we've learned and expand this important work. So to that end, we'll continue to work on documenting what we've learned and sharing it more broadly. In part we're doing this through development of a toolkit. Because the project is ongoing, the toolkit has been developed so that it can be shared in phases.

Aaron Todd (00:28:44):

And the first phase is what we discussed around identification of veterans via standardized process should be available within the next two months. We'll also help to identify how we can continue evolving our model of care to be more seamless between our health centers and the VA system, and hopefully rollout this partnership to other health centers in the state.

Aaron Todd (00:29:03):

One of our next steps is to start a dialogue with the VA that serves the other half of Iowa. And I wanted to note here as well, two of our staff members, Deb Casper, Zach and Emily, both on the Iowa PCA team.

I know I'm very biased, but believe I have a really great team here at the PCA and these two really exemplify that work. And I'm very grateful to all of their efforts to move this along.

Aaron Todd (00:29:26):

And Dick already mentioned it but I wanted to also mention that Ted Bosun who is my predecessor, CEO of the Iowa PCA, who was a driving force to get this project started and moving, and I'm the beneficiary of that vision and works over it. So now I'll turn it over to Mac to talk about veterans work to incorporate lessons from this collaboration within the UDS process.

Mac Schoen (00:29:55):

So I just like to echo what Aaron and Ron and everyone was saying about how important it is to make sure that we are aware of and at least being able to track the impact that our programs have on America's veterans. So I came to the Bureau of Primary Health Care not too long ago from VA's Center of Excellence for Suicide Prevention, where, as part of then Secretary Schulkins top and only clinical priority, which was to focus on all veteran suicide, we had to better understand how to positively identify title 10 and likely title 32 veterans from Department of Defense and other administrative sources.

Mac Schoen (00:30:40):

And then link those population estimates across other data products in order to do our analysis and reporting and everything. When I arrived at HRSA, I was pleased to learn that veterans are one of our top tract special populations and really sit first and foremost in a lot of our public facing publications and reports. I noticed that our health centers identified serving 385,000 veterans in 2018.

Mac Schoen (00:31:08):

However, I was new and I was yet to know how this number would match with the concepts that VA census ACS products and then other organizations concepts of veteran status. So this difference usually stems from mismatches in veteran determination between data driven and self reporting methods as was mentioned earlier. And this mismatch in the meaning of veteran can happen when there's identifying questions or even just in the minds of former service members, as already mentioned.

Mac Schoen (00:31:44):

So for example, census acknowledges in some of their publications on their public facing website, that their ECS products might have a deviation in the estimate for a veteran population that's based on self response of that veteran status, the way that they do their survey and estimates. So many former service members who are legally defined as veterans, and this is slightly different than who's eligible for VHA services or VA benefits or VCA funeral services.

Mac Schoen (00:32:14):

They don't self report their status sometimes if they don't serve in conflict. And then in other situations their self report for veteran affirmative report, veteran status might be based on state National Guard duty, where the legal definition for eligibility in care and veteran status can start to get extremely complex.

Mac Schoen (00:32:37):

The National Guard and Reserve obviously function in a slightly different way than the sort of standard branches of the armed forces that most people think of. Now I think since 2016, after 20 years and retirement, both reservists and guard members who have never been deployed or had federal paid service under Title 32, they can now use the veteran title even if nothing that they did qualify is for Title 10 or 32 VHA benefits.

Mac Schoen (00:33:09):

However, we know that after six years of guard service that you might be eligible for other VA services through the VA, such as home loans. So the situation gets very complex. So when we think about it from a health perspective, this variance can add up to a difference in millions of the estimated number of veterans in the United States compared with VA models or ACS products.

Mac Schoen (00:33:34):

I think in 2018, this was 20.3 million versus 17.9 million depending on which product you were using. So you can imagine that this variation can have knock on effects down to the county level, and we saw that in the maps with ACS products. You can start modeling how many veterans probably live within the catchment areas of the VA, both in driving time and distance.

Mac Schoen (00:34:00):

And then that is further compounded by what was the Choice Act and now the Mission Act for extension of care into the community and reimbursement models. So at BPHC when I arrived, I discussed some of these possibilities with our UDS having maybe some of the same issues that VA and ACS has. So in our annual review of UDS content, we identified middle last year that the veteran definition was a place for focus.

Mac Schoen (00:34:36):

During our internal discussions, we worked to find some evidence of other ways this was being handled. In an article in the Journal of community health, we found, I think, days after publication that supported our efforts, which was great to find and it contributes to the more inclusive definition that we had planned to implement for UDS in 2020.

Mac Schoen (00:35:00):

We believe that the efforts to further clarify who should be included in this definition will allow health centers to better support the veteran population that they're engaged with. I think we've seen that in the previous presentations. We think this is really important to engaging veterans in primary and preventative care, especially with mental health.

Mac Schoen (00:35:18):

And my background in suicide prevention, we saw that as a very important element of suicide prevention for the, I think, two thirds of veterans who are eligible for VHA care, to some degree, but are not receiving their primary care through VHA. And you can look up those numbers on the VA website. I'm not saying that that's the exact numbers.

Mac Schoen (00:35:40):

So furthermore, we think that a harmonized understanding of this veteran status across all the programs will allow for HRSA to plan for better resource allocation and further participate in any implementations that might support community based care and the goals of the mission act. So I just wanted to go over the changes that we've made and they'll be available in the 2020 manual, which is currently in the process of being set for release.

Mac Schoen (00:36:08):

There's been some changes because of the COVID adjustments with everything. We've still planned to get it out earlier than ever, but it needs to make sure that it's the most helpful state. So the current state for 2019 in the manual is that all health centers should report the number of patients served, who have been discharged from the uniformed services.

Mac Schoen (00:36:32):

So an interesting difference there from armed services of the United States and that this element should be included for the patient intake form. And then the caveats and carve outs were only those who affirmatively indicate don't count, non response or other indicators that you've noticed that they don't possibly indicate. Don't consider persons who are still in the uniformed services, including soldiers on leave and National Guard members who aren't serving on active duty, so non active duty status as veterans.

Mac Schoen (00:37:04):

We also had, don't count veterans of other nations militaries, even if they served as allies, or were in wars that we were involved with. And then a little note to say, don't make this an exclusive category that you can have veterans experiencing homelessness and others. And if they're a veteran experiencing homelessness, count them also as a veteran, because that's another tract population.

Mac Schoen (00:37:30):

So we figured that that was a little confusing. The use of uniformed services, the use of these carve outs and the mentioning of non active duty and everything else was possibly causing some confusion and implementation complexities. So for the future state, we're planning to have the following language which is that all health centers should report the number of patients who served in the activity military naval or air service, which includes full time Air Service and the Air Force, Army, Coast Guard, Marines and Navy or as a commissioned officer of the Public Health Service DHS, or the National Oceanic and Atmospheric Administration, NOAA.

Mac Schoen (00:38:14):

So those are commissioned officers in the uniformed services. So it explicitly states what was more implicit in the old definition. In addition, we asked that they included patients who served in the National Guard or the Reserves on an active duty status. So this is a slight difference from what was presented earlier. But we think it's in line with pre-standard practices for identifying likely Title 10 and Title 32 veterans.

Mac Schoen (00:38:40):

And then we ask that it's put into the intake form. So the carve outs here are report only those who are discharged or released under conditions other than dishonorable. So that gets into some other elements

of the health aspect of veteran definition, and then report only those who affirmatively indicate that they previously served in the above branches of the military armed forces.

Mac Schoen (00:39:03):

So again, it's just hearkening back to the definition I had said earlier, which was the full time service and active duty status and garden reserves. There's no change to our other exclusions about non response or foreign allied armed forces. So we look forward to seeing how this can better align with VA numbers and how we can use this for better policy planning, as I mentioned earlier. Okay, so back to Dick to open up the Q&A portion of the webinar.

Dick Bohrer (00:39:37):

Well, again, thank you to Bryant, Aaron, Ron, Mac for taking up this session. I know we've got one question that came in through the chat function. And while others of you may be thinking of questions that you want to do, let me just again, mention something else that you see on this slide. When we started Emily did an introduction. And she mentioned that she was joined today by Gina Capra.

Dick Bohrer (00:40:13):

And as Aaron said about Ted Boson on and his champion of this pilot project, Gina has been a champion in many different roles for veterans and veterans getting access to benefits and care, it's appropriate. It would be wrong if I didn't Gina, at least give you a chance to say hello to the folks on the phone and really add your perspective to what we've heard from the folks who've worked on this project in Iowa, and then Mac's sharing okay with how the bureau prime healthcare as you see it. So Gina, you want to unmute? You did. Well, I thought she unmuted.

Gina Capra (00:41:11):

I think I unmuted. Can you hear now?

Dick Bohrer (00:41:13):

Now you're going. There you go, kiddo, great.

Gina Capra (00:41:17):

Well, thanks so much for the generous comments Dick and special thanks to this faculty today who show that if you can find the right partners, with the right attitude, this can work. And so I think my message would be that it's worth a try. And for help center folks who are on the line or Primary Care Association folks who are on the line, don't give up on trying this project, as described by our colleagues in Iowa.

Gina Capra (00:41:55):

Reach out to us here at NACHC. Reach out to our faculty. Let us help make connections if needed, but it matters for our veteran patient population for so many of the reasons presented today. And for those on the line who have served or our family members of those who have served, I just want to say thanks for your sacrifice and your service. And with that, I'd like to turn it back over so we have some Q&A and discussion time.

Dick Bohrer (00:42:27):

Great, thanks, Gina. And I thought for sure Gina was going to mention but she didn't, so I will. The first bullet under questions is one of the things that NACHC does support is a veteran's interest group, very informal. It's not a committee you apply for or anything else. It's people who come from the health center world, board members, clinicians, executives, administrators.

Dick Bohrer (00:42:58):

We try to routinely do email communication to the group when we're able to meet in person. We try to afford those opportunities, but if you are interested in this subject matter, topic and you're not a member of the interest group, please use the trainings@nachc.org to get on board. So the one question I'm seeing in the chat box and again Emily, there may be others is a question for Matthew about determining if a guard person is considered a veteran.

Dick Bohrer (00:43:42):

Mac, you may have commented a little bit about this, but I'm going to format open it up for you. I'm going to ask Ron, or Brian or Aaron, when you were putting the pilot project together, how did you approach the question that Matthew poses?

Ronald Kemp (00:44:07):

This is Ron, we defer to the VA staff to help us with those. So Bryant, if you could answer that specific question, that may be the broader question that Dick is posing.

Bryant Howren (00:44:19):

Yeah, absolutely. And I think that Mac had mentioned some specific elements that would count someone from the National Guard as a veteran. We started more broadly, and the idea was to move from just a very general and simple are you a veteran, which is a bit of a loaded question in that it can mean many different things to many different people.

Bryant Howren (00:44:41):

And oftentimes, and I think the slide that shows our identification veterans from 2015, 16 to now demonstrates that we weren't picking up a lot of these individuals. But our goal was to identify veterans who may count in be classified as veterans, I should say sorry. Because there's so many implications for being a veteran in terms of treatment and care. And if you simply ask a very specific question about well, did you serve in this way or that way, in this service or that service?

Bryant Howren (00:45:21):

That's sort of starting out the conversation on a negative note, there are a lot of details there. So we just wanted to keep it as high level and succinct as possible, but also improve on the are you a veteran, if that makes sense. I don't know if Mac wants to add anything to this piece or not about the specifics. But the idea is that you asked that question, then you sort of drill down a bit.

Bryant Howren (00:45:43):

And this is similar to I think, if you're familiar with the VA has a community care toolkit online? And they encourage asking the question in this way, and then actually also inquiring about is he or she's not a veteran, if whether they have family members who are veterans. And so you may be picking up on

individuals that have needs that are outside of that one particular patient interaction, I think is what that's getting at a little bit.

Bryant Howren (00:46:10):

But the last point I'll make before I turn it back over to Mac is that this is extremely complex. And that is one of the reasons why I think collectively people have recognized there's been a great need to improve upon how we ask about this.

Mac Schoen (00:46:26):

Yeah, this as a Mac Schoen. I completely agree with what was just said. So I spoke quickly earlier, but a National Guard member can have various complex meanings to what veteran status grants and what veterans status means. And so specifically for National Guard, VA is the only organization that can, through the legal entitlements granted by Congress, decide who is a veteran for benefits, funerals and health care.

Mac Schoen (00:47:06):

It's DOD provides the paperwork. It's brought over by the veteran. There's various exchanges that are happening with data, but VA is the only organization that actually makes this determination from a legal basis for their services. Now, there was a law that was passed that said, if you are entitled to retirement, 20 year retirement from the Reserve or National Guard, but you don't qualify as a veteran other ways, then you can call yourself a veteran and it's not "illegal".

Mac Schoen (00:47:37):

But again, there's a difference between what you would want to do as a health center and what the VA can do as the legal entity that can determine this. So the standard understanding of this is that, yes, there's a minimum number of days of federal activated service. So if their paycheck is coming from the federal government, there's a cumulative number of days that qualify.

Mac Schoen (00:48:02):

These are again, not training, not their upkeep and training is not the initial AIT stuff. It's only when they're being deployed and federalized. So that's a whole can of worms with individuals needing multiple paper works with discharges and adding it all up in just the first day count last day count. So again, we're not asking people to do through the UDS.

Mac Schoen (00:48:30):

So our definition just says, did they serve on an active duty status? Because that that gets you into the discussion later with hey, why don't we go talk with the VA MC and their enrollment center about what you might not know that you're eligible for. So again, this is about opening the veteran up to possible other sources of care and the collaboration with health centers, rather than bestowing some legal status.

Bryant Howren (00:49:03):

Yeah, and I want to add one more thing to what Mac ... That's a great point that you're making. We actually have instances where individuals who believe themselves to be ineligible for various services because of this project, and because they answered the question affirmatively as we had presented it,

they otherwise would have answered likely no to this. Are you a veteran? Well, I don't believe myself to be a veteran for various reasons.

Bryant Howren (00:49:24):

And then what ends up happening is they found out after the fact and it was a pleasant surprise for many that they are actually entitled to additional services that they didn't otherwise know about.

Mac Schoen (00:49:34):

Yeah, I would echo that and say from our work, my former work with VA, and the Suicide Prevention Center of Excellence we really honed in on there's two groups of veterans, but there's one major population size one, which is kind of like after Vietnam and before the Gulf War, where if you asked someone, are you a veteran because of social reasons? They were not in any of those two conflicts.

Mac Schoen (00:50:02):

And in that time period, military service was seen slightly more differently than in our current contemporary context. They are more likely to say, well, no, I just was in the army for four years. I was driving trucks in Ohio, I'm not a veteran. So that's not my opinion. That's that's the things that we've heard. And there's a great document I can try to describe where to find it.

Mac Schoen (00:50:28):

If you kind of search like ACS veteran status question, you'll find some policy papers they've written on why they asked things in a certain way they do and why they suggest that there might be some shortcomings to that.

Dick Bohrer (00:50:41):

So I'm going to ask ... Thanks Mac and Bryant. Great exchange, but a couple of folks who've raised their hand virtually have a chance to raise some questions. I'm going to turn it over to you, Emily. I know some folks from Union Community Health Center have their hand up.

Emily DeMent (00:50:59):

Thanks, yeah. I'm going to unmute Union Community Center now. So they're live now if you want to ask your question, or make a comment. I'm going to leave them unmuted. Maybe they're having a moment but we have a couple questions. Dick, would you like me to start going through those?

Dick Bohrer (00:51:29):

Go for it, Emily, go for it.

Emily DeMent (00:51:31):

All righty. So you got the one from Matthew, so that's great. We have two questions from Thomas Klobucar. I hope that I said that correctly. Can you talk about the impact of this on FQHC revenues, either positive or negative? Has the clinical lost patience to VA? Or has their revenue increased through VA reimbursement for services provided to previously enrolled in VA veterans? And also I'll send that one to you all because it's a longer one.

Ronald Kemp (00:52:04):

So this is Ron, I'll try to answer that. To be very blunt, we haven't looked at that. It hasn't been a guide to how we proceeded in the process. And it clearly is something that has been asked me is 'jeez, aren't you encouraging some of your patients to get services from the VA that they may be not getting at this time?' If the answer's yes, but it worked for the vet. That's the way that we should be conducting our service.

Ronald Kemp (00:52:38):

So again, there's no significant change that I could see in a budgetary, either in terms of loss revenue or gained revenue just from how we look at revenue. We do not look at the vets as payer source or the vets service in terms of a separate payer source. But just intuitively, but it's not the driver. The driver's, how we get in the service that's going to work for that patient.

Ronald Kemp (00:53:04):

And if they're selecting the VA, and we encourage them to use the services that are going to work for them, that's the driver. So I don't know if that might be a disappointment in terms of what you might be looking for. But that is the CEO that's how I expected our staff to respond and I believe that's how our especially our care managers in their relationships with the vet patients and the vet families.

Dick Bohrer (00:53:32):

And Ron as long as your Chief Finance Officer would agree with you, then I think we're on the record. So Union Community Center, Emily left you open if you-

Emily DeMent (00:53:50):

Yeah, they sent me a message that they have no phone. So unfortunately they won't be able to provide a comment at this time. But if they connect a phone then they'll let me know, but great. So we have some more questions again from Thomas Klobucar. Can you talk about where you plan on continued expansion, just Iowa or other places as well?

Bryant Howren (00:54:19):

This is Bryant Howren, and I can add a little bit to that. And Thomas it's good to have you on the call, by the way. So I actually used to work in my former life for time coworkers, the director of the VA is Office of Rural Health and he's joined us today. So we're looking in Iowa right now, because obviously we have a footprint. We have people we've worked with for quite a while who are there. I came to Florida, I'm at Florida State University, the Florida Panhandle which is where Tallahassee Florida is.

Bryant Howren (00:54:48):

And once you get outside of Tallahassee it becomes very rural very quickly. And, of course, there's a high density of veterans in the state. So we're looking in these two areas simply because we're situated in these places. We're still working with another colleague, he was mentioned. He's the clinical champion for the project. He's not a presenter today, but his name is Dr. Abrams.

Bryant Howren (00:55:08):

He's a psychiatrist at the Iowa City VA. And so he's played a large role in this and since he and a lot of the individuals on the call are situated in Iowa. That's a natural first place to look, Florida as well, but we're

open to doing this in more than just those two places. I think as we start out growing though, it just makes most sense, practically speaking.

Emily DeMent (00:55:34):

Awesome. And I just got a message from union so I'm going to go ahead and unmute them. They said they have their phone connected now. So go ahead and unmute them if you want to speak. And still don't hear them, so I'll leave them unmuted if they want to try connecting their phone. I know that they had a question earlier, which was when you say FQHC was allowed to view and edit data in the VA EMR. Can you expand on that and how this data exchange was implemented?

Ronald Kemp (00:56:15):

Bryant, I would hope that you would do that.

Bryant Howren (00:56:17):

Yeah, I'm sure. Part of this we didn't cover today, and this is something I guess we're still in essence experimenting with, but we were able to obtain what's called WOC or without compensation status, or the nurses who are participating on this project. So they have an actual an official VA appointment, which is technically an unpaid but it allows them access through various steps to be able to see the medical record for these patients.

Bryant Howren (00:56:44):

So this is one of the things that if it were a larger scale, it might be a bit onerous. There are mechanisms in place to get community based providers these appointments through VA. I can't recall the name of the program that VA started a few years ago, but the idea was to connect interested providers who are in the community and know that they serve a significant number of veterans as sort of a conduit into VA.

Bryant Howren (00:57:11):

That's something I can circle back and give some information if people are interested in looking at that program. I'd have to do a little of extra research on my end, but anyway, that's the mechanism we use to get them into the VA EMR.

Dick Bohrer (00:57:27):

Emily, do we have one more question because I think we're going to need to move to wrap up?

Emily DeMent (00:57:33):

Yeah, we have four more questions, but I know that we talked about possibly getting together some document or whatever to answer some of these questions later. So maybe we can add some of the extras there. I can tell you, Angela Hurley asked, can he repeat the language they use for defining the services counted?

Mac Schoen (00:57:58):

I'm imagining you mean in the UDS or from the study?

Emily DeMent (00:58:04):

I'm assuming so. , Yes.

Mac Schoen (00:58:10):

For UDS, we are, again, more explicitly listing out the uniform services. So the uniform services are the Armed Forces plus PHS and NOAA, which are they're commissioned officers because their proceeding services before they were called that were doing activities in areas of the world during conflicts that should they be captured, they would be treated instead as captured officers instead of bad spies.

Mac Schoen (00:58:43):

So they're uniformed wearing members of the uniformed services. So that's NOAA, PHS, Army, Air Force, Coast Guard, Marines, Navy. So don't get mad at me in the order I said that. Some people are very particular about that order, but it also includes those who served in the National Guard or Reserves on active duty status. I hope that answers your question.

Dick Bohrer (00:59:12):

Thank you. Again, let me move to get us to closure. I'll make three points. I'll reiterate what Emily stated, which is the questions or comments that you provided us during the call that we didn't get to, we'll make sure that there's a way that we get responses and we post them, we make it available. On the slide that you're seeing right now, again, the people here today who shared their story and their contact information.

Dick Bohrer (00:59:49):

And again I thank them for spending the time today, but more importantly, spending the time that they spend on reaching a population that we're all committed to serving and serving well. And then finally, Emily go to the next slide to again, remind you that there's a lot of work that NACHC puts into this area The toolkit and the fact sheets that you see recently have been updated.

Dick Bohrer (01:00:24):

And I think on that note, I'm going to thank all of you who attended today. Wish you good afternoon, or good morning if you're still on the west coast, and I don't think you end any of these anymore without saying that please stay safe. And we look forward to a day when we can all be together in person again. Thank you very much. And again, Emily, thank you so much for being the real moving force behind today So with that, I will conclude today's webinar.

Emily DeMent (01:01:03):

Thanks all and if anyone has any other questions that they want to add, feel free to put them in the chat. I'll leave the webinar open for a couple minutes, that way you can put in any questions we can address. Thanks.