Phase II: Improving Behavioral Health Screening & Access to Treatment for Veterans in Community Care

Iowa Primary Care Association

Community Health Centers of Southeastern Iowa, Inc.

VA

U.S. Department of Veterans Affairs

Veterans Health Administration

Office of Rural Health

Improving Behavioral Health Screening & Access to Treatment for Veterans in Community Care, Phase 2: Establishing Care Management

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Related Publications

Howren MB, Kazmerzak D, Kemp RW, Boesen TJ, Capra G, Abrams TE. (2020). *Identification of Military Veterans Upon Implementation of a Standardized* Screening Process in a Federally Qualified Health Center. *Journal of Community Health, 45,* 465-468. https://doi.org/10.1007/s10900-019-00761-3

Also available at https://www.nachc.org/wp-content/uploads/2019/10/Article_Identificationof-MilitaryVeterans_J-Comm-Health.pdf

Howren MB, Kazmerzak D, Pruin S, Barbaris W, Abrams TE. (2021). Behavioral Health Screening and Care Coordination for Rural Veterans in a Federally Qualified Health Center. Journal of Behavioral Health Services & Research. [online ahead of print]

Available at https://pubmed.ncbi.nlm.nih.gov/34036516/

Phase 2 - Establishing Care Management

Overview
With funding secured from the Veterans Rural Health Resource Center in Iowa City (VRHRC-IC), a pilot project called *Improving Behavioral Health Screening and Access to Treatment for Veterans in Community Care* was established in 2016 with four primary aims:

1. Screen all patients presenting for care at CHC/SEIA for veteran status using a standardized methodology;
2. Screen all adult patients to identify behavioral health issues, including depression, anxiety, substance use disorder, and Post-Traumatic Stress Disorder (PTSD);
3. Identify and assist interested, eligible veteran patients with accessing VA care enrollment and services; and
4. Ensure veteran patients screening positive for behavioral health issues are offered and/or receive timely behavioral healthcare at a VA facility or CHC/SEIA.

The first project aim - screening all patients presenting for care at CHC/SEIA for veteran status using a standardized methodology - is described in **Phase 1.** Focusing on identifying veterans was an important first step and critical to the success of the remaining project.

This section of the toolkit will address steps taken and processes developed for the remaining project aims.

Phase 2 At-a-Glance

Phase 2 addresses a component of the second aim by establishing behavioral health (BH) screening mechanisms and processes for veterans, and the third and fourth aims described above.

The various components described did not all occur chronologically or in a linear fashion. Some activities moved forward simultaneously, while others occurred as more of a step by step process. This section will focus on describing the most important elements of this phase, including:

- Training provided by VA personnel to CHC/SEIA employees;
- Assistance provided by the CHC/SEIA RN Care Managers to veterans interested in pursuing eligibility for VA healthcare;
- Integration of care;
- Behavioral health screening; and
- Establishing care management services.

The section concludes with some final thoughts and lessons learned, as well as post-project plans by CHC/SEIA to continue to serve this population.

Narrative Description

Phase 2 - Training

In a busy primary care practice serving primarily under-resourced populations, virtually every patient has needs beyond the presenting issue for which they are seeking care. Addressing the complex issues of trauma, inadequate or no healthcare, one or more chronic conditions, and other social determinants of health is critical to maintaining and improving health for every patient. The underlying economic and social issues driving inequities in health outcomes are complex and current healthcare payment and delivery systems do not adequately resource the interventions required for change. Safety net providers, including Federally Qualified Health Centers, are constantly faced with the dilemma of how to resource a model of care that accounts for the enhanced and customized services to under-resourced communities in Iowa.

In light of these factors, taking on a new project in this environment requires commitment. In this case, training proved instrumental in garnering commitment for this project from staff. For this project, general staff training aimed at providing education and awareness of military culture and issues facing veterans was provided, along with more focused training that provided practical information for the RN Nurse Care Coordinators dedicated to this project, to guide their day to day work.

The Iowa City VA Health Care System devotes significant resources to outreach and education, and this project was able to leverage that capacity to provide a variety of training sessions for the staff at CHC/SEIA. The purpose of the training sessions varied, from building support and awareness, to training on a specific component important to the project. Each training provided is described below.

All staff training - To gain support and inform staff about this project, an overview of this project was provided during an all staff meeting. CHC/SEIA leadership felt it was important for staff to understand the barriers veterans experience in accessing care, and why this partnership between the health center and VA was so unique and innovative. The project team provided an overview of the project, including the project aims, barriers and issues facing many veterans, and specific changes that would impact workflow and focus of staff. In the days and weeks following this training, the interest, support and commitment voiced by staff was significant. The number of staff members that came forward to acknowledge their own veteran status, or that of family members, was also noteworthy. As a result, the belief that this population should receive special focus from the health center has never been questioned, despite the impact that new projects and changes to workflow typically cause a busy clinical practice.

VA Healthcare eligibility training - Understanding, even at a basic level, the ever-changing, complex web of services and supports available to veterans, the eligibility criteria for different programs, and information required of the veteran or those assisting them to make a referral was important to the success of this project early on. If the RN Nurse Care Coordinators were to be able to provide meaningful assistance to veterans, understanding the essential criteria and processes was key. While CHC/SEIA does not determine eligibility for VA Healthcare services as part of this project, understanding the

basic requirements, timelines and processes related to eligibility determination was a high priority and has since proved invaluable to this effort. The RN Care Coordinators actively engage with the VA Eligibility and Enrollment Office; having a basic understanding of eligibility aids in communications with the Office as well with the veterans themselves.

VA healthcare eligibility training was provided on two separate occasions to staff at CHC/SEIA, largely due to turnover in the RN Care Coordinator positions. For each training, staff from the VA's Eligibility and Enrollment Office traveled to the main site at CHC/SEIA to deliver training. Staff involved in the training participated onsite or virtually and included the RN Care Coordinators, front desk and billing staff. A simple "eligibility tip sheet" (available in the **Resources** section) was developed by the Iowa PCA from these training sessions for distribution to staff. The tip sheet provides basic parameters of eligibility guidelines, key forms and contacts for assisting with eligibility and enrollment and has proven helpful for some staff as an introduction to the topic. The knowledge and expertise of the RN Care Coordinators, however, quickly developed far beyond the basic information included in this resource.

It is worth noting that there was an unintended, beneficial impact from this training for the VA Eligibility and Enrollment staff as well. Through these training sessions, the VA Eligibility and Enrollment Office staff gained understanding of this project, which led to improved cooperation and strong working relationships between the RN Care Coordinators at CHC/SEIA and the Eligibility and Enrollment Office at the Iowa City VA. The process of assisting veterans with eligibility and enrollment became increasingly easier to navigate as these relationships were established; and in some ways, though the Care Coordinators were employed at CHC/SEIA, they are now viewed functionally as members of the VA team.

Military culture and suicide prevention training - One concern of project partners and both behavioral health and primary care clinicians at CHC/SEIA related to a general, perceived lack of understanding of military culture and challenges veterans face. The belief that veterans may have difficulty relating to those that have not experienced deployment, combat, or military service; and conversely, that providers may have trouble adequately treating or supporting veterans due to their lack of understanding of these issues - including, significantly, behavioral health and suicide among veterans - was a potential barrier to this project. Concern about saying the wrong thing, using the wrong terminology, or making incorrect assumptions was expressed by clinicians at CHC/SEIA, and with good reason, as this is an important consideration for many veterans in seeking care.

To address these concerns, the VA partner facilitated access to two training sessions, both held at CHC/SEIA. In a lunch and learn format, an experienced veteran with a behavioral health background provided military culture training to CHC/SEIA behavioral health and primary care clinicians. This training focused on attitudes of veterans and the public toward different wars and conflicts, and functional challenges to veteran reintegration into the community, such as difficulty in finding meaningful work that aligns with skills gained in the military. CHC/SEIA clinicians also learned about things like how best to frame questions, assumptions to avoid, hazards veterans were

exposed to in different service-based conflicts, common behavioral health issues and treatment modalities, and more.

In a separate training session, also held onsite at CHC/SEIA, the VA provided training on suicide prevention, specifically as it relates to veterans. There had been some recent suicides by veterans in the area, along with the rising number of suicides among veterans nationally, that spurred interest in understanding this issue specifically as it relates to veterans. Clinical staff - including medical and behavioral health - and front desk staff received this training that was provided by behavioral health staff from the Iowa City VA.

Observing a VA community-based outpatient clinic (CBOC) - Independently and preceding this project, CHC/SEIA had been working toward improved integration between their medical and behavioral health departments. This project afforded an opportunity to learn from the VA's significant experience in integrated care to inform the integration efforts at CHC/SEIA. The RN Care Coordinator was able to visit an area community-based outpatient clinic (CBOC) to shadow the work of the care coordinators there and learn more about the VA's model, called Primary Care - Mental Health Integration (PC-MHI). This proved helpful for the RN Care Coordinator in realizing the potential for her role with this project as well, where she would be working within both the VA and CHC/SEIA (FQHC) systems.

VA electronic medical record training - In order to efficiently communicate with VA partners and assist veterans with accessing VA healthcare, key project personnel, including the RN Care Coordinators and supervisors applied for Without Compensation (WOC) appointments within the VA. This process is described in the **Integration** subsection of this toolkit. One of the primary goals of obtaining a WOC appointment was to gain access to the VA's electronic medical record - the Computerized Patient Record System (CPRS). CHC/SEIA traveled to the VA Healthcare System in Iowa City to receive training on CPRS, to enable them to navigate the system. Access to CPRS allowed the RN Care Coordinators, initially, to view a patient's current and past medical history within the VA system. The utilization of CPRS by the RN Care Coordinators is also described in the **Integration** subsection.

Phase 2 - Eligibility Assistance

Background information

A key role of the health center's RN Care Coordinators working on this VA collaboration is that of assisting veterans interested in exploring their eligibility for VA healthcare. Important background useful to this discussion is found elsewhere in this toolkit as described below:

- *Identifying veteran status.* Before one can assist a veteran with eligibility, a patient has to be identified as a veteran. The first important outcome of this project stems from the health center's successful effort to improve the identification of veteran status among adult patients presenting for care. While collecting this demographic item had long been required of this (and all) FQHCs across the country, the concerted effort to improving identification undertaken at CHC/SEIA resulted in a significant gain in the number of veterans identified.

More information about the process undertaken and outcomes achieved is found in **Phase 1** of this toolkit.

- *Eligibility training.* The training section of this toolkit describes the training provided to the RN Care Coordinators and others at the health center. While the RN Care Coordinators are not responsible to determine eligibility for VA healthcare, this training was beneficial to the project in two ways: by establishing a relationship between the Iowa City VA Health Care System Eligibility and Enrollment Office and the RN Care Coordinators, and in facilitating the RN Care Coordinator's basic understanding of eligibility guidelines, processes, documentation needed to determine eligibility, and the eligibility infrastructure within the VA system. Refer to the **Training** subsection for more information about the training provided.
- *Veterans may not be aware of their eligibility status or opt not to pursue eligibility.* There are myriad reasons veterans may not be aware or their eligibility status or have chosen not to pursue eligibility for VA healthcare. It is important to understand these issues in the context of the eligibility assistance offered by the RN Care Coordinators because it facilitates appreciation of the significance of this work and the success the RN Care Coordinators experienced. See the **Introduction** section of this toolkit for a description of some of the reasons that veterans do not readily self-identify.

Eligibility Assistance

No workflow process is uniformly followed at all times, as circumstances are unique to individuals and do not present in a uniform manner. However, for purposes of relaying the general process undertaken by the health center's RN Care Coordinators in assisting veterans with VA healthcare eligibility, the following narrative describes the typical process involved.

Veteran identification occurs prior to engagement of the RN Care Coordinators. This screening process is described in the **Phase 1** section of the toolkit.

The health center's EMR network (Heartland Network, NextGen EMR) provides the RN Care Coordinators a report of veterans with scheduled appointments in the next 30 days. This report is generated daily and sent to the RN Care Coordinators via secure email. This triggers engagement of the RN Care Coordinators to contact those veterans with upcoming appointments. The report includes patient number, date and location of appointment.

Prior to the appointment, the RN Care Coordinator reviews the CHC/SEIA patient chart for any relevant information, such as behavioral health screenings (a priority of this project). If possible, the RN Care Coordinator meets with the veteran at the time of their appointment, to discuss their services, VA eligibility status, and, if the veteran is not enrolled in VA healthcare, assesses their interest in pursuing eligibility.

For veterans interested in pursuing eligibility, a release of information is signed that enables the RN Care Coordinator to access any existing VA records so that eligibility history can be ascertained. At this point, the RN Care Coordinator typically assists the

veteran with completing and assembling paperwork needed to determine eligibility - the application, the DD214, the income verification form (1010EZ or 1010EZ-R) - and sends the information via fax to the VA Eligibility and Enrollment Office at the Iowa City VA.

Eligibility determination is made by the Eligibility and Enrollment Office. Often this occurs swiftly upon receipt of information, but sometimes additional information is needed to make the determination. Eligibility for VA healthcare is complex, and veterans' eligibility can change based on significant changes in circumstances, such as a reduction in income due to retirement or other reason, or other instances in which other service-related circumstances may come to light and result in eligibility for services.

For those veterans determined ineligible or opting not to pursue VA care but interested in receiving ongoing care management services, the RN Care Coordinator periodically contacts the veteran to inquire about changes in circumstances. This serves to keep the relationship between veteran and Care Coordinator intact and the potential for VA eligibility at the forefront. Therefore, when life circumstances do change that could result in eligibility status changes, the Care Coordinator is able to assist the veteran to pursue eligibility and reduce or eliminate the potential that the veteran does not pursue services for which they may be eligible.

Primarily, the veterans served by this project - including receiving assistance with eligibility - are those that present for care at CHC/SEIA. However, as time passed and the number of veterans assisted by the RN Care Coordinators grew, they began hearing from individuals in the community that had heard of the services provided to veterans at CHC/SEIA. Those making contact via word of mouth are also assisted by the RN Care Coordinators, thus expanding the reach, the impact, and the number of veterans served through this project.

It is important to note a significant component of this project. Many veterans are identified through the initial screening - some of which are ultimately determined eligible for VA healthcare and other services. However, many veterans are already aware or found not to be eligible. Care management from the RN Care Coordinators does not stop there. For those interested in care coordination services, CHC/SEIA continues to assist veterans with their care needs utilizing their own comprehensive primary care services as well as other services available in the community. Veterans may be deemed ineligible but still have experienced exposure to myriad hazards, service-related trauma and other factors associated with serving in the military. Treating veteran status - regardless of eligibility for VA healthcare and other services - as a social determinant of health is an important outcome of this project that had not necessarily been recognized at the outset.

Case Scenarios from RN Care Coordinators

"I assisted an elderly male veteran to confirm his eligibility, which gave him a much-needed boost in self-worth. He was VERY surprised he was eligible as he didn't feel deserving and had an overall negative attitude. He has established care with the VA community-based outpatient clinic where he loves the attention he receives."

"In 2019 I began working with a veteran. VA benefits were explained to the patient and his wife. Initially the veteran declined establishing with the VA. A relationship was developed over time by following up with the veteran after surgeries and hospitalizations. By later in the year, he and his wife were comfortable calling me with their needs. As his health continued to decline, the veteran's primary care clinician included me in developing his plan of care. Coordination with the VA began, and I worked closely with the VA RN Care Manger in the nearest VA clinic. Coordinating care allowed the patient to obtain the medication he needed at an affordable cost, durable medical equipment, in-home physical therapy, nursing visits and homemaker visits. The patient's health continued to decline. The VA was able to coordinate with specialists in the community and the patient regarding multiple complex chronic conditions. Knowing the patient was exposed to Blue Water in Vietnam, I was able to provide the patient and wife with the contact information to apply for compensatory benefits for Agent Orange exposure."

"I assisted an elderly veteran get established with the Iowa City VA. He loves it, and says, 'They treat us like kings.' We have since transferred all his care to the VA and he has begun behavioral health treatment for ongoing depression. He had been a patient at CHC/SEIA but had not been utilizing BH services. Since establishing with the VA, he began getting BH treatment in Iowa City."

There is an important final point to make related to the eligibility assistance provided by the RN Care Coordinators. Like any large system, the VA has unique funding and programmatic priorities. Learning to navigate and understand such a system requires targeted training and focused time by healthcare staff. The value of having one person - with whom the veteran has a relationship - to help navigate the VA eligibility process and sometimes subsequent services and access to care cannot be emphasized enough. The RN Care Coordinators gained knowledge and experience in navigating the VA; and have been able to ease veterans' minds and secure needed services they may never have pursued on their own.

Phase 2 - Integration

To serve veterans in a seamless way, partners resolved to integrate care between the VA and CHC/SEIA as much as possible. While not fully integrated, significant gains were made which is notable given the level of leadership commitment and resources required to work through the privacy, security, policy, and other regulatory standards in place for both organizations.

Without Compensation Appointment (WOC)
The first significant step toward integration was to establish a way for the RN Care Coordinators at CHC/SEIA to access the VA medical records of veterans they were assisting. Within the VA, the mechanism to allow this is a Without Compensation Appointment (WOC). Establishing this appointment allowed the RN Care Coordinators direct access to VA personnel and veterans' medical records. The application process for WOC requires several steps and assistance was received from administrators at the Iowa City VA.

Effectively, someone with a WOC appointment is considered an employee of the VA without receiving salary and benefits. Those with WOC appointments are subject to ethics and other regulations. Appropriate background checks and trainings are required, and the individual is credentialed to allow access to veterans' medical records. The process requires multiple steps and, to those outside the VA, was intimidating. Having someone within the VA to assist in navigating the process was important to facilitate communications.

To help ensure a smooth process for future staff in securing WOC appointments, a checklist was developed that outlined the required steps. Additional checklists are available through various sources. The checklist developed by this project is included in the **Resources** section.

Electronic Medical Record Access
Providing the RN Care Coordinators and other key team members with access to the VA's electronic medical record was a primary reason to pursue WOC appointment and a valuable asset to this project. Once WOC appointments were approved, team members were able to access training on the VA's Computerized Patient Record System (CPRS).

Initially, the CHC/SEIA team was allowed "read only" access to CPRS. This allowed the RN Care Coordinators to view the eligibility and medical histories of veterans they were assisting, identify providers and check the status of current appointments, test results, and other medical information. For many veterans who struggle to navigate the VA healthcare system, this proved invaluable.

More recently, the RN Care Coordinators' permissions were upgraded to allow limited documentation in CPRS, to include inputting consults for the Community Care program (see insert below). The VA clinical champion for this project was instrumental in securing agreement to increase the level of access. This has eliminated extra work required to connect with VA partners and streamlined communications and timeliness of care delivery significantly. The authorization process for Care in the Community services is reduced by several days. Previous to this access, paper requests were made which took up to one week for authorization, requiring daily status checks of the VA record, phone calls, and sometimes duplicate paper processes for requests that were not received.

There are benefits to having access to veterans' VA medical records - examples include:

- Records can be accessed while the patient is in the CHC/SEIA clinic, so things like test results and specialists' reports can be immediately available and a plan of care can be established expediently
- Test and procedure results can be accessed (i.e. colonoscopy reports) for population health management
- Medication lists can be accessed to reconcile/compare between the two care providers
- Documentation on discussions with the veteran can be accessed, to better understand previous communications and relay or reinforce information provided
- Tracking down which staff made referrals for efficient follow up
- Veterans often contact the CHC/SEIA RN Care Coordinator to inquire about their next VA appointment or other information they need due to the ease with which they can be reached, and the trusting relationship established

The significance of these components - achievement of WOC status and the resulting access to veterans' medical records - should be underscored. The rather unique application of the WOC, while complex, has proven to be one of the most important benefits to this project. This facilitated the ability for CHC/SEIA RN Care Coordinators to do their work efficiently; but more importantly, the WOC status and subsequent access to the veterans' medical records has reduced frustration and streamlined care received by the veteran.

Community Care Overview

VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual veterans: https://www.va.gov/communitycare/.

Phase 2 - Behavioral Health Screening

As the second aim of this project, project partners expect to impact all adult patients presenting for care at CHC/SEIA. This is an important step and in alignment with broader, national efforts to integrate behavioral and primary health care. Treating behavioral health as a part of the primary care continuum helps reduce stigma and ensure those with behavioral health issues are identified and offered services.

The goal of this project was to ensure all adults are screened in a standardized way. CHC/SEIA decided to begin initial implementation with veterans and, once processes were securely in place, expand the screenings to all adult patients presenting for care at the health center.

Initial Decisions
Accomplishing this aim required two important decisions: 1) determining which issues/diagnoses would be the focus of screening efforts; and 2) identifying the screening tools to implement.

Consistent with VA clinical practice mental health screening standards, it was determined that screening would target depression, substance misuse, anxiety and Post Traumatic Stress Disorder (PTSD). The decision to focus on these conditions reflected agreement between the VA clinical champion and clinical leaders at CHC/SEIA and ensured adequate confidence among staff and clinical resources potentially needed for increased recognition of mental health conditions in veterans. Identification of these issues would provide a starting point from which to ensure patients with behavioral health needs are identified. Additional screenings could occur following referral for behavioral health treatment to further aid in diagnosis and determine the most effective treatment modalities.

CHC/SEIA Implementation of Screening
Once partners had determined which mental health conditions should be assessed in a standardized way, CHC/SEIA evaluated current screening protocols and practices in place to ascertain the need for changes or additions to current workflow processes. A number of behavioral health screenings were already in place; however, some were administered based on visit type rather than as a standard of practice for adult patients.

Alcohol, Drug Use
Screening, Brief Intervention, and Referral to Treatment (SBIRT) had been in place for a number of years. SBIRT is an evidence-based practice used to identify, reduce and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. SBIRT protocol begins with a two-question screen that includes one question related to alcohol use and one concerning illicit drug use. This is asked of all adult patients on an annual basis.

The following SBIRT questions were in place at CHC/SEIA prior to this project. The alcohol screening questions vary based on established standards for risky behavior. The same drug screening question is asked of all adult patients.

Alcohol use prescreen:
- For adult males: How many times in the past year have you had five or more drinks in a day?
- For adult females: How many times in the past year have you had four or more drinks in a day?
- Any adult greater than age 65: How many times in the past year have you had four or more drinks in a day?

Drug use prescreen:
- How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

Patients screening positive on the alcohol question were then administered the Alcohol Use Disorders Identification Test (AUDIT). This ten-question tool assesses alcohol consumption, drinking behaviors, and alcohol-related problems. The Drug Abuse Screening Test (DAST) was used to assess drug use for patients with positive responses to the drug use question. The DAST-10 was designed to provide a brief, self-report instrument for population screening, clinical case finding and treatment evaluation research and can be used with adults and older youth.

For CHC/SEIA, these tools were imbedded in the EMR prior to this project due to previous implementation of SBIRT. Practices were already in place for this screening, though screening processes had to be aligned with VA practices for this project, beginning with ensuring all veterans were systematically screened on an annual basis or more frequently, if indicated.

Depression
To screen for depression, the two-question pre-screening Patient Health Questionnaire (PHQ-2) was already in use at CHC/SEIA, using the following questions:

- Have you felt down, sad or depressed in the last two weeks?
- Have you felt decreased enjoyment or pleasure in the last two weeks?

The two-question pre-screen was in place prior to this project with all adult patients for every visit, as part of the patient registration/check in process. Patients with positive responses to either question were administered the Patient Health Questionnaire (PHQ - 9). Protocols in place for follow up were based on the score of the full screen.

Anxiety
Anxiety screening was also in place at CHC/SEIA in certain circumstances, using the Generalized Anxiety Disorder - 7 Item Scale (GAD-7), and similarly, protocols were in place for follow up based on the results.

Post-Traumatic Stress Disorder (PTSD)
CHC/SEIA had not been regularly screening for PTSD, therefore, adding this screen required additional effort to incorporate it into the health center workflow. Considering the frequency of PTSD in veterans, partners knew it was important to add and standardize screening for this diagnosis into the workflow at the health center. CHC/SEIA was able to add the identified screening tool (PCL-5) to the EMR (NextGen) so that results of the screens could be easily incorporated and tracked in patients' medical records.

The decision was made at CHC/SEIA to focus on identified veterans to ensure all behavioral health screens were completed on at least an annual basis. An initial workflow was established that has been adjusted over time as needed. Currently, it is a responsibility of the RN Care Coordinator to check the veteran patient's chart to ensure screens are completed. If due or indicated, the RN Care Coordinator administers missing screens and the information is recorded in the patient's medical record. Follow up is completed, via warm handoffs or referrals, either to CHC/SEIA primary care or behavioral health clinicians, VA clinical departments, or other local behavioral health

services as needed based on availability and patient preference. The workflow for behavioral health screening is included in the **Resource** section of the toolkit.

An additional resource that has proven beneficial to this project is having access to and a relationship with a VA clinical champion. Consultation occurs when there are questions, concern about a patient or uncertainty about clinical or treatment direction. Having timely access to a clinician trained in and familiar with issues veterans face as well as VA resources available has been a valuable asset to this project.

Case Scenarios from RN Care Coordinators

"In 2019 I began working with a young lady who in the initial interview talked about being sexually assaulted and raped in basic training. She was in the National Guard and was not called up for Federal active duty. Because of this, she was not eligible for benefits. She had been receiving therapy using Medicaid. The counselor notified her she was no longer accepting Medicaid. She could not afford to pay for the visits herself. Working with the VA clinical champion and his contacts at the VA, I was able to direct her to a Veteran Service Organization (VSO) to see if she would qualify for a service-connected disability. In the meantime, we were able to schedule her at CHC/SEIA with our counselor. She ultimately received a service-connected disability and will qualify for VA benefits. When I shared the news with her, she was so grateful. If our services were not available, she would not have known to pursue her options with the VA or how to go about it. This program has had a positive impact on her mental health. It has opened opportunities to receive the care she needs. Her VA benefits will allow her to afford her medications and allow her to be compliant with her treatment plan."

"A veteran was in crisis and had barricaded himself in his home. The police were called as the situation escalated. The VA clinical champion helped me arrange admission to the VA Hospital in Iowa City if needed. Fortunately, the situation was successfully managed, and a hospitalization was avoided."

"I was working with a gentleman in assisted living and diagnosed with Alzheimer's Disease. He began exhibiting behaviors that put the staff and other residents at risk and the family had been served with a 30-day eviction notice. They were unable to find placement for him. Because of our existing relationship, I was able to place a call to psychiatry at the Iowa City VA to inquire about a telehealth visit. The psychiatrist decided to transport the patient to the VA in Iowa City where he would do a medical and psychological work up. Knowing that if the patient left the facility, the facility would not take him back, the patient was kept at the VA hospital where they are working to find an alternative, appropriate placement."

Screening Tools Utilized at CHC/SEIA

Screening, Brief Intervention, Referral to Treatment (SBIRT)
https://www.integration.samhsa.gov/clinical-practice/sbirt

Alcohol Use Disorders Identification Test (AUDIT)
https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf

Drug Abuse Screening Test (DAST)
https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69

Patient Health Questionnaire (PHQ -9)
http://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf

Generalized Anxiety Disorder - 7 Item Scale (GAD-7)
https://www.mirecc.va.gov/cih-visn2/Documents/Clinical/GAD_with_Info_Sheet.pdf

PTSD Checklist for DSM-5 (PCL-5)
https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Phase 2 - Care Management

Providing care management for veterans has proven invaluable to those veterans interested in this level of service. Although the primary focus of this project was on identifying behavioral health needs and engaging veterans in care - either with the VA (if eligible), CHC/SEIA or another provider - veterans often presented with other needs. The RN Care Coordinators assisted with those other needs as well.

Assisting interested veterans with eligibility determination for VA healthcare is a significant component of the care management provided by the RN Care Coordinators. Given the importance of this work and the impact on veterans' access to care, the work the RN Care Coordinators do to assist veterans in applying for VA healthcare is described in great detail in the **Eligibility Assistance** subsection. Similarly, the process utilized for screening veterans for behavioral health needs is covered in the **previous** section.

As with any care management program, the services provided are varied and based on the individual veteran's needs and desired level of assistance. For this project, the two RN Care Coordinators have somewhat different veteran populations in their care management caseloads. One RN Coordinator has more older veterans with higher levels of need and reliance on the Care Coordinator's assistance; while the other has younger, more self-sufficient veterans that may only need assistance once or with less frequency.

A workflow outlining the care management process has been created and is provided in the **Resource** section. The workflow outlines, in general, the processes established to

offer care management services to the population. No workflow can capture the nuances of all individual situations, but they can be instructive for those creating similar programs, as a training tool, or as a way to describe and bring consistency to the work performed.

As previously described, screening for veteran status occurs as the veteran presents for care at CHC/SEIA. Once veterans are identified and established in the electronic medical record (EMR), the health center's network creates a daily report of veterans with scheduled appointments in the next 30 days. This is the mechanism that allows the RN Care Coordinators to make initial contact with veteran patients.

Prior to scheduled appointments, the RN Care Coordinators are able to review both the CHC/SEIA and VA medical records for indicated screenings, history with either provider, and other relevant information. The value of the RN Care Coordinators' access to the VA medical record cannot be understated. This access simplifies the process for the RN Care Coordinators and ensures more timely and efficient care management and thus, more effective services to the veterans.

With this background information available for review, the RN Care Coordinator can then meet with the veteran (if the veteran is willing), to explain possible VA care options and offer care management services. Depending on the level of interest expressed by the veteran, the RN Care Coordinator adds the veteran to care management services, flags the chart for later follow up, or for no follow up if that is the veteran's desire.

When behavioral health or other needs are identified, the RN Care Coordinators assist veterans in myriad ways. Again, the ability to access the veteran's VA health record facilitated communications between the RN Care Coordinators and VA Care Managers. The CHC/SEIA RN Care Coordinators were also able to view veterans' history and status with VA health care (for those veterans that have signed releases).

Once eligibility for VA healthcare is determined the work of the RN Care Coordinators diverges as other, individual needs of the veterans are addressed. If behavioral health needs are known or identified through the screening process, acuity and urgency are assessed and the veteran is linked to appropriate care. Those eligible for VA care have the option of accessing behavioral health care at the VA or at CHC/SEIA. Those not eligible for VA care have options to seek care at CHC/SEIA, with other community providers, or the veteran may be connected to the local Veteran Service Organization (VSO) to explore additional options.

The VA's Care in The Community program was established during the course of project implementation and became the mechanism to facilitate access to the most appropriate, available services to the veteran based on need and veteran choice. The RN Care Coordinators have gained extensive knowledge about this program, to the benefit of veterans served in this project. More information about the VA's Community Care program can be found at this link: https://www.va.gov/communitycare/.

Sometimes veterans have other insurance in addition to VA healthcare, such as commercial insurance through their employer, or Medicare or Medicaid coverage. The

RN Care Coordinators have developed extensive knowledge of which payer provides greater benefit for certain services and are able to offer guidance to veterans and their families and caregivers as they navigate their options.

Those veterans that have commercial insurance through their employer are frequently uninterested in pursuing VA healthcare. Or, due to employment status or other financial factors, the veteran is ineligible for VA healthcare due to income status. In those instances, the RN Care Coordinators may flag the charts to follow up with these veterans after an anticipated retirement or other significant life event that impacts financial status. Often, the veteran then opts to accept the assistance of the RN Care Coordinator in applying for VA healthcare.

Other aspects of the RN Care Coordinator's efforts to manage the care of veterans would appear much the same as any other care management program, with referrals and follow ups based on the individual needs of the veteran. What is specific to this project is the potential access to VA healthcare and all the services that opens up for veterans in need of care. By making this assistance approachable and accessible, at the point of care at CHC/SEIA and with a RN Care Coordinator with whom the veteran has an established relationship, project partners are convinced that many veterans pursued eligibility and, for those eligible and enrolled, therefore benefitted from the VA healthcare system. Still more veterans received targeted care management services regardless of eligibility status.

Case Scenarios from RN Care Coordinators

"Home health care benefit provided by VA is a real asset. The VA philosophy is to keep veterans at home. Durable medical equipment is often free with VA healthcare benefits, depending on the veteran's level of qualifications. The VA will help build ramps to homes. Veterans can get their eyeglasses from the VA - there is a rather complex process, but I can manage that for the veteran so that they can get their eyeglasses at no cost. Often veterans have just 'made do' because they lack the knowledge or capacity to follow up to get a proper fit."

"I assisted a WW2 veteran to get Care in the Community. After moving to the area from Ohio a few years ago, he had been getting care at the Iowa City VA, but he could no longer make the drive there. He began receiving care at CHC/SEIA but didn't want to lose his VA medical benefits. He is very pleased with his care at CHC/SEIA via Care in the Community and is thankful for the opportunity."

Tools and Resources

- VA Without Compensation (WOC) Checklist
- Eligibility tip sheet
- Workflow
- Tip sheet for Talking with Veterans
- Patient brochure
- Sample waiting room poster
- Sample exam room poster

Phase 2 - Final Thoughts and Project Lessons

As of late Summer 2021, the formal, funded phase of this partnership between the VA's Office of Rural Health (ORH) Veterans Rural Health Resource Center in Iowa City (VRHRC-IC), the Iowa PCA, and CHC/SEIA is ending. The entire process - from initial exploration between the VRHRC-IC and Iowa PCA, to the selection of CHC/SEIA, addition of funding, and formation and implementation of a formal project - spanned nearly six years. Funding was available for four of those six years. Learning to work within and in concert with unfamiliar organizational bureaucracies created steep learning curves and staff changes slowed implementation of the full care management model. That all original partners remained engaged and moving forward with this work, however, speaks to the level of commitment by all partners to improve access to care for veterans.

This toolkit was intended to capture the processes undertaken and lessons learned over the course of this project in order to smooth the path for future organizations embarking on integrating services across organizations.

Project Lessons

Funding
Conceivably, funding is not required to do this work. However, even a modest amount is often instrumental in gaining commitment to take new projects on; and it adds an element of accountability to partners, which keeps focus on the work to ensure it moves forward. As noted previously, in busy health systems there are many competing demands and priority populations; the presence of funding can move the needle toward the decision to proceed with such a partnership.

Continuity and Strong Project Management
From the outset, project partners had a sense of common goals and desired outcomes, but with no history of FQHCs and the VA partnering in this way (at least none partners could access), partners were essentially "plowing new ground". How much could be accomplished - and how fast - was nearly impossible to clearly define and direct.

With a relatively small project such as this, with staff changes, busy partners and a span of several years, having key staff involved from the beginning and throughout was very important. The value of this continuity and "institutional knowledge" of the project, the history, partners, purpose and aims, proved itself repeatedly throughout the history of the project.

Equally important was to have one entity charged with a project management role. With monthly meetings, different nomenclature, unfamiliarity with the rules and regulations governing FQHCs and VA healthcare, and competing demands on all partners; retaining the details, threads and nuances of discussions, rationale for decisions and identified next steps was quite difficult. The project manager role - in this case the Iowa PCA - helped ensure the project did not get too far off track and kept things moving forward.

VA Clinical Champion

The presence of a VA clinical champion is invaluable to this work in a variety of ways. The clinical champion interfaced with various VA departments to cut through bureaucratic barriers and ensure the RN Care Coordinators were met with cooperation and an understanding of project goals. The clinical champion is also available to the Care Coordinators to discuss patient care issues, and in some urgent instances, has assisted in arranging access to care for veteran patients in crisis. And, for overall project planning and discussions; the clinical voice is important to keep at the forefront to ensure decisions are focused on the best medical interests of veterans.

Data

Data is important for a variety of reasons - reporting, patient management, cross-system communication, and dissemination of findings. In the spirit of assisting CHC/SEIA with a temporary, easy way to capture data, the Iowa PCA offered to create an initial tracking tool so that partners could assess progress and report to the funder, the VA's Office of Rural Health. Though well-intentioned, making the investment of time and dollars to modify the EMR at CHC/SEIA to capture and extract project data early on would have been a better use of time and resources than creating a temporary tool. Still, data was generated that satisfied grant requirements, and much was gained in the process of identifying data points that would capture the work done and veterans assisted.

Data points important to capturing work accomplished through this project included:

- Identifying veteran status (the EMR was modified to capture this data point)
- Number of behavioral health screens completed and screening results
- Eligibility for VA healthcare
- Number of veterans referred for behavioral health services (at VA, at CHC/SEIA or with another provider)
- Veterans' interest in receiving care management services and types of services veterans desired assistance with, including medications, vision, medical, behavioral health and dental care
- Numbers of services veterans were assisted with
- Types of contacts with veterans (phone, in person, mail, etc.)

Other one-time data requests were made of CHC/SEIA and provided to VA partners for research and publications purposes throughout the course of the project.

As the project ends and CHC/SEIA assesses their capacity and considers which elements of the work with veterans are most important, work continues to modify the EMR to capture the data most relevant to the work of the RN Care Coordinators.

Value of Training

CHC/SEIA benefitted from a number of training opportunities provided by the VA, as outlined in the **Training** subsection. In an environment where nearly every patient has significant barriers to accessing care, it can be a difficult sell to commit to focusing on yet another population. Offering training to staff at CHC/SEIA early on was important in securing staff commitment to serving veterans. And that commitment remains in place, with plans to continue to provide care management services to veterans despite the

end of the formal project. CHC/SEIA considers veteran status as a social determinant of health and believes a population health management approach is both important and necessary to the provision of quality care to veterans.

VA EMR Access
Securing access to the VA EMR for CHC/SEIA RN Care Coordinators was invaluable to their eligibility assistance and care management work. This was the single, most important component of this project that had the biggest impact on the efficiency and efficacy of their work. Further, this allowed for continuity of care for the veterans. The RN Care Coordinators were able to directly schedule follow up visits and coordinate the care within the VA's EMR system.

Relationships
Largely facilitated through access to the VA EMR, the relationships developed between the CHC/SEIA RN Care Coordinators and VA eligibility staff, care managers and other program staff smoothed the path so that veterans could be served in a more seamless, efficient way. Similarly, for the veteran, having a relationship with the RN Care Coordinator to assist with VA eligibility and services was less intimidating than approaching the unknown face of the VA bureaucracy. And it is very likely that many veterans agreed to pursue VA services because of those relationships.

Next Steps
With the conclusion of the formal project, CHC/SEIA plans to continue their focus on serving veterans through funding one FTE RN Care Coordinator to work with veterans. Work continues to determine the most useful data elements to capture in the EMR and ensure the EMR is modified to capture those data. Care management services to interested veterans will continue, likely at a somewhat reduced level. Maintaining access to the VA health record (achieved through the Without Compensation, or WOC appointment process) is essential to this work, and VA partners are working with CHC/SEIA to ensure this access continues.

Part of the project's second aim - screen all adult patients to identify behavioral health issues, including depression, anxiety, substance use disorder, and Post-Traumatic Stress Disorder (PTSD) - remains to be finalized. While the depression, anxiety and substance use disorder screens were in place at CHC/SEIA prior to this project, they were not universally applied to all adult patients. And the PTSD screen was not regularly used. Now that the screens are fully in place and aligned with VA practice protocols for veteran patients, CHC/SEIA intends to ensure these screenings are applied across their entire adult patient population.

Conclusion
The ultimate takeaway from this project is that a close partnership focused on streamlining access to care for veterans between the VA and a FQHC benefits all involved - especially veterans. To ensure success, learning and relationship building takes time and has to occur at many levels. Even with funding, a person or entity tasked with keeping the project moving forward was critical. Valuable knowledge was gained

and will be utilized going forward to ensure CHC/SEIA can maintain a focus on serving veterans. Most importantly, in some cases the rewards for the veterans are significant - even life-changing.