

# Working Even *Harder* for Our Veterans: Recommendations to Continue Improving Healthcare Access, Resource Allocation, and Accountability

Prepared for:

The Honorable Kevin Brady, United States House of Representatives

The 8th Congressional District of Texas

December 8, 2017

This Capstone was researched during the 2017 academic year by students of the Online Executive Master of Public Service and Administration program from the Bush School of Government and Public Service at Texas A&M University, College Station.



## ABOUT THE PROJECT

This project was completed in partial fulfillment of the Executive Masters of Public Service Administration program at the Bush School of Government and Public Service. Our team worked with Congressman Brady and his staff producing original research to support evidence-based decisions regarding veteran constituents' healthcare needs within the 8th Congressional District of Texas.

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***“Our men and women in uniform have sacrificed everything for their country and they deserve an effective, accountable VA that protects the rights they fought to defend.”***

***U.S. Congressman Kevin Brady (TX-08)***

Congressman Kevin Brady is committed to fighting for veterans within his district, across the state of Texas, and throughout the United States. So much so that he led the effort to establish a veteran’s clinic in Conroe, opening the current facility in late 2015. Always looking for better ways to serve his veteran constituency, Congressman Brady and his staff asked the Bush School Capstone Team to examine issues related to the effectiveness of VA services in the 8th Congressional District.

## **METHODOLOGY**

Originally tasked with examining three questions focusing on financial implications of VA health expenditures, policy implications of the Veterans Choice Act, and veteran homelessness and suicide, the Capstone Team conducted a literature review of scholarly, peer-reviewed articles which allowed the team to identify cross-cutting issues specifically applicable to the 8th Congressional District. These included:

- Veterans Choice Act
- Veteran dual users of both VA and non-VA providers
- Female veteran healthcare proportionality (how well the Conroe CBOC’s gender-specific services reflect the proportion of female veteran constituents)
- Wait times
- Mental health, military sexual trauma (MST), and suicide
- Homelessness
- Financial implications

Over a two-semester period, the Capstone Team collected information, examined data, analyzed results, and developed recommendations for these areas. Research consisted of a combination of elite interviews, content analysis of additional peer-reviewed literature, and thorough reviews of applicable archival, and publically available datasets. Overall, the Capstone Team used a mixed methods approach, collecting both quantitative and qualitative data needed to answer our refined research questions. The Capstone Team encountered limitations in data collection that are detailed in the formal report.

## **FINDINGS AND RECOMMENDATIONS**

Veterans have unique and different needs when seeking medical care than non-veterans. Ultimately, the Capstone Team's recommendations are made with the intention that they will build on the existing strengths of the Conroe CBOC and continue to improve accessibility, resource allocation, and accountability for the veterans of the 8th Congressional District of Texas. Summarized findings, conclusions, and recommendations are presented:

### **Veterans Choice Act (VCA)**

Quantitative usage data regarding the VCA is not publically available. *(Note: This information has been requested through a FOIA request and there are plans to examine this data during the next Capstone.)*

The lack of available data regarding the VCA and the Veteran Choice Program (VCP) limits the ability to collect, aggregate, and analyze program performance and impact on the 8th Congressional District.

#### **VCA Recommendations**

1. Ensure VCA usage-rate reports are publicly available.
2. Conduct further study regarding access and usage of the VCA before making extension decisions about the policy (see Dual Usage below).
3. Amend the VCA-community provider search tool to query VCA-approved community providers in various ways.
4. Provide some type of financial incentive for providers to become part of the VCP particularly in harder-to-serve areas.

5. Prioritize war-related physical injuries and other traumas (such as PTSD and other mental health needs) and utilize community providers (such as VCA-approved) for routine care and specialized services.

### **Dual Usage (Veterans using a VA provider and non-VA provider)**

Although dual usage is not tracked in the 8th Congressional District, we ultimately believe dual usage promotes access to care. There are, however, challenges for veterans who choose to see VA and non-VA providers. These include, care fragmentation and lack in the continuity of care, conflicting diagnosis and duplication of services, and higher rates of exposure to potentially unsafe medications.

#### **Dual Usage Recommendations**

1. Adopt the usage of a sharable electronic medical record to provide safeguards and increase communication.
2. Implement the usage of the Blue-Button tool for dual-using veterans and educate veterans on how to utilize this system.
3. Allow limited access to the VA Electronic Medical Record for VCA-approved community providers.
4. Consider launching a mandatory insurance claims database in Texas like that utilized in New Hampshire to improve tracking of dual-usage veterans.

### **Female Veteran Healthcare Proportionality (how well the Conroe CBOC's gender-specific services reflect the proportion of female veteran constituents)**

We were unable to confirm female veteran healthcare proportionality through quantitative data regarding the number of women who receive care at the CBOC, the number of women from the 8th Congressional District who receive care at the DeBakey Medical Center, or the number of gender-specific trained providers (as required by VHA Directive 1330.01(1)). *(Note: This information has been requested through a FOIA request and there are plans to examine this data during the next Capstone.)*

By 2035, the 8th Congressional District in Texas will practically double in the percent of female veterans, growing from 9% to 17%. In 2045, it is projected that 22% of veterans in the 8th Congressional District will be female, greater than the projected 20% in Texas and the projected 18% in the nation. Although the proportion of female veterans within the 8th Congressional District is growing, the Conroe CBOC has no gender-specific healthcare programming in place.

#### **Female Veteran Healthcare Proportionality Recommendations**

1. Comply with VHA Directive 1330.01(1), Health Care Services for Women Veterans
2. Survey eligible female veterans in the 8th Congressional District to determine their specific needs.
3. Attend (or send representation to) the National Women's Veteran Summit to learn more about the needs of female veterans.

### **Wait Times**

Conroe CBOC wait times are equivalent to other clinic wait times. The 8th Congressional District has a high percentage of rural dwelling veterans. Rural dwelling veterans are at greater risk for mental health issues.

#### **Wait Time Recommendations**

1. Reduce wait times for mental health appointments in the Conroe CBOC, ideally to zero days.
2. Retest wait times in December 2018 to determine if wait times for mental health appointments have been reduced to zero days as a result of a current effort to hire seven new mental health providers.

### **Mental Health, MST, and Suicide**

Statistics were not available to test the relationships between homelessness and mental health, MST, and suicide specifically within the 8th Congressional District. *(Note: This information has been requested through a FOIA request and there are plans to examine this data during the next Capstone.)* From 2012 -2015, a general increase of suicides was reported among post deployed veterans who suffered from substance abuse and adjustment disorders. In addition, suicides and

suicide attempts have increased for both genders. The greatest increase occurred within the 17 to 24 age group.

#### **Mental Health, MST, and Suicide Recommendations**

1. Continue to provide information from case managers concerning the different forms of assistance available for veterans.
2. Promote Peer Counseling within proven successful venues such as the VFW and Texas Department of Criminal Justice (Veterans Court).
3. Encourage VA collaboration with local community agencies to establish Tele-Med Mental Health Hubs for greater access to healthcare

#### **Homelessness**

Screening by Veteran Coordinators within the VA and utilizing local community resources appears to have been effective in reducing veteran homelessness within Texas. Since 2010, homelessness has decreased by 70% among veterans living in Texas. In light of potential funding changes for homeless veterans, the following recommendations are made.

#### **Homelessness Recommendations**

1. Conduct outreach events such as community fairs or symposiums just for veterans (in hopes to attract rural veterans) and their families.
2. Encourage case managers (or Veteran Coordinators) to continue creating partnerships with local medical and mental health professionals within TX-08.
3. Continue to maintain an updated referral list for veterans and family members to seek tangible and intangible resources.
4. Establish Tele-Med Mental Health Hubs with local community agencies in order to provide complete care and services for veterans.
5. Examine how to create a Rural Transportation Service for Veterans who live too far from the Conroe CBOC so they can receive access to health and behavioral care.

## Financial Implications

We were unable to calculate the financial impact of VA health expenditures because financial information regarding the Conroe CBOC is not transparent. Without transparency of financial information, tax payers cannot hold the VA accountable for funds spent. Furthermore, without financial data, analyses cannot be made regarding efficiencies, impact, and investment priorities driven by the local demographics and the specific risk factors of the veteran constituents of the 8th Congressional District. *(Note: We have requested detailed financial information through a FOIA request and plan to examine during the next Capstone.)*

### Financial Implications Recommendation

1. Continue to support the transparency of financial information either through FOIA requests and/or through a request to CRS, specifically as related to the next Capstone.

#### FOIA

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This paper provides additional detailed information on our research and findings supporting the results, conclusions, and recommendations above. Our sincere hope is that this research will enable Congressman Brady and his staff to make evidence-based decisions in the best interests of all veterans for the 8th Congressional District and across the nation.



## ACKNOWLEDGMENTS

Our team would like to sincerely thank Congressman Brady for giving us the opportunity to work on this project on behalf of the veterans within his district. We would also like to thank his Director of Communications, Ms. Tracee Evans, for being prompt, professional, encouraging, and accommodating to our needs and requests. Of course, this project would not have been possible without the coordination and support of Dr. Danny Davis of the Bush School of Government and Public Service.

We would also like to thank the following individuals who have assisted us in obtaining leads or information for our project:

- Joan Clifford, Deputy ADUSH - Office of Veterans Access to Care
- Maureen Dyman, Press Inquiries - DeBakey VA Medical Center in Houston
- Rola El-Serag, MD - Medical Director, Women Veterans Health Program
- Pedro Leon, Nurse Manager - Conroe CBOC
- Kate Machado, VP Business Development - Atlas Research
- Dylan MacInerney, Legislative Assistant, Congressman Brady's D.C. office
- Laura Marsh, Director of Mental Health - DeBakey VA Medical Center in Houston
- Aimee M. Sanders, Physician Educator, Women's Health Education - Women's Health Services, VHA Central Office
- Terri Tanielian, Senior Behavioral Scientist - Rand Corporation
- Jim Wartski, Director - Veterans Experience Office, VA; assistant- Andrea Martinez
- Kayla Williams, Center for Women Veterans - Department of VA

We are additionally appreciative of the Bush School of Government and Public Service staff for their assistance with this project including Ms. Lisa Brown, Ms. Rebecca Burgner, Ms. Christina Storey, and Ms. Linda Heritage.

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## INTRODUCTION

When President Reagan signed legislation in March of 1989 he established the U.S. Department of Veterans Affairs (DVA) in its current form. This includes three subsidiary elements— the Veterans Health Administration (VHA,) the Veterans Benefit Administration, and the National Cemetery System (V.A. History in Brief.) In June of 2017, when our team was tasked with this Capstone, we were asked to look specifically at the VHA (referred to the VA for purposes of this report).

The VHA is one of the largest healthcare systems in the world, and exists today to meet the medical and quality-of-life needs for veterans after they serve our country. The VA is a leader in veteran-specific medical needs and often provides better healthcare than non-VA providers. VA medical research benefits individuals far beyond just those who have served in the armed forces, and the VA oversees the largest medical education and training program in the nation (V.A. History in Brief). However, the VA has not been without criticism.

A recent example of this was brought into the public eye in 2014 regarding the extensive wait times veterans experienced when seeking care. VA medical facilities had wait times as high as 115 days for initial primary care appointments and it was reported as many as 40 veterans died waiting on medical care (Campbell 2016, 75). Campbell stated that “as many as 60 percent of clinics falsely reported their statistics regarding veterans’ wait times” (2016, 75). Thus, the VHA was failing to meet the core mission to “Honor America’s Veterans by providing exceptional health care that improves their health and well-being” (Campbell 2016, 75).

Because of his commitment to fighting for veterans, Congressman Brady and his staff asked our team to examine aspects of the VA specifically as they related to his district. This included VA healthcare expenditures, the Veterans Choice Act (VCA) legislation, and mental health and homelessness. Over a two-semester period, our team collected information, examined data, analyzed results, and developed recommendations.

Our team documented this research in the following report. The organization of this report is as follows. Chapter 1 provides the foundation for this research including the background, problem statement, significance of research, definitions and key terms, assumptions, research and design, and questions. Chapter 2 discusses our review of existing scholarly literature on these topics. Chapter 3 details our research results. Chapter 4 outlines our discussion and implications. Chapter 5 identifies our limitations and recommendations. And, Chapter 6 provides the reader with a conclusion.

## CHAPTER 1

### BACKGROUND

Congressman Brady and his staff are passionate about helping veterans living in the 8th Congressional District of Texas. It is important for the Congressman and his staff to understand the needs of veterans, which of these needs are unmet, and how they can help meet these needs. Our capstone team was presented with three initial research questions, provided by Congressman Brady's staff, all related to his district. These questions were:

- What are the financial impacts of VA health expenditures?
- What are policy implications of the VCA?
- What information exists about veteran homelessness? How does this information relate to veteran suicide?

Anticipating minimal available scholarly research specific to the 8th Congressional District of Texas, our team conducted a hybrid literature review that consisted of a scoping study, followed by a more in-depth search of scholarly, peer-reviewed articles focusing on the themes of VA health expenditures, the VCA, and veteran homelessness and suicide. Arksey and O'Malley (2005) defined a scoping study as "an approach to reviewing the literature which to date has received little attention in the research methods literature" (19). This method of literature review is also a good technique to identify available literature across broad disciplines (Arksey and O'Malley 2005).

The team conducted this search through the use of the Texas A&M University (TAMU) library system. We compared characteristics to identify overlapping themes and unanticipated findings. From this process, we were able to determine the original three questions posed by Congressman Brady and his office could be modified into 11 refined research questions. After speaking to Evans regarding our modification of the original questions, the refined questions were approved on August 23, 2017.



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## PROBLEM STATEMENT

United States Congressman Kevin Brady and his staff lacked specific information regarding the Conroe CBOC and his veteran constituency.

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## SIGNIFICANCE OF RESEARCH

Congressman Brady is committed to helping veterans within his district, in Texas, and throughout the nation. Through our literature review, information collection, and data analysis, our team was able to examine available information and identify cross-cutting issues specifically applicable to the 8th Congressional District including:

- Dual usage
- Wait times as they apply to rural veterans and mental healthcare
- VCA impact and challenges
- Gender-specific healthcare and female veteran healthcare implications
- Financial implications
- Homelessness and suicide

Veterans have unique and different needs when seeking medical care than non-veterans. Subpopulations of veterans, such as female veterans and those living in rural areas, have even more specific needs in regard to access to care. Ultimately, our research identified gaps in scholarly research regarding veteran healthcare in the 8th Congressional District and provides evidenced-based research on which Congressman Brady may better advocate for the veterans living in his district.

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## DEFINITIONS AND KEY TERMS

Definitions and key terms are presented:

Community Based Outpatient Clinic (CBOC): A VA-operated clinic, a VA-funded, reimbursed health care facility; site that is geographically distinct or separate from the parent medical facility. (National Center for Veterans Analysis and Statistics n.d.)

Department of Veterans Affairs (DVA): Established as an independent agency under the President by Executive Order 5398 on July 21, 1930, was elevated to Cabinet level on March 15, 1989 (Public Law No. 100-527). DVA's mission is to serve America's Veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive medical care, benefits, social support, and lasting memorials promoting the health, welfare, and dignity of all Veterans in recognition of their service to this Nation. (National Center for Veterans Analysis and Statistics n.d.)

Dual Use(r): A veteran concurrently accessing care from the VA and a non-VA health system, whether a VCA-approved facility or a non-VCA approved facility.

Female Care Proportionality: A term we coined to describe how well the percent of female-specific medical services available at the Conroe CBOC corresponded to the female veteran constituency of the 8th Congressional District.

Homelessness according to the McKinney-Vento Act: An individual who lacks a fixed, regular, and adequate nighttime residence, and a person who had a nighttime residence that is: a supervised publicly or privately-operated shelter designed to provide temporary living accommodations; an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (Balshem et al. 2011,15).

Military Sexual Trauma (MST): A psychological trauma, which resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment that occurred while a Veteran was serving on active duty or active duty for training. (National Center for Veterans Analysis and Statistics n.d.)

P.I.T. (Point-In-Time) Count: A count of sheltered and unsheltered homeless persons on a single night in January. ([www.va.gov/homeless/pit\\_count.asp](http://www.va.gov/homeless/pit_count.asp).)

Post-Traumatic Stress Disorder (PTSD): Psychological condition that affects those who have experienced a traumatizing or life-threatening event such as combat, natural disasters, serious accidents, or violent personal assaults. (National Center for Veterans Analysis and Statistics n.d.)

Unique Patient: A Veteran patient counted as a unique in each division from which they receive care. For example, if a patient receives Primary Care at one VA facility and specialty care from another VA facility, he/she will be counted as a unique patient in each division.

VA Benefits: The eligible services and programs offered by VA such as pensions, education assistance, housing, burial aid, life insurance, employment preferences and other services. VA benefits vary depending on the Veteran's service record. A Veteran, his/her spouse and dependents may be eligible for different types of benefits provided by VA. (National Center for Veterans Analysis and Statistics n.d.)

VA Medical Center (VAMC): A VA hospital facility that provides a diverse range of healthcare services to Veterans. (National Center for Veterans Analysis and Statistics n.d.)

VA Regional Office (VARO): A collection of 57 benefits offices that provide benefits information and process claims. At least one VARO is located within every state and as well as the District of Columbia, Puerto Rico, and the Republic of the Philippines. Some VAROs also provide out-based services to Veterans being discharged from active service at various military separation centers around the country as well as in the Federal Republic of Germany and the Republic of Korea. (National Center for Veterans Analysis and Statistics n.d.)

Vet Center: A type of VA health care facility designed to provide outreach and readjustment counseling services. There are 232 community-based Vet Centers located in all 50 states, the District of Columbia, Guam, Puerto Rico, American Samoa, and the U.S. Virgin Islands. Veterans, who served in the active military during the Vietnam-era, but not in the Republic of Vietnam, must have requested services at a Vet Center before January 1, 2004. Vet Centers do not require enrollment in the VHA Health Care System. (National Center for Veterans Analysis and Statistics n.d.)

Veterans Health Administration (VHA): A VA organizational component that is responsible for coordinating and providing healthcare for all enrolled Veterans based upon need and service. VAMCs within a Veterans Integrated Service Network (VISN) work together to provide efficient, accessible healthcare to Veterans in their areas. Additionally, the VHA also conducts research and education, and provides emergency medical preparedness. (National Center for Veterans Analysis and Statistics n.d.)

Veterans Integrated Service Network (VISN): A Veterans Integrated Service Network known as VISNs, these are organizational elements within VA's healthcare system. There is a total of 21 VISNs which provide geographic oversight to a collection of healthcare facilities within the established jurisdictions. (National Center for Veterans Analysis and Statistics n.d.)

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## ASSUMPTIONS

Assumptions for this study include:

### Dual usage and lack of communication

Because we did not have quantitative data to analyze how many veterans are dual users or how many have access to the Joint Legacy Viewer (JLV) or Virtual Lifetime Electronic Record (VLER) to analyze communication between VA and non-VA healthcare providers we relied on content analysis of additional peer-reviewed articles to detail the negative effects inherent in dual use when a tracking and communication system are not put into place. Because of the lag time built-into the peer-review process we are operating with the assumption that the information presented in our findings is relevant, albeit 18 - 24 months behind.

### Veterans Choice Act

Because we did not have quantitative data to analyze how many VCA-approved community providers are located within any given area or how many veterans have utilized the Veterans Choice Act, our findings on this subject relied on content analysis of peer-reviewed articles. Because of the lag time built-into the peer-review process (18-24 months), we are operating with the assumption that the information presented in our literature review findings on the VCA is still relevant although much of it was released after studying the policy for just one year of implementation.

### Veteran Suicide

In analyzing rates of veteran suicide, we used <http://www.dspo.mil/Prevention/Data-Surveillance/DoDSER-Annual-Reports/>. We are assuming this information is correct and VA Centers are screening and reporting veteran homelessness, suicide events, and MST as required by regulations for screening veterans upon entrance to the VA Healthcare system. Milestones of these screening and tracking efforts include:

- In 2004, VA centers began screening for MST for potentially early markers for homelessness.

- In 2012, all veteran suicide attempts and deaths started to be reported by the VHA to the Suicide Prevention and Application Network (SPAN).
- In 2013, all VA centers were instructed to screen all veterans eligible for VA healthcare for eminent risk of homelessness and connecting veterans to support services.

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## DELIMITATIONS

Upon beginning our Capstone project, the team set the following delimitations:

1. We would study only those in the U.S. Armed Forces.
2. Research from 2011 -2017 would be considered.
3. Research on homeless veteran population was based on PIT counts done by the Texas Homeless Network.

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## RESEARCH DESIGN AND RESEARCH QUESTIONS

Our ultimate research design consisted of receiving three original research questions from the Client, refining our original three research questions into 11 refined research questions through a hybrid literature review, identifying additional sub questions, dividing the 11 refined research questions and sub questions into themes, assigning those themes to individual team members, and using exploratory, mixed research methods per theme. Details are reported as follows:

A. The original research questions given to us by the Client included (all pertaining to TX-08):

- What are the financial impacts of VA health expenditures?<sup>1</sup>
- What are policy implications of the VCA?
- What information exists about veteran mental health, homelessness, and suicide?

B. After our completion of a hybrid literature review, our team expanded the three original research questions into 11 refined research questions. These questions were:

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<sup>1</sup> Note: Because we were not able to find specific financial information related to the Conroe CBOC, we were not able to fully address this question. Additional information on this topic is included in the Recommendations and Conclusion sections of this paper, and FOIA requests can be viewed in Appendix 5 and 5.1

1. Is there a tracking mechanism to track dual usage of healthcare systems among veterans in the 8th Congressional District? If not, can we look at studies done in other areas to extrapolate data?
2. How many VCA-approved community providers already exist within the 8th Congressional District compared to Texas and the nation? What is the current process to become a VCA-approved community provider? Is there a financial incentive for a community provider to become VCA-approved?
3. Who has utilized the VCA in the 8th Congressional District, and how does it compare to Texas and the nation?
4. Has the number of veterans using VCA-approved community care increased since the passing of the VCA in the 8th Congressional District, and how do these numbers compare to the state and the nation? What is the comparison to the number of veterans who had access to VA-approved community care through Patient-Centered Community Care (PC3,) the predecessor program to the VCA, and those who now have access using VCA?
5. How are the VCA and non-VCA providers currently communicating regarding the VCA-approved community visits? How can communication be improved between the VA and non-VA providers?
6. What are the wait times in the 8th Congressional District compared to Texas and the nation? How do they related to health expenditures (services offered, planning and resource management)?
7. What services are offered to female veterans at the Conroe CBOC? (“female care proportionality”) What percentage of veterans in the district are female, compared to Texas and nation? What is the population of female veterans compared to male veterans in the 8th Congressional District, Texas and nationally?
8. What is the rural versus urban access to mental health care in the 8th Congressional District, versus Texas and the nation and/or are there differences between rural and urban access to mental health care?
9. What are the rates of Military Sexual Trauma per gender compared to homelessness? How many veterans report Military Sexual Trauma (MST)? How many veterans reporting MST are homeless?

10. What information exists on homelessness and suicide among veterans in the 8th Congressional District? How many veterans are at risk of homelessness? How many veterans who have committed suicide, attempted suicide or report suicide ideation are homeless? What is the population of homeless female veterans compared to homeless male veterans in the 8th Congressional District, Texas and nationally.
11. What is the cost allocated per veteran in the 8th Congressional District, and how does it compare to Texas, and the nation? What is the cost spent per veteran in the 8th Congressional District, and how does it compare to Texas, and the nation? What are the top line items in the 8th Congressional District, and how do they compare to Texas, and the nation? <sup>2</sup>

C. The following sub questions developed from the research being done on the refined research questions. The full list of refined research questions, with sub questions is presented:

1. Is there a tracking mechanism to track dual usage of healthcare systems among veterans in the 8th Congressional District? If not, can we look at studies done in other areas to extrapolate data?
  - a. Sub Question 1.1: What are the effects on veterans stemming from dual usage?
2. How many VCA-approved community providers already exist within the 8th Congressional District compared to Texas and the nation? What is the current process to become a VCA-approved community provider? Is there a financial incentive for a community provider to become VCA-approved?
3. Who has utilized the VCA in the 8th Congressional District, and how does it compare to Texas and the nation?
4. Has the number of veterans using VA-approved community care increased since the passing of the VCA in the 8th Congressional District, and how do these numbers compare to the state and the nation? What is the comparison to the number of veterans who had access to VA-approved community care through Patient-Centered Community Care (PC3,) the predecessor program to the VCA, and those who now have access using VCA?

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<sup>2</sup> Note: Because we were not able to find specific financial information related to the Conroe CBOC, we were not able to fully address this question.

5. How are the VA and non-VA providers currently communicating regarding the VCA-approved community visits? How can communication be improved between the VA and non-VA providers?
  - a. Sub Question 5.1: What are the effects on veterans stemming from the current VA and non-VA provider communication system?
6. What are the wait times in the 8th Congressional District compared to Texas and the nation? How do they related to health expenditures (services offered, planning and resource management)?
7. What services are offered to female veterans at the Conroe CBOC? What percentage of veterans in the district are female, compared to Texas and nation? What is the population of female veterans compared to male veterans in the 8th Congressional District, Texas and nationally?
  - a. Sub Question 7.1: How many female veterans are utilizing the Conroe CBOC?
  - b. Sub Question 7.2: How much is spent/budgeted on top line item services at the Conroe CBOC; what is the percent of female veterans utilizing these services compared to male veterans?
  - c. Sub Question 7.3: How many female veterans from the 8th Congressional District are utilizing the DeBakey Women's Health Center (WHC) in Houston?
  - d. Sub Question 7.4: What training is provided to staff and medical providers at the Conroe CBOC that is gender specific? What does this training entail? Is there continuing medical education required? How much of the Conroe CBOC has received this training?
8. What is the rural versus urban access to mental health care in the 8th Congressional District, versus Texas and the nation and/or are there differences between rural and urban access to mental health care?
  - a. Sub Question 8.1: How many veterans are considered rural dwelling in the 8th Congressional District compared to the state and the nation?
  - b. Sub Question 8.2: How many rural dwellers go to Conroe CBOC for mental health appointments?
  - c. Sub Question 8.3: What are the wait times for mental health appointments for urban dwellers versus rural dwellers?



- d. Sub Question 8.4: How many female veterans utilize their Mental Health Benefits?
- 9. What are the rates of Military Sexual Trauma per gender compared to homelessness? How many veterans report Military Sexual Trauma (MST)? How many veterans reporting MST are homeless?
  - a. Sub Question 9.1: How many veterans report MST?
  - b. Sub Question 9.2: How many veterans reporting MST are homeless?
- 10. What information exists on homelessness and suicide among veterans in the 8th Congressional District? How many veterans are at risk of homelessness? How many veterans who have committed suicide, attempted suicide or report suicide ideation are homeless? What is the population of homeless female veterans compared to homeless male veterans in the 8th Congressional District, Texas and nationally.
  - a. Sub Question 10.1: How many veterans are at risk of homelessness?
  - b. Sub Question 10.2: What are P.I.T. Counts for the subpopulation, veterans?
  - c. Sub Question 10.3: What are the gender comparisons for veterans who have been screened for suicide?
  - d. Sub Question 10.4: What are the social and economic characteristics for female veterans, gender comparisons, and female veterans compared to non-veterans?
- 11. What is the cost allocated per veteran in the 8th Congressional District, and how does it compare to Texas, and the nation? What is the cost spent per veteran in the 8th Congressional District, and how does it compare to Texas, and the nation? What are the top line items in the 8th Congressional District, and how do they compare to Texas, and the nation?<sup>3</sup>

D. Refined questions were then divided into three themes. These themes included:

- I. Dual usage and the Veterans Choice Act
- II. Wait times, female veteran healthcare, and rural veterans
- III. Mental health, military sexual trauma (MST), veteran homelessness, and suicide

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<sup>3</sup> Note: Because we were not able to find specific financial information related to the Conroe CBOC, we were not able to fully address this question.

E. Each theme was assigned to a team member to research. To answer these 11 refined research questions and sub questions, our team used exploratory research. This consisted of a combination of elite interviews, content analysis of additional peer-reviewed literature, and thorough reviews of applicable, archival, and publically available datasets. Overall, the capstone team used a mixed methods approach, collecting both quantitative and qualitative data needed to answer our refined questions.

Using exploratory mixed research methods per theme, each member led the research on one theme. Castro led the research on dual usage and Veterans Choice Act, Hare led the research on wait times, female veteran healthcare, and rural veteran populations, and Willis led the research on mental health, veteran homelessness, and suicide. Specific research designs are presented per theme:

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## I. DUAL USAGE & VETERANS CHOICE ACT

The original research question, “What are the policy implications of the Veterans Choice Act?” was narrowed into five refined research questions following our initial scoping study and literature review. The five refined research and sub questions were:

1. Is there a tracking mechanism to track dual usage of healthcare systems among veterans in the 8th Congressional District? If not, can we look at studies done in other areas to extrapolate data?  
Sub Question 1.1: What are the effects on veterans stemming from dual usage?
2. How many VCA-approved community providers already exist within the 8th Congressional District compared to Texas and the nation? What is the current process to become a VCA-approved community provider? Is there a financial incentive for a community provider to become VCA-approved?
3. Who has utilized the VCA in the 8th Congressional District, and how does it compare to Texas and the nation?
4. Has the number of veterans using VA-approved community care increased since the passing of the VCA in the 8th Congressional District, and how do these numbers compare to the state and the nation? What is the comparison to the number of veterans

who had access to VA-approved community care through Patient-Centered Community Care (PC3,) the predecessor program to the VCA, and those who now have access using VCA?

5. How are the VA and non-VA providers currently communicating regarding the VCA-approved community visits? How can communication be improved between the VA and non-VA providers?

Sub Question 5.1: What are the effects on veterans stemming from the current VA and non-VA provider communication system?

## METHOD

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Driven by the five refined and sub research questions assigned to this theme, the ideal analysis would have been a mixed method of qualitative and quantitative analysis. However, the first identified limitation was the lack of quantitative information. After many failed attempts at elite interviews and lack of accessible numbers and hard data, this section relied on qualitative data.

## DATA

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The data analyzed was qualitative in nature. This included additional peer-reviewed scholarly journal articles and organizational and programmatic websites.

## PROCEDURES

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Castro led this research. Research into this theme entailed the following:

1. Content analysis of additional peer-reviewed articles was conducted specifically for refined research questions one and five. Castro reviewed an additional nine articles concerning dual use and VA/non-VA provider communication. These nine articles provided a springboard for additional sources through hand-searches by which two more useful articles were identified. Castro used inductive questioning in reviewing these articles, starting with small bits of information and expanding. Articles simultaneously addressing both dual use and communication systems reached a level of saturation for Castro, thus these questions were combined into the one topic.
2. Elite interviews were utilized for each refined research question; this lead Castro to focused action research on the Veterans Affairs and TriWest health contractor websites.

3. Our team compiled an aggregated questions document, and Castro contacted DeBakey VA Medical Center and House Committee on Veterans Affairs staff so they could assist us in obtaining answers or point us in the appropriate direction. The following questions which apply to this section were included in the aggregated list:

1. Is there currently a mechanism used to track dual users of two different healthcare systems? (When the VA is one of the healthcare systems.)
2. Who should we talk to in order to find the number of VCA-approved community providers within the 8th Congressional District, Texas, and the US?
3. What is the reimbursement rate for community providers who partner with the VA through the Veterans Choice Act to provide medical services to veterans? Is there a financial incentive to partner with the VA?
4. Does information exist about the number of unique veterans who utilize the Veterans Choice Act?
5. Do we have access to the number of veterans who received community care through Patient-Centered Community Care (PC3) before the VCA was enacted? Do we have access to the number of veterans who have received community care through the VCA?

4. Additionally, the following requests for information were made:

Castro reached out to Dylan MacInerney, Congressman Brady's Legislative Assistant via email on September 6, 2017 and they spoke by phone on September 8, 2017. Mr.

MacInerney directed us to the following links:

- <https://www.va.gov/opa/choiceact/index.asp> for questions on the VCA
- <https://www.ruralhealth.va.gov/> for questions on rural veterans
- <https://www.va.gov/health/access-audit.asp> for questions on wait times
- Castro reached out to the Office of Veterans Access to Care on September 13, 2017, September 15, 2017, September 18, 2017, and October 4, 2017. No information was received.

## SAMPLING

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Castro used similar inclusion/exclusion criteria as was used in the general literature review. In addition, Castro completed action research, especially on the VA and TriWest contractor websites, in order to find specific answers to questions.

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## II. WAIT TIMES, FEMALE VETERAN HEALTHCARE, AND RURAL VETERAN POPULATIONS

Wait times, female veteran healthcare, and rural veterans are discussed.

### WAIT TIMES

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Through our literature review, we refined our research question six to read “What are the wait times in the 8th Congressional District compared to Texas and the nation?”

### METHOD

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Driven by the refined research question, we used statistical testing to examine wait times for services provided at the Conroe CBOC, for both new and established patients compared to the same services at other clinics in the nation and state (the full list of hypotheses can be viewed in Appendix 4).

### DATA

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Quantitative data was used to study Conroe CBOC wait times. This included information collected from the VA Open Data Website (<http://www.data.va.gov/>). This database included average wait times for medical services (audiology, mental health, optometry, and primary care) offered to new and established patients, per service, at CBOCs across the nation. Data included average wait times calculated over 40 days, starting on July 13, 2017 and ending August 21, 2017.

### PROCEDURES

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Hare led this research. Research into this theme entailed the following:

1. Our team compiled an aggregated questions document which Castro emailed to DeBakey VA Medical Center and House Committee on Veterans Affairs staff. We asked for answers or for referrals to the correct staff member. The following questions which apply to this section were included in the aggregated list:
  1. Is there a location online where VA's post their wait times?
  2. What is the difference between the established wait time and new wait time?
  3. Are VA's required to report wait times by department or services?
2. Hare emailed James Wartski directly for information on wait times. Our request was forwarded by Wartski's assistant to Joan Clifford, the Deputy ADUSH at the Office of Veterans Access to Care. Clifford provided the team with information on the access to care website (<http://www.accesstocare.va.gov/>) and scheduled a time to speak on the phone with Hare about the way to utilize this website.
3. Hare did a search on the VA's open data site ([www.data.va.gov](http://www.data.va.gov)). We were able to access a full spreadsheet from the end of August 2017 that had the wait times recorded for new and established patients in all VA hospitals and clinics in the nation. Hare was able to share this document with Clifford who confirmed that '9999' listed as an average wait time indicated no appointments were made in the 40-day time period in which this information was gathered. Clifford also explained further that wait times are recorded by established patients and new patients.
4. Hare removed the VA hospitals from the list, so that the team only compared the Conroe CBOC with other clinics. She sorted this data to a sample that the team could use and then determined the average wait time for new and established patients by service for the nation and the state.
5. Hare then performed ANOVA: Single Factor tests on the data collected. Results can be viewed in Appendix 4.

## SAMPLING

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The population data we collected from the VA Open Data Website (<http://www.data.va.gov/>) regarding wait times is a population of new and established patient appointments for the last 40 days (ending August 21, 2017), documented by the clinics.

## FEMALE VETERAN HEALTHCARE

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After the initial scoping study and scholarly literature review we determined that we needed to further explore and examine female veteran VA usage in the 8th Congressional District. We determined refined research question seven to read “What services are offered to female veterans at the Conroe CBOC? What percentage of veterans in the district are female, compared to Texas and nation? What is the population of female veterans compared to male veterans in the 8th Congressional District, Texas and nationally?” As we worked through data collection and research, the following four sub questions emerged:

- a. Sub Question 7.1: How many female veterans are utilizing the Conroe CBOC?
- b. Sub Question 7.2: How much is spent/budgeted on top line item services at the Conroe CBOC; what is the percent of female veterans utilizing these services compared to male veterans?
- c. Sub Question 7.3: How many female veterans from the 8th Congressional District are utilizing the DeBakey WHC in Houston?
- d. Sub Question 7.4: What training is provided to staff and medical providers at the Conroe CBOC that is gender specific? What does this training entail? Is there continuing medical education required? How much of the Conroe CBOC has received this training?

## METHOD

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Driven by the refined research and sub questions, we used inductive research methods to gather data about the trends in growth of female veterans in the 8th Congressional District, Texas and the nation and compared this to the trends in growth of male veterans. We explored the proportionality between female veterans and healthcare services provided, specifically at the Conroe CBOC. We analyzed the number of female veterans in the 8th Congressional District who are said to be utilizing the Conroe CBOC and the services offered for female veterans. We also attempted to examine the number of female veterans from the 8th Congressional District who are going to DeBakey VA Medical Center to receive services.

## DATA

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Quantitative and qualitative data used to study female veteran healthcare included:

- Hare obtained quantitative data sets on the projected growth of female and male veteran populations in the country through 2045 from a review of archival, publicly available data. These data sets were found on the VA Vet Data site <https://www.va.gov/vetdata/>. Hare disaggregated this data by state and district for a more detailed analysis.
- Hare obtained qualitative data from elite interviews conducted with:
  - Leon regarding female-specific services available at the Conroe CBOC.
  - Sanders regarding gender-specific training mini residencies
  - Dr. El-Serag regarding gender-specific training offered at the Conroe CBOC and DeBakey VA Medical Center.

## PROCEDURES

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Procedures included:

1. Hare emailed Leon at the Conroe CBOC. After a follow up call, Leon emailed back stating that the Conroe CBOC does not have a women's health center, and that all services provided at the Conroe CBOC are available for both male and female veterans; there are no female-specific services offered.
2. Hare found all population data for male and female veterans currently living in the nation broken down by state and congressional district. She was also able to find the projections from the VA for this growth until 2045. Hare calculated the growth for female veterans over the next 29 years in the 8th Congressional District, Texas and the nation, as well as the growth for male veterans.
3. After a follow up call with Dyman, Hare reached back out to Leon to find out what percentage of veterans served at the Conroe CBOC was female and if we could determine what services were used most by female veterans. According to Leon, approximately 10% of veterans served at the Conroe CBOC are women, however he did not have information on percentage of females served by service.
4. Staff at DeBakey verbally confirmed it was possible to run a report in order to determine the number of female veterans from the 8th Congressional District that were utilizing the DeBakey Veterans Medical Center in Houston, Texas. Hare provided a list of zip codes for the 8th Congressional District. After multiple follow up attempts, our team did not hear back or receive this information.



5. Dyman noted on a call with the team that providers at the clinics could take training on gender-specific services to better meet the needs of female veterans utilizing the clinic. Dyman suggested we reach out Dr. El-Serag, the Medical Director of Women Veterans Health Programs at DeBakey Veterans Medical Center in Houston.
6. Hare emailed Dr. El-Serag requesting information on gender-specific training offered for providers at the Conroe CBOC. Hare received information regarding this training from Dr. El-Serag through an elite interview on the phone and a follow up email where she stated there are different ways to be certified in gender-specific training and that providers should all meet certain criteria related to gender-specific needs. Hare did a search of archival, publically available data to find additional information on gender-specific training. Hare was able to find information on a training being proctored by Ryan Mullins. After reaching out to Mullins, he directed Hare to speak with Aimee M. Sanders, the Physician Educator and Women's Health Education for Women's Health Services at the VHA Central Office. Through an elite interview on the phone, and subsequent follow up emails, Sanders provided Hare with extensive information on the gender-specific training mini-residencies and the content of the training.
7. Hare followed up with Sanders and Dr. El-Serag for information on any mandates from the VA on female veteran healthcare. On November 21, 2017, the VHA Directive 1330.01(1) Health Care Services for Women Veterans, was provided to Hare by Sanders. This directive was originally published February 15, 2017 and was amended September 8, 2017. The purpose of the directive is to ensure that female veterans have access to "all medically necessary services" (VHA Directive 1330.01(1) 2017).

#### SAMPLING

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The data found on male and female veteran populations and projections is population data from the district, state, and nation.

#### RURAL VETERAN POPULATIONS

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The original research question, "What information exists about veterans homelessness within the 8th Congressional District? How does this information relate to veteran suicide?," was focused into one refined research questions following our initial scoping study and literature review. The

refined research question is question 8: “What is the rural versus urban access to mental health care in the 8th Congressional District, versus Texas and the nation, and/or are there differences between rural and urban access to mental health care?” Our team determined that to better analyze this question, we would need to know the population data of rural dwelling veterans in the 8th Congressional District, state and nation. This section examines Question 8, Sub Question 1: “How many veterans are considered rural dwelling in the 8th Congressional District compared to the state and the nation?”

## METHOD

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Driven by the refined research and sub question, we used a quantitative approach. This included reviewing and analyzing applicable, publically available data in order to determine the population of rural dwelling veterans.

## DATA

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Data used to study rural veteran populations included:

- The VA Open Data Website (<http://www.data.va.gov/>) for the number of rural veterans registered to use VA services in the state and in the nation in 2014 (<https://www.data.va.gov/dataset/rural-veterans-state-2014>). Note: We were unable to find the number of rural dwelling veterans living in the 8th Congressional District from this source.
- We collected the number of rural veterans who live in the counties that are located in the 8th Congressional District. (<http://www.factfinder.census.gov/facts/tableservice/jsf/pages/productview.xhtml/?src=CF>).

## PROCEDURES

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Hare led this research. Research into this theme entailed the following:

1. Our team compiled an aggregated questions document which Castro emailed DeBakey VA Medical Center in Houston and House Committee on Veterans Affairs staff so they could assist us in obtaining answers or provide an appropriate referral. The following questions which apply to this section were included in the aggregated list:

1. How can we access data on the number of rural veterans in the nation, by state and by district? Is this demographic information available to the public? If not, who can we reach out to in order to gather more information on rural veterans?
2. Hare did a search of the VA open data website (<http://www.data.va.gov/>) where she was able to find a spreadsheet titled “Rural Veterans by State (2014)” listing the rural dwelling veterans by state and the total for the nation.
3. The team requested additional information from Dyman on information regarding rural dwelling veterans in the 8th Congressional District. We set up a phone call with her, in which she explained that the location a veteran is living (rural or urban) is only gathered when the veteran registers for VHA services. There is no way to track veterans once they leave the service as some have no interest in being “tracked” or “located” and there is no system in place where they can update this information. Because of this, we cannot determine how many rural dwelling veterans live in the 8th Congressional District through the VA. Dyman also informed us that the spreadsheet we located on the VA data site was limited to those veterans who were using VA services. Using information from the 2010 census, Hare was able to create a spreadsheet of all the zip codes that are part of the 8th Congressional District. Willis was able to gather information on rural veterans living in the counties within the 8th Congressional District through census data.
4. Hare was able to determine the percentage of rural veterans living in each state based on data collected from the spreadsheet “Rural Veterans by State (2014)” found on the VA data site. This showed that Texas has the largest percentage of rural veterans living in the state who are utilizing VA services. Through the information Willis gathered from the census data, we removed two counties (Leon and Harris) from our examination of rural veterans living in the 8th Congressional District because these counties are not fully located in the 8th Congressional District. An additional county in the district (Montgomery) was not included in our analysis because we could not separate rural dwelling from urban dwelling. Of the 6 counties in the 8th Congressional District that we examined, all 6 are completely rural dwelling.

## SAMPLING

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The VA Open Data Website uses a non-random sample of the population of rural veterans. Dyman reported veterans are only determined to be rural dwellers when they register to use VA services. Therefore, unless the veteran is registered with VHA, they are not tracked regarding geographic residence. Willis was able to determine the number of rural veterans residing in the 8th Congressional District through searching population census by counties within the 8th Congressional District, however this sample has limitations. One limitation is that the 8th Congressional District includes lower part of Leon and upper part of Harris Counties and population statistics are unavailable for partial counties. A second limitation is that we were unable to separate rural veterans living in Montgomery County from urban dwelling veterans (*refer to Rural Veteran Population Results*).

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## III. MENTAL HEALTH, MILITARY SEXUAL TRAUMA (MST), VETERAN HOMELESSNESS, AND SUICIDE

The original research question posed by Congressman Brady and his staff was “What information exists about veteran mental health, homelessness, and suicide?” After the initial scoping study and scholarly literature review, the team modified this question into 3 refined research questions and 9 sub questions. The refined research questions for Mental Health, Military Sexual Trauma (MST), Veteran Homelessness, and Suicide as well as the methods for research are listed below.

### MENTAL HEALTH

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The refined research and sub questions for the Mental Health are: Question 8, What is the rural versus urban access to mental health care in the 8th Congressional District, versus Texas and the nation and/or are there differences between rural and urban access to mental health care?

- a. Sub Question 8.2: How many rural dwellers went to Conroe CBOC for mental health appointments?
- b. Sub Question 8.3: What are the wait times for mental health appointments for urban dwellers versus rural dwellers?

c. Sub Question 8.4: How many female veterans utilized their mental health benefits?

#### METHOD

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Driven by the refined research and sub questions, Willis researched potential applicable databases. Hare and Willis collaborated sharing (<http://www.factfinder.census.gov/facts/tableservice/jsf/pages/productview.xhtml/?src=CF>). database. Willis supplemented this effort with an elite interview and additional qualitative data including reviewing further scholarly journals and VA program details from between 2011 - 2017.

#### DATA

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The team was unable to identify datasets containing specific information regarding the CBOC or DeBakey VA Medical Center (VAMC) on the number of rural dweller veterans receiving mental health care, wait times for rural mental health appointments, and the number of female veterans utilizing their mental health benefits.<sup>4</sup> In lieu of quantitative data, Willis conducted an elite interview, action research, and reviewed additional research studies.

#### PROCEDURES

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Willis led this research. Research into this theme involved the following:

1. Willis contacted Kayla Williams, Center for Women Veterans via email. Williams sent public data information concerning rural and mental health.
  - a. [www.va.gov/homeless/pit\\_count.asp](http://www.va.gov/homeless/pit_count.asp)
  - b. [www.ruralhealth.va.gov](http://www.ruralhealth.va.gov)
  - c. [www.mentalhealth.va.gov/msthome.asp](http://www.mentalhealth.va.gov/msthome.asp)
2. The website [www.ruralhealth.va.gov](http://www.ruralhealth.va.gov) lead to information on Rural Veterans Coordination Pilot (RVCP) grant that provides veterans and their families who live in rural areas with support programs.

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<sup>4</sup> FOIA request was sent requesting this specific information. See Appendix 5.

- a. The RVCP program was conducted in 2015 and 2016 in Maine, Nebraska, New Mexico, North Louisiana, parts of Texas, Arkansas and Oklahoma, Washington and Oregon.
- 3. One scholarly journal article was located through the TAMU library by advanced search
  - a. Adler, Pritchett, Kauth, and Mott. 2015. “Staff Perceptions of Homeless Veterans’ Needs and Available Services at Community-Based Outpatient Clinics.”
    - i. The research interviewed the staff at 30 CBOCs within Veterans Integrated Service Network (VISN) 16 and 6. VISN 16 consists of rural areas located from the Florida panhandle to east Texas and is comprised of eight states; this area includes the 8th Congressional District of Texas.

#### MILITARY SEXUAL TRAUMA (MST)

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After the initial scoping study and scholarly literature review, the team refined our research questions regarding Military Sexual Trauma (MST) to the following question and sub questions: Question 9. What are the rates of Military Sexual Trauma per gender compared to homelessness? How many veterans report Military Sexual Trauma (MST)? How many veterans reporting MST are homeless?

- a. Sub Question 9.1: How many veterans reported MST?
- b. Sub Question 9.2: How many veterans reporting MST are homeless?

#### METHOD

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Driven by the refined research and sub questions, Willis researched potential applicable databases. Although Willis identified a database providing quantitative data on homelessness, no information was identified on MST. Willis supplemented this effort with elite interviews and additional qualitative data including reviewing further scholarly journals and VA program details from between 2011 - 2017.

#### DATA

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The team was unable to identify datasets containing specific information regarding the CBOC or DeBakey VA Medical Center (VAMC) on MST. P.I.T. data was used to answer questions

related to homelessness, although no analysis could be made between the variables MST and homelessness.<sup>5</sup> Willis supplemented this data with elite interviews, action research, and reviewed additional research studies.

## PROCEDURES

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Willis led this research. Research into this theme entailed the following:

1. Willis contacted Williams, Center for Women Veterans via email. Williams sent public data information concerning rural and mental health.
  - a. [www.va.gov/homeless/pit\\_count.asp](http://www.va.gov/homeless/pit_count.asp)
  - b. [www.ruralhealth.va.gov](http://www.ruralhealth.va.gov)
  - c. [www.mentalhealth.va.gov/msthome.asp](http://www.mentalhealth.va.gov/msthome.asp)
2. The website [www.mentalhealth.va.gov/msthome.asp](http://www.mentalhealth.va.gov/msthome.asp) lead to a fact sheet on MST.
3. Four scholarly journals were located through the TAMU library by advanced search.
  - a. Mankowski and Everett. 2016. "Women service members, veterans, and their families: What we know now."
  - b. Brignone, Gundlapalli, Blais, et al. 2016. "Differential Risk for Homelessness Among US Male and Female Veterans With a Positive Screen for Military Sexual Trauma"
  - c. Reppert, Buzzetta, and Rose. 2014. "Implications for Practice: Assisting Female Veterans in their Career Development."
  - d. Ganzer. 2016. "Veteran Women: Mental Health-Related Consequences of Military Service."

## VETERAN HOMELESSNESS AND SUICIDE

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The refined research question and sub questions regarding veteran homelessness, and suicide are listed below:

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<sup>5</sup> FOIA request for this information was sent by our team. See Appendix 5 and 5.1

Question 10. What information exists on homelessness and suicide among veterans in the 8th Congressional District? How many veterans are at risk of homelessness? How many veterans who have committed suicide, attempted suicide or report suicide ideation are homeless? What is the population of homeless female veterans compared to homeless male veterans in the 8th Congressional District, Texas, and nationally.

- a. Sub Question 10.1: How many veterans are at risk of homelessness?
- b. Sub Question 10.2: What are P.I.T. counts for the veterans?
- c. Sub Question 10.3: What are the gender comparisons for veterans who have been screened for suicide?
- d. Sub Question 10.4: What are the social and economic characteristics for female veterans, gender comparisons, and female veterans compared to non-veterans?

## METHOD

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Driven by the refined research and sub questions, Willis used a mixed methods approach. This included a qualitative approach based on content analysis gathered from archival data and examining publicly available datasets to analyze homeless veteran populations, suicide among veterans, and social and economic characteristics of female veterans.

## DATA

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Quantitative and qualitative data was used. This included conducting elite interviews, examining publicly available datasets, and reviewing additional scholarly journal articles published between 2011 - 2017. Publically available datasets utilized include:

- Veterans at risk of homelessness (<http://thn.org/data/point-time-pit-count-reports/>),
  - Veterans at risk of suicide (<http://www.dspo.mil/Prevention/Data-Surveillance/DoDSER-Annual-Reports/>),
  - Social and economic characteristics of women veterans  
([https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_16\\_1YR\\_S2101&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S2101&prodType=table)), .
-



Willis led this research. Research into this theme entailed the following:

1. Willis contacted Terri Tanielian (Senior Behavioral Scientist at Rand) via email. Tanielian sent public data sets concerning homeless veterans and veteran populations.
  - a. [www.va.gov/vetdata/veteran\\_population.asp](http://www.va.gov/vetdata/veteran_population.asp)
  - b. [www.va.gov/vetdata/docs/specialreports/homeless\\_veterans 2009-2010.pdf](http://www.va.gov/vetdata/docs/specialreports/homeless_veterans_2009-2010.pdf)
  - c. [www.va.gov/vetdata/docs/specialreports/states\\_summaries/Texas.pdf](http://www.va.gov/vetdata/docs/specialreports/states_summaries/Texas.pdf)
2. Willis contacted Williams, Center for Women Veterans via email. Williams sent public data information concerning homeless count.
  - a. [www.va.gov/homeless/pit\\_count.asp](http://www.va.gov/homeless/pit_count.asp)
  - b. [www.ruralhealth.va.gov](http://www.ruralhealth.va.gov)
3. Willis contacted Kate Machado, VP of Business Development at Atlas Research. Machado sent public data information and referred Willis to her colleague Hilda Heady, at Atlas Research, who sent publicly available access point.
  - a. [https://www.va.gov/vetdata/docs/SpecialReports/Rural\\_Veterans\\_ACS2014\\_FIN AL.pdf](https://www.va.gov/vetdata/docs/SpecialReports/Rural_Veterans_ACS2014_FIN_AL.pdf)
  - b. [https://www.va.gov/vetdata/docs/SpecialReports/Rural\\_Veterans\\_ACS2010\\_FIN AL.pdf](https://www.va.gov/vetdata/docs/SpecialReports/Rural_Veterans_ACS2010_FIN_AL.pdf)
  - c. <https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-36.pdf>
  - d. <https://www.census.gov/topics/population/veterans.html>
  - e. <https://www.va.gov/vetdata/report.asp>
  - f. <https://www.hudexchange.info/resources/documents/2016-AHAR-Part-1.pdf>
  - g. <http://www.homelesshouston.org/local-data-and-research>
  - h. <https://www.mentalhealth.va.gov/docs/data-sheets/Suicide-Data-Sheet-Texas.pdf>
4. Willis obtained clarification on the definitions of homelessness and risk of homelessness: [https://www.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition\\_Criteria.pdf](https://www.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition_Criteria.pdf)
5. Four scholarly journals were located through the TAMU library by advanced search.

- a. Brignone et al. (2017) “Non-routine Discharge From Military Service: Mental Illness Substance Use Disorders, and Suicidality.”
- b. McCarthy et al. 2012. “Suicide Among Patients in the Veterans Affairs Health System: Rural-Urban Differences in Rates, Ricks, and Methods.”
- c. Thorne et al. 2017. “Traumatic Stress and Suicide Risk: the Role of Rural Origin.”
- d. Pedersen et al. 2015. “Public-Private Partnerships for Providing Behavioral Health Care to Veterans and Their Families.”

## CHAPTER 2: LITERATURE REVIEW SUMMARY

### INTRODUCTION

To answer initial research questions, we conducted a hybrid literature review. Our hybrid review consisted of two combined research methods. The first was a scoping study. We chose to initially conduct a scoping review because we anticipated finding minimal scholarly research specific to the 8th Congressional District in Texas. Grant and Booth (2009), recommend a scoping study to assess potential size and choice of available research. Once we identified the wider, non-scholarly resources, we then conducted a narrative, thematic scholarly review.

What follows is a summary of our literature review. This includes an overview of project purpose and methods, findings and connections between themes, gaps in research, our 11 refined research questions, and a conclusion. The full hybrid literature review can be located in Appendix 2.

### OVERVIEW OF PROJECT PURPOSE AND METHODS

The purpose of this hybrid literature review was to review the existing literature, identify connection between themes, find gaps in the literature (see Appendix 2), and to refine the initial research questions provided by the Client. The initial questions were:

1. What are the financial impacts of VA health expenditures?
2. What are policy implications of the VCA?
3. What information exists about veteran homelessness and suicide?

Our scoping study familiarized our team with Congressman Brady, the 8th Congressional District of Texas, veteran resources, policies, and issues and existing opinions on the topic. Through this familiarization we were able to narrow the research questions given to us by the Congressman and his staff into keyword search phrases to utilize in our scholarly literature review. As we narrowed our research questions we were able to identify the four themes on which we based our scholarly literature review. These themes were:

1. Dual usage and the VCA

2. Wait times, female veterans, and rural veteran populations
3. MST, homelessness, and suicide

Our scoping study was also integral in helping us identify the research gap that existed for material specific to the veterans within the 8th Congressional District of Texas. After completing a scoping study, we focused on scholarly peer-reviewed publications.

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## FINDINGS AND CONNECTIONS BETWEEN THEMES

Through our literature review we compiled a number of findings. These are listed as follows:

1. We found the VHA Strategic Plan mentioned frequently in our research, however researchers were equally concerned about the implementation of it due to previous concerns regarding governance of the VHA and the lack of clear accountability. Some researchers, including Giroir, Turek, and Wilensky, called for a complete overhaul of the VHA system. The researchers that called for an overhaul felt that would include shifting the VHA focus to medical issues specific to veterans such as “wounds of war,” like traumatic brain injuries and psychological health for which the VA are industry leaders, and use non-VHA providers to treat the bulk of veterans more general health needs. Giroir and Wilensky stated that recent trends in healthcare “necessitate reconsideration of whether the VHA should aim to be the comprehensive provider for all veterans’ health needs or should emphasize more limited centers providing specialized care” (2015, 1694). Turek described her vision for this system, “in the same way that Medicaid and Medicare provide healthcare benefits without running their own facilities, VA could eliminate their smaller outpatient facilities and set up a billing system similar to that of Medicaid and Medicare” (2016, 226). Wilensky noted that “7 of the 15 members of the congressionally created Commission on Care call[ed] for the VA to become primarily a payer for care, with no new VA hospitals and clinics and a Base Realignment and Closure (BRAC)–like process to close some existing facilities” but those members were shut out by many involved in the VHA establishment (2016, 2).

2. Researchers including Everett, Mankowski, and Turek identified mental health as a significant issue for veterans, especially among OEF and OIF veterans.
3. All researchers reviewed agreed reducing wait times at the VA is still a priority even after the implementation of the VCA. Many researchers pointed out that appointment wait times continue to be lengthy even for veterans who utilize the VCA- Mattocks et al stated that “many Veterans who may have had to wait 35 days for care in the VA were being shifted to the community, where wait times could approach 3–6 months for certain specialty services” because of lack of providers (2017, S73).
4. According to researchers Bartel et al, Finley, Lacoursiere Zuccherro, and Nuti the VA is a leader in veteran-specific medical needs. In one study non-VA providers had a lower adenoma detection rate (ADR) than VA providers which is generally accepted in the medical community to mean that the doctors took less time and were less thorough at screening for precancerous polyps. Bartel concluded, “lower ADRs raise concern that referring veterans outside the VA system may impact colonoscopy quality” (2016, 1). Older men (65 and up) who suffered heart attacks, heart failure, or pneumonia and were hospitalized at VA facilities versus non-VA facilities had “lower 30-day risk-standardized all-cause mortality rates” (Nuti 2016, 1). For those seeking care for PTSD from non-VA community providers “only 15.0% of providers reported regularly conducting psychotherapy for PTSD following a treatment manual, and fewer than half reported any use of evidence-based psychotherapies (EBPs) for PTSD with patients” (Finley 2017, 1). In each of these studies, the medical care provided by the Department of Veterans Affairs was as good, if not better than, the care provided by non-VA services. A reason given for the VA’s comparatively high performance is their understanding of veterans and veteran issues (Lacoursiere Zuccherro 2016, 6). The VA is a leading provider for issues more prevalent in veterans such as PTSD and understand the “military culture” better than general community providers.
5. Telemedicine in general is becoming a more widely acceptable way to practice medicine. Researchers we reviewed, including Kehle-Forbes, Lee, Perdew, and Powers agreed, when done correctly, telemedicine can be helpful for the provision of VA services to those unable to see VA providers in person. Through the widespread use of technology telehealth is becoming an increasingly available option to provide

- care to rural, aging, and female veterans. Telemedicine can “meet” rural and aging veterans at locations convenient to them and can provide an opportunity for the VA to form female-specific mental health groups and meet gender-specific needs when the number of female veterans in one location is not high enough to merit women-specific groups or facilities.
6. Researchers including Charlton, Gellad, Hogan et al, Lacoursiere Zuccherro, Suda, Thorpe, and West were concerned with the continuity of care for veterans who are “dual users,” and access two health systems at a time (VA and a private health insurance plan or VA and Medicare/Medicaid). A major concern is how to achieve continuity of care when veterans utilize two systems. A major barrier to this continuity is that non-VA providers do not have access to the electronic medical records (EMR) of the VA. Gellad stated that “laboratory tests performed under Choice will not be found in the same section as tests performed in a VA facility, and instead may be buried in pages of scanned material” which can have huge implications for duplication of services for dual-using veterans (2015, 154).
  7. Researchers including Kehle-Forbes et al, Brooks and Koblinsky and are concerned that the VA health system may not be meeting the gender-specific medical needs of female veterans. VAMCs are described as uncomfortable and unwelcoming; in fact, one female veteran described the VA as sparking trauma-related memories, “It’s the overwhelming presence of male veterans. I don’t know them. It doesn’t matter. It triggers me” (Kehle-Forbes 2017, 4).
  8. Community partnerships among VA Centers and local community agencies are vital to rural veterans and their families. “Partners need to be Flexible in adapting to technological innovations, information technology, needs of the target population, funding environments and changes to strategic objectives over time” (Pedersen et al. 2015.1).

#### REFINED RESEARCH QUESTIONS

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Through this literature review our team was able to focus the scope of our research to 11 refined research questions which we organized into themes. These are:

## **I. Dual usage and the Veterans Choice Act**

1. Is there a tracking mechanism to track dual usage of healthcare systems among veterans in the 8th Congressional District? If not, can we look at studies done in other areas to extrapolate data?

a. Sub Question 1.1: What are the effects on veterans stemming from dual usage?

2. How many VCA-approved community providers already exist within the 8th Congressional District compared to Texas and the nation? What is the current process to become a VCA-approved community provider? Is there a financial incentive for a community provider to become VCA-approved?

3. Who has utilized the VCA in the 8th Congressional District, and how does it compare to Texas and the nation?

4. Has the number of veterans using VA-approved community care increased since the passing of the VCA in the 8th Congressional District, and how do these numbers compare to the state and the nation? What is the comparison to number of veterans who had access to VA-approved community care through Patient-Centered Community Care (PC3,) the predecessor program to the VCA, and those who now have access using VCA?

5. How are the VA and non-VA providers currently communicating regarding the VCA-approved community visits? How can communication be improved between the VA and non-VA providers?

a. Sub Question 5.1: What are the effects on veterans stemming from the current VA and non-VA provider communication system?

## **II. Wait times, female veteran healthcare and rural veteran populations:**

6. What are the wait times in the 8th Congressional District compared to Texas and the nation? How do they related to health expenditures (services offered, planning and resource management)?

7. What services are offered to female veterans at the Conroe CBOC? What percentage of veterans in the district are female, compared to Texas and nation? What is the population of female veterans compared to male veterans in the 8th Congressional District, Texas and nationally?

- a. Sub Question 7.1: How many female veterans are utilizing the Conroe CBOC?
- b. Sub Question 7.2: How much is spent/budgeted on top line item services at the Conroe CBOC; what is the percent of female veterans utilizing these services compared to male veterans?
- c. Sub Question 7.3: How many female veterans from the 8th Congressional District are utilizing the DeBakey WHC in Houston?
- d. Sub Question 7.4: What training is provided to staff and medical providers at the Conroe CBOC that is gender specific? What does this training entail? Is there continuing medical education required? How much of the Conroe CBOC has received this training?

### **III. Mental health, military sexual trauma (MST), homelessness, and suicide**

8. What is the rural versus urban access to mental health care in the 8th Congressional District, versus Texas and the nation and/or are there differences between rural and urban access to mental health care?

- a. Sub Question 8.1: How many veterans are considered rural dwelling in the 8th Congressional District compared to the state and the nation?
- b. Sub Question 8.2: How many rural dwellers go to Conroe CBOC for mental health appointments?
- c. Sub Question 8.3: What are the wait times for mental health appointments for urban dwellers versus rural dwellers?
- d. Sub Question 8.4: How many female veterans utilize their Mental Health Benefits?

9. What are the rates of military sexual trauma per gender compared to homelessness? How many veterans report military sexual trauma (MST)? How many veterans reporting MST are homeless?

- a. Sub Question 9.1: How many veterans report MST?



- b. Sub Question 9.2: How many veterans reporting MST are homeless?
10. What information exists on homelessness and suicide among veterans in the 8th Congressional District? How many veterans are at risk of homelessness? How many veterans who have committed suicide, attempted suicide or report suicide ideation are homeless? What is the population of homeless female veterans compared to homeless male veterans in the 8th Congressional District, Texas and nationally.
- a. Sub Question 10.1: How many veterans are at risk of homelessness?
  - b. Sub Question 10.2: What are P.I.T. Counts for the subpopulation, veterans?
  - c. Sub Question 10.3: What are the gender comparisons for veterans who have been screened for suicide?
  - d. Sub Question 10.4: What are the social and economic characteristics for female veterans, gender comparisons, and female veterans compared to non-veterans
11. What is the cost allocated per veteran in the 8th Congressional District, and how does it compare to Texas, and the nation? What is the cost spent per veteran in the 8th Congressional District, and how does it compare to Texas, and the nation? What are the top line items in the 8th Congressional District, and how do they compare to Texas, and the nation?<sup>6</sup>

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## CONCLUSION

The next phase of our capstone project will begin with us developing hypotheses based on our eleven refined research questions. We will then investigate our research questions through the use of both quantitative and qualitative data analysis and further examination of scholarly literature with a focus on improving healthcare access, resource allocations, and accountability.

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<sup>6</sup> Note: Because we were not able to find specific financial information related to the Conroe CBOC, we were not able to fully address this question.

## CHAPTER 3: RESULTS

Results of our research are presented per theme.

### I. DUAL USAGE & VETERANS CHOICE ACT

Results for dual usage and veterans choice act are presented per refined research question.

Q.1: Is there a tracking mechanism to track dual usage of healthcare systems among veterans in the 8th Congressional District? If not, can we look at studies done in other areas to extrapolate data?

- a. Sub Question 1.1: What are the effects on veterans stemming from dual usage?

A.1: A mechanism called the Virtual Lifetime Electronic Record (VLER) does exist to track dual usage of healthcare systems among veterans which allows approved community providers limited access to the VA electronic medical record (EMR). But, the VLER is currently only utilized by four non-VA health systems in the state of Texas, none of which are found within the 8th Congressional District.

A.2: A tool exists for communication between the Department of Defense and the Department of Veterans Affairs. But, only certain VA medical centers utilize it. DeBakey VA Medical Center (the closest VAMC to the 8th Congressional District) does not utilize the Joint Legacy Viewer.

A.3: Negative effects stemming from dual use of healthcare systems include care fragmentation and lack in the continuity of care, conflicting diagnosis and duplication of services, and higher rates of exposure to PUMs (potentially unsafe medications.)

Q.2: How many VCA-approved community providers already exist within the 8th Congressional District compared to Texas and the nation? What is the current process to become a VCA-approved community provider? Is there a financial incentive for a community provider to become VCA-approved?

A.1: We are not able to answer how many VCA-approved community providers already exist within the 8th Congressional District, Texas, or the nation. There is a search tool on

the VA website which is built to locate providers near a locale, but this tool will not query the total number of VCA-community providers in a given area. We were able to ascertain that the contractor used by the VA to administer the VCA program in Texas is TriWest Healthcare Alliance.

A.2: The current process to become a VCA-approved community provider is: First, interested providers must set up an agreement with the contractor who services their region, either TriWest Healthcare Alliance or Health Net Federal. TriWest Healthcare Alliance services Texas. Then, the provider must ensure they meet the following criteria: accept Medicare rates; meet Medicare “Conditions of Participation and Conditions for Coverage;” be in compliance with all federal and state requirements that apply; have the same or similar credentials as VA staff; and agree to submit a copy of the medical records to the contractor for medical care and services provided to veterans for inclusion in the VA electronic medical record (How to become a Veterans Choice Program Provider, 2016.)

A.3: VCA-approved community providers are reimbursed at the Medicare rate.

Q.3: Who has utilized the VCA in the 8th Congressional District, and how does it compare to Texas and the nation?

A.1: We are not able to report how many veterans have utilized the Veterans Choice Program (VCP) in the 8th Congressional District of Texas, Texas, or the nation.

Q.4: Has the number of veterans using VA-approved community care increased since the passing of the VCA in the 8th Congressional District of Texas, and how do these numbers compare to the state and the nation? What is the comparison to number of veterans who had access to VA-approved community care through Patient-Centered Community Care (PC3,) the predecessor program to the VCA, and those who now have access using VCA?

A.1: We are not able to report how many veterans have utilized the VCP in the 8th Congressional District of Texas, Texas, or the nation.

A.2: We are not able to report how many veterans accessed community care through PC3 prior to the enactment of the VCA.

Q.5: How are the VA and non-VA providers currently communicating regarding the VCA-approved community visits? How can communication be improved between the VA and non-VA providers?

- a. Sub Question 5.1: What are the effects on veterans stemming from the current VA and non-VA provider communication system?

A.1: A mechanism does exist to track dual usage of healthcare systems among veterans called the Virtual Lifetime Electronic Record (VLER). This allows approved community providers limited access to the VA electronic medical record (EMR.) But, the VLER is currently only utilized by four non-VA health systems in the state of Texas, none of which are found within the 8th Congressional District.

A.2: A tool exists for communication between the Department of Defense and the Department of Veterans Affairs. But, only certain VA medical centers utilize it. DeBakey VA Medical Center (the closest VAMC to the 8th Congressional District) does not utilize the Joint Legacy Viewer.

A.3: Negative effects stemming from lack in communication between the VA and non-VA providers include documents scanned into the VA EMR (electronic medical record) from community providers not being queried in the same way as VA medical records; much of the burden of communicating complex medical history being placed on veterans and their family members; and, outside providers not being able to follow the VA's formulary guidelines for prescriptions because 1) they don't know them and 2) cannot use the same ordering system.

## II. WAIT TIMES, FEMALE VETERAN HEALTHCARE, AND RURAL VETERAN POPULATION

Results for wait times, female veteran healthcare, and rural veteran populations are presented per refined research question.

### Wait Times:

Q.6: What are the wait times in the 8th Congressional District compared to Texas and the nation? How do they related to health expenditures (services offered, planning, and resource management)?

A.1: After running ANOVA: single factor tests on all four services, divided by established patients and new patients, we failed to reject all our null hypotheses, signifying wait times of services at the Conroe CBOC for both new and established patients are not statistically different than those at clinics in the nation and the state of Texas. *ANOVA tests can be viewed in appendix 4.*

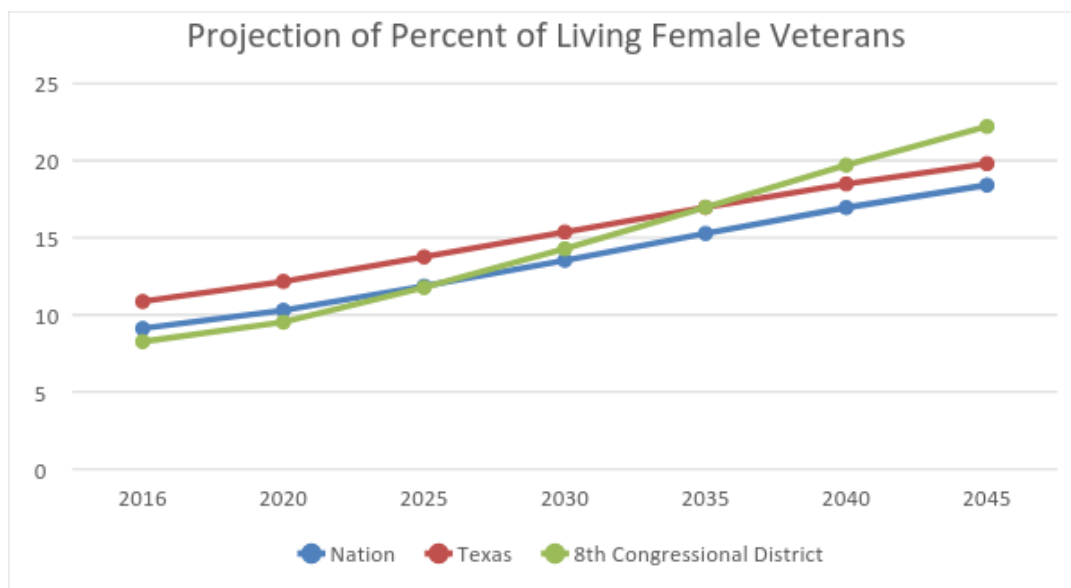
A.2: We were unable to acquire financial information on the Conroe CBOC, and were unable to determine how these wait times relate to health expenditures, including services offered, planning, and resource management at the Conroe CBOC.

### Female Veteran Healthcare

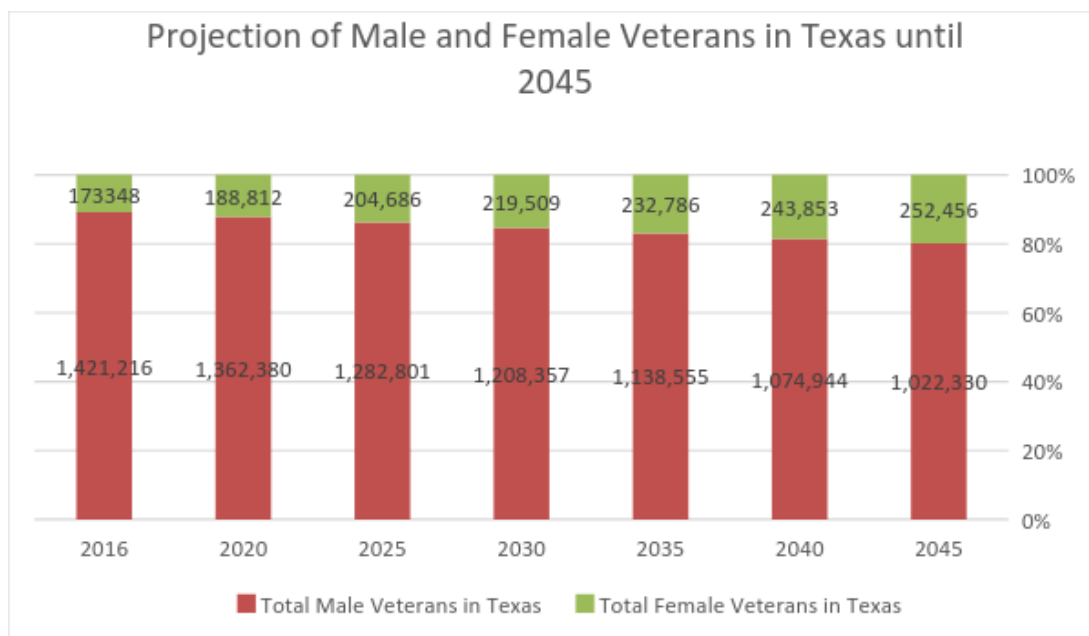
Q.7: What services are offered to female veterans at the Conroe CBOC? What percentage of veterans in the district are female, compared to Texas and nation? What is the population of female veterans compared to male veterans in the 8th Congressional District, Texas and nationally?

A.1: According to Leon at the Conroe CBOC, there are no services specific to female veterans offered at the Conroe CBOC. All services offered are the same for male and female veterans. A female veteran can request an annual exam from a primary care physician.

A.2: Currently, 9.4% of veterans living in the United States are female; Texas has a slightly larger percentage of female veterans compared to the country with 11.2%, of veterans in Texas being female. The percentage growth of female veterans in Texas and the nation is consistent, with 18.41% of female veterans in the nation in 2045, and 19.8% in Texas. The percent of female veterans in the 8th Congressional District will surpass the state and the nation, projecting the 8th Congressional District in Texas will double the number of female veterans in the district by 2035 (8.55% female veterans in 2017; 16.97% female veterans in 2035). The percent of female veterans living in the 8th Congressional District will surpass the state and nation percentages of female veterans by 2045, where 22.21% of veterans in the 8th Congressional District will be female, 19.80% of veterans in Texas will be female, and 18.41%, of veterans in the nation will be female.



A.3: In 2016, 90.88% of veterans living in the nation were male and 9.12% were female. Male veterans in Texas accounted for 89.13% of veterans in the state in 2016, and male veterans accounted for 91.72% of veterans in the 8th Congressional District in 2016. However, the growth of female veterans is disproportionate to the growth of male veterans over the next 28 years. By 2025, it is projected that only 88.2% of veterans living in the 8th Congressional District will be male, while 11.78% will be female. By 2045, this will have shifted even more, with 77.79% of veterans in the 8th Congressional District being male, and 22.14% will be female. This trend in growth of female veterans is matched across the state and the nation.



Sub Question 7.1: How many female veterans are utilizing the Conroe CBOC?

A.1: We requested this information, and were told in an elite interview that 10% of patients at the Conroe CBOC were female, however we were unable to verify the statement, thus we are unable to determine.

Sub Question 7.2: How much is spent/budgeted on top line item services at the Conroe CBOC; what is the percent of female veterans utilizing these services compared to male veterans?

A.1: We were unable to acquire financial information from the Conroe CBOC, thus we are unable to answer this question.

Sub Question 7.3: How many female veterans from the 8th Congressional District of Texas are utilizing the DeBakey WHC in Houston?

A.1: We requested this information from DeBakey VA staff but never received a response or any information, thus we are unable to answer this question.

Sub Question 7.4: What training is provided to staff and medical providers at the Conroe CBOC that is gender specific? What does this training entail? Is there continuing medical education required? How much of the Conroe CBOC has received this training?

A.1: Through an elite interview Dr. El-Serag told Hare that providers at Conroe CBOC are encouraged to attend mini-residency training hosted 1-2 times a year. Other training options Dr. El-Serag stated were available included courses designated by the Office of Women Veterans through the TMS educational system and hands-on training, where a provider is shadowed onsite at the CBOC by a women's health expert. DeBakey has a simulation lab that providers are able to utilize for individual practice on pelvic exams and breast exams.

A.2: According to information provided by Sanders, the the VHA Women's Health Services uses mini-residencies to provide gender-specific training (including physical examination and critical thinking) to VA clinical staff in order that they may provide high quality care to female veterans.

A.3: Mini-residency training is organized into 4 different trainings aimed at different clinical professionals. Information below is from an email provided by Sanders regarding content of mini-residency training:

1. Women's Health Mini-Residency for Primary Care Providers
  - a. Target Audience - VA physicians, nurse practitioners, and physician assistants who provide primary care to women Veterans.
2. Women's Health Mini-Residency for Primary Care Nurses
  - a. Target Audience - for VA nursing staff (RN and LPN/LVN) who provide primary care to women Veterans.
3. Women's Health Mini-Residency for Primary Care Providers and Nurses (Interprofessional)
  - a. Target Audience - VA providers (physicians, nurse practitioners, physician assistants) and VA nursing staff who provide primary care to women Veterans, training in teams to align with how care is provided in the clinic setting.
4. Women's Health Mini-Residency for Emergency Care Providers and Nurses (Interprofessional)
  - a. Target Audience – VA Emergency Care Providers (physicians, physician assistants and nurse practitioners) and Emergency Care Registered Nurses working in VA Emergency Departments (EDs) or stand-alone Urgent Care



Clinics (UCCs), training in teams to align with how care is provided in the acute care setting

The training covers core women's health topics in lecture format including cervical cancer screening, breast health, contraception, uterine bleeding, sexually transmitted infections, and gynecological emergencies. There are additional lectures on intimate partner violence (including MST) and post-deployment issues for women. There is hands on training (simulation or live participant, depending on program) for breast and pelvic exams. Small groups facilitated by subject experts discuss application of knowledge to cases. While this makes up the core of training, additional training on different subject matters is provided depending on the program type.

A.4: Mini-residency training is 18-19 hours of training, and is fully accredited by ACCME, ACCME-NP and ANCC. When the participant completes training they receive 18-19 CME/CEU credits. Once this training is completed, they have the opportunity to be designated as a Women's Health Primary Care Provider (WH-PCP). This distinction includes additional training beyond just the mini-residency. To maintain this distinction, they must complete 10 CME or CEU's every 2 years in women's health.

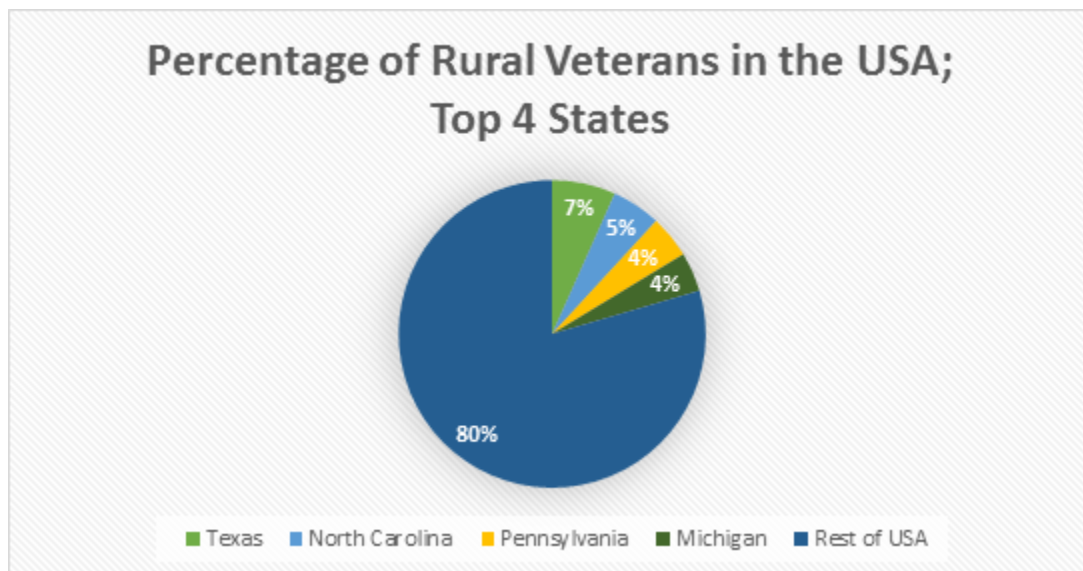
A.5: We were unable to verify the number of providers at the Conroe CBOC who have received gender-specific training. Dr. El-Serag stated that Conroe CBOC should have all of their providers meeting the proficiencies, and that they maintain a list of how each provider has met said proficiencies, however we were never provided this information, and thus cannot verify.

A.6: On November 21, 2017, Sanders provided Hare with the VHA Directive 1330.01(1), Health Care Services for Women Veterans, which was published February 15, 2017 and amended September 8, 2017. This directive breaks down the responsibilities of VHA staff in upholding equitable and comprehensive medical care of female veterans, and details the requirements for WH-PCPs (Women's Health Primary Care Physician) and WH-PACTs (Women's Health Patient Aligned Care Team) as well as the steps to ensure female veterans receive equitable and comprehensive medical care.

### Rural Veterans, Population:

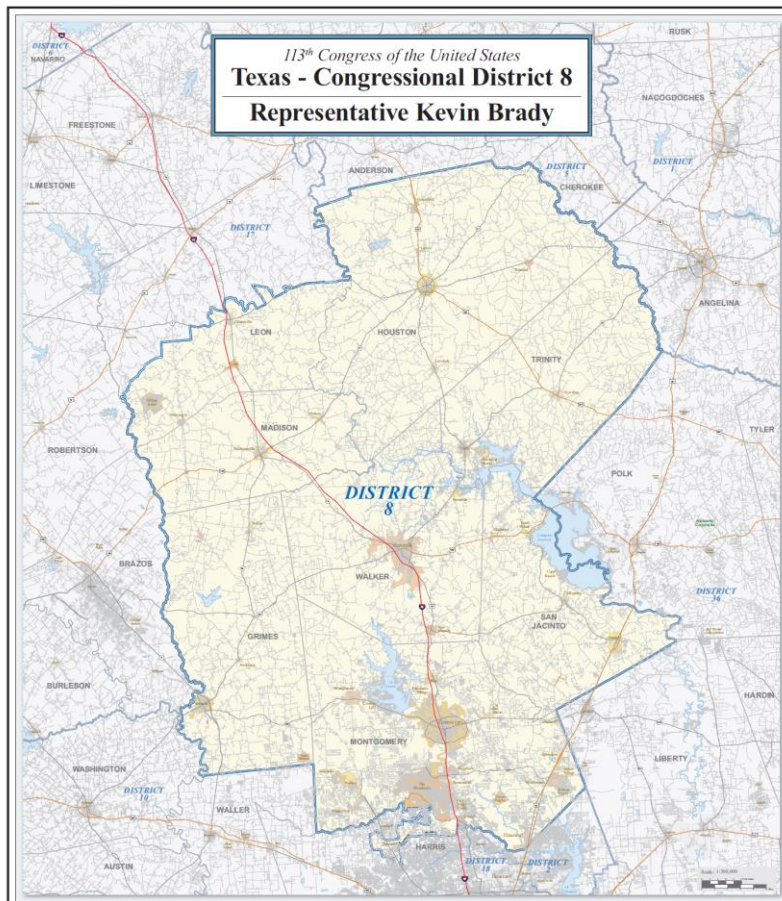
Sub Question 8.1: How many veterans are considered rural dwelling in the 8th Congressional District compared to the state and the nation?

A.1: In 2014, 24% of veterans in the United States were classified as rural dwelling and 7% of rural-dwelling veterans in the nation live in Texas. Of veterans living in Texas in 2014, 21% were considered rural dwelling. Determining rural-dwelling veterans within the 8th Congressional District was less straightforward. Excluding counties not fully located within the district (Leon and Harris) as well as counties we could not delineate rural versus urban dwelling veterans (Montgomery)<sup>7</sup>, we calculated all of 14,200 veterans living within counties fully located within the district (Walker, Grimes, San Jacinto, Houston, Trinity, and Madison) are rural dwelling. Therefore, the percent of rural dwelling veterans within the 8th Congressional District (100%) exceeds both Texas (21%) and the nation (24%).



<sup>7</sup> Based on data from 2014 of populations living, there are nine counties in the 8th Congressional District. Two of these counties (Leon Co. and Harris Co.) are partial counties, meaning neither is located completely within the 8th Congressional District, and for this reason we did not include them in our count. Based on the census data we collected, we were unable to delineate rural and urban dwelling veterans living in Montgomery Co. and for this reason, did not include Montgomery in our count. Because we did not include these three counties into our examination, we are unable to determine the exact number of rural veterans living within the 8th Congressional District.

## Map of the 113th Congressional District 8 of Texas



### III. MENTAL HEALTH, MILITARY SEXUAL TRAUMA (MST), HOMELESSNESS, AND SUICIDE

#### Mental Health.

Q.8: What is the rural versus urban access to mental health care in the 8th Congressional District, versus Texas and the Nation and/or are there differences between rural and urban access to mental health care?

Sub Question 8.2: How many rural dwellers go to Conroe CBOC for mental health appointments?

A.1: Information for specific demographics of veterans attending the Conroe CBOC was not obtained.

Sub Question 8.3: What are the wait times for mental health appointments for urban dwellers versus rural dwellers?

A.3: Information for rural veterans wait times for mental health appointments was not obtained.

Sub Question 8.4: How many female veterans utilize their Mental Health Benefits?

A4: Information for gender specific veterans utilization of their mental health benefits was not obtained.

### Military Sexual Trauma (MST).

Q. 9: What are the rates of Military Sexual Trauma per gender compared to homelessness? How many veterans report Military Sexual Trauma (MST)? How many veterans reporting MST are homeless?

Sub Question 9.1: How many veterans report MST?

A.1: Utilizing scholarly literature, “VA’s national screening program, in which every Veteran seen for health care is asked whether he or she experienced MST, provides data on how common MST is among Veterans seen in VA. National data from this program reveal that about 1 in 4 women and 1 in 10 men respond ‘yes,’ that they experienced MST, when screened by their VA provider”

([https://www.mentalhealth.va.gov/docs/mst\\_general\\_factsheet.pdf](https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf)). Datasets to identify how many veterans report MST were not available.

Sub Question 9.2: How many veterans reporting MST are homeless?

A.1. Through review of literature, a study of veterans who attended the VHA to “identify and substantiate MST as a risk factor for homelessness” (Brignone et al 2016, 583). At each visit a “clinical reminder appears on the electronic medical record if the veteran has not been screened for MST. Veterans were identified as having evidence of post deployment homelessness” (584). Datasets to identify homeless veterans reporting MST were not available.

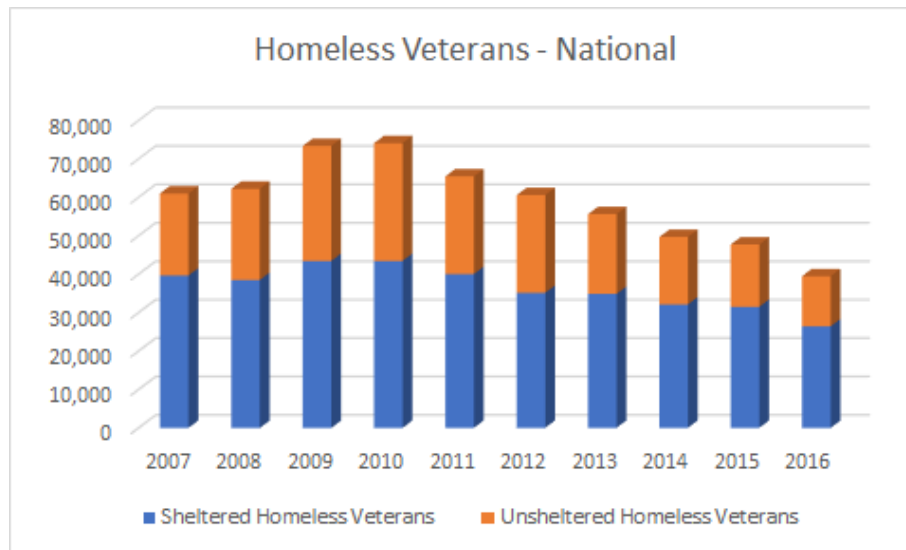
## Homelessness and Suicide.

Q. 10: What information exists on homelessness and suicide among veterans in the 8th Congressional District? How many veterans who have committed suicide, attempted suicide or report suicide ideation are homeless? What is the population of homeless female veterans compared to homeless male veterans in the 8th Congressional District, Texas and nationally.

The following sub questions emerged from the original question:

- a. Sub Question 10.1: How many veterans are at risk of homelessness<sup>8</sup>?
- b. Sub Question 10.2: What are P.I.T. Counts for the subpopulation, veterans?

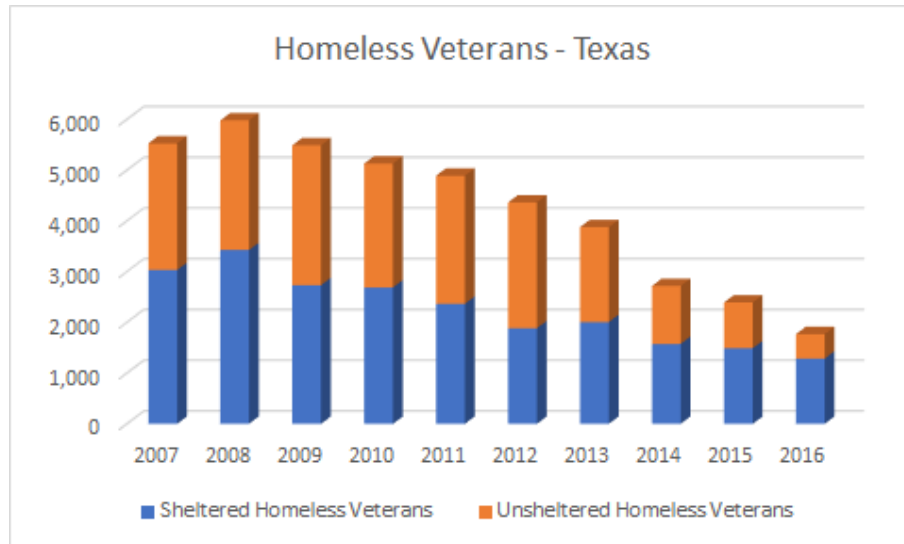
A. 1 and 2: In June 2010, Congress was presented a federal strategic plan to end homelessness particularly veteran homelessness by 2015. This mandate came from President Obama after the 2007 – 2009 recession when over 74,087 veterans were reported as homeless or at risk of homelessness. By 2016, homelessness among veterans nationally declined by 47%.



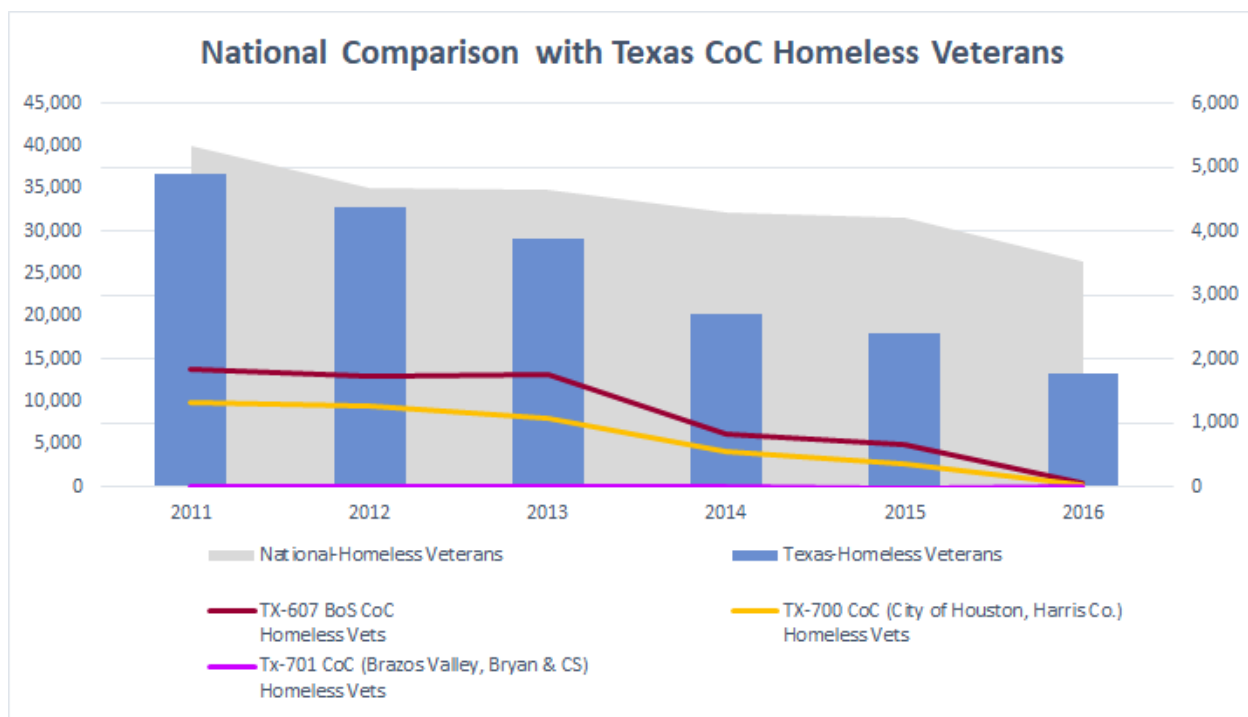
<sup>8</sup> “At risk of homelessness is defined by Department of Housing and Urban Development’s (HUD) Point-In-Time (PIT) count as an individual or family who: (i) has an annual income below 30% of median family income for the area; AND (ii) Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the “homeless” definition; AND (iii) Meets one of the following conditions...

([https://www.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition\\_Criteria.pdf](https://www.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition_Criteria.pdf)).” See complete chart on Appendix 6.

Texas veterans were affected by the recession in 2008, at which point there were 5,982 veterans who were homeless. By 2016, homelessness among Texas veterans declined by 70%. Veterans who are in an emergency shelter and transitional housing will have access to permanent housing solutions through the Rapid Re-Housing (RRH) or Housing First programs.



“In 2005, the Texas Interagency Council for the Homeless appointed Texas Homeless Network (THN) as the host agency for the Texas Balance of State Continuum of Care (TX BoS CoC). The TX BoS CoC includes 215 counties that cover the areas made up of mid-sized and smaller cities and rural communities. These areas do not have the resources or capacity that larger cities have to measure homelessness. THN works with the Local Homeless Coalitions (LHCs) in these areas to assist them with coordinating funding and programs that address homelessness (<http://thn.org/about/>).” The 8th Congressional District of Texas includes Walker, Montgomery, San Jacinto, Trinity, Houston, Grimes, and Madison counties which are all within the TX BoS CoC statistics. According to [www.hudexchange.info/resources](http://www.hudexchange.info/resources) Montgomery County (includes Conroe) were listed in TX-607 in 2015 but beginning in 2016, will be included in TX-700's data.



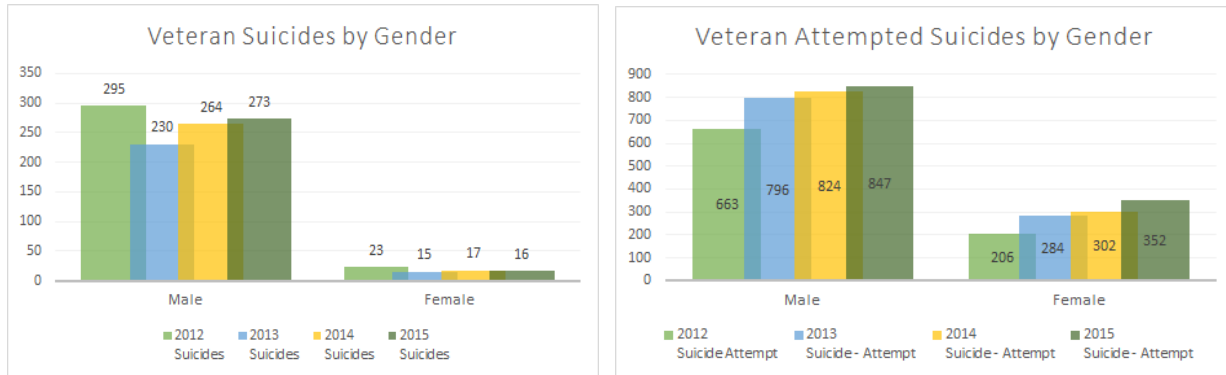
Specific data on homeless veterans living in the 8th Congressional District of Texas was not accessible but with the decline in homeless veterans nationally, within the state of Texas and the TX BoS CoC (which services small and rural communities across Texas) my assessment is that the veterans who live in the counties Walker, Montgomery, Houston, San Jacinto, Grimes, and Madison (northern parts of Harris County and southern part of Leon County) have also declined.

Sub Question 10.3: What are the gender comparisons for veterans who have been screened for suicide?

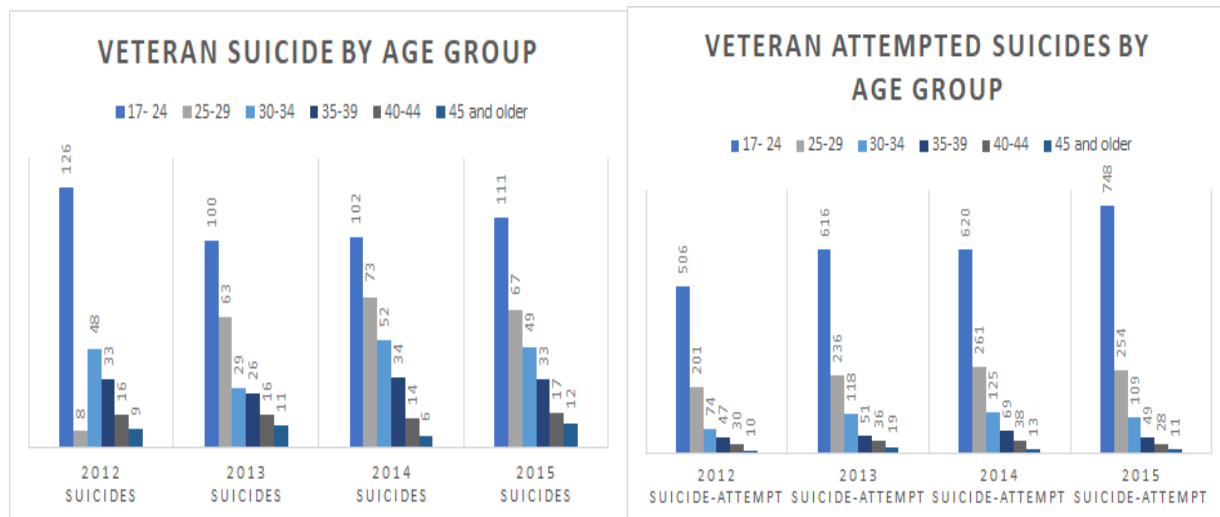
A3: In 2012, the Suicide Prevention Applications Network (SPAN), a VHA internal suicide event case management and tracking system, was implemented. The most recent report from the Office of Suicide Prevention at the Department of Veteran Affairs states, “21.6 million Veterans across the country — including almost 2 million women — just over 8.5 million are enrolled for care from a VA provider” (2016). “In 2014, an average of 20 Veterans died by suicide each day. Six of the 20 were users of VHA services” (<https://www.va.gov/>).



According to the annual Department of Defense Suicide Event Reports (DoDSER) from 2012 -2015 the rate of suicide among veterans are calculated by 100,000 per unit measure.



The rate of suicide among male veterans increased by 19% and female veterans increased by 7% since 2013. The rate of attempted suicides among male veterans increased by 28% and female veterans increased by 71%. Nationally, attempted suicides by veterans has steadily escalated since 2012.

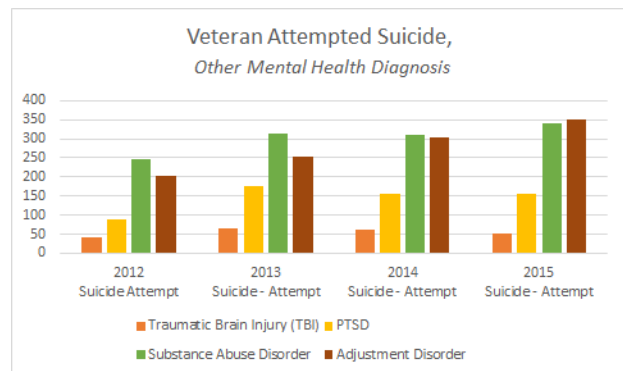
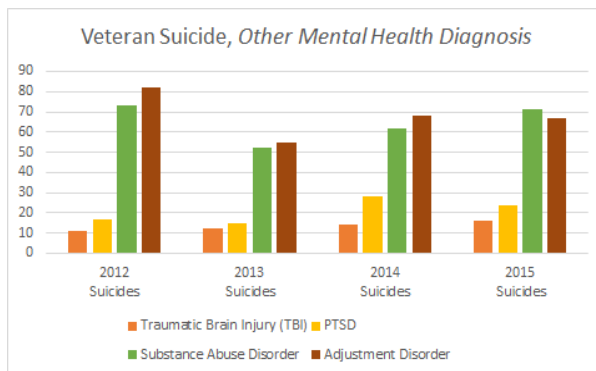


The greatest number of suicides and attempted suicides among veterans were within the 17-24 year old age group.

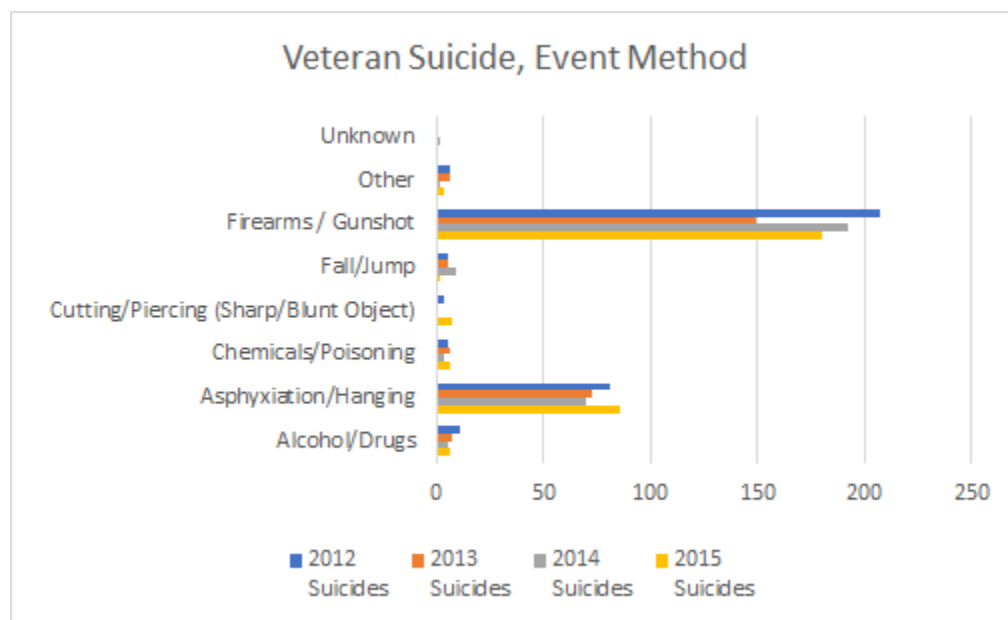
Veteran suicides among the the age group 25 - 29 year olds increased substantially (73.8%) and the age group 45 years and older witnessed the greatest decrease (-25%) in suicides from 2012 -2015.

Veteran attempted suicides among the age group 17 - 24 year olds increased (48%), while the 30 - 34 age group decreased significantly (-32%).

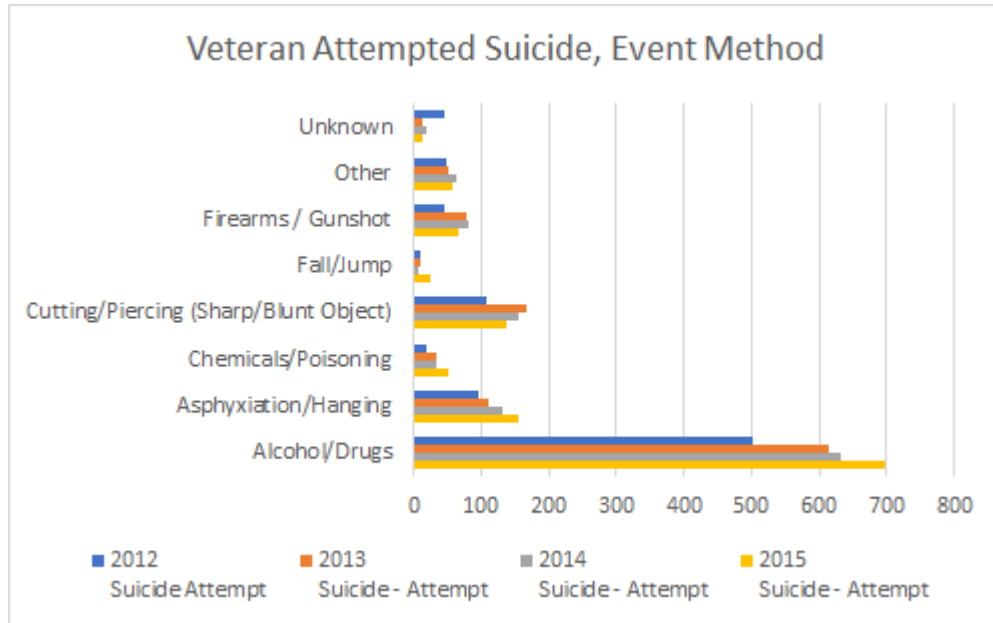




The most common risk factors for veteran suicide and attempted suicide is Substance Abuse Disorder and Adjustment Disorder.



Majority of veterans choose firearms and hanging as the preferred method of suicide.



Most veterans choose alcohol, drugs, hanging, and cutting with a sharp or blunt object as the preferred method of suicide attempts.

Sub Question 10.4: What are the social and economic characteristics for female veterans, gender comparisons, and female veterans compared to non-veterans?

A1: The total 2016 United States population consisted of 92.6% non-veterans and 7.4% veterans. Female veterans are 8.6% of the general population compared to male veterans who make up 91.4%.

## Veterans Social & Economic Characteristics In United States

Subject	United States											
	Total		Percent		Veterans		Percent		Nonveterans		Percent	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
POPULATION												
Civilian population 18 years and over	248,478,651	+/-32,612	(X)	(X)	18,496,937	+/-66,959	7.4%	+/-0.1	229,981,714	+/-63,644	92.6%	+/-0.1
GENDER												
Male	120,513,069	+/-26,568	48.5%	+/-0.1	16,898,924	+/-64,236	91.4%	+/-0.1	103,614,145	+/-63,923	45.1%	+/-0.1
Female	127,965,582	+/-21,818	51.5%	+/-0.1	1,598,013	+/-19,686	8.6%	+/-0.1	126,367,569	+/-27,228	54.9%	+/-0.1
MEDIAN INCOME IN THE PAST 12 MONTHS (IN 2016 INFLATION-ADJUSTED DOLLARS)												
Civilian population 18 years and over with income	29,591	+/-80	(X)	(X)	39,494	+/-183	(X)	(X)	28,347	+/-82	(X)	(X)
Male	(X)	(X)	(X)	(X)	40,076	+/-123	(X)	(X)	35,365	+/-71	(X)	(X)
Female	(X)	(X)	(X)	(X)	34,178	+/-592	(X)	(X)	23,445	+/-59	(X)	(X)
EDUCATIONAL ATTAINMENT												
Civilian population 25 years and over	217,863,148	+/-66,606	(X)	(X)	18,258,487	+/-65,037	(X)	(X)	199,604,661	+/-71,397	(X)	(X)
Less than high school graduate	27,410,053	+/-102,884	12.6%	+/-0.1	1,151,468	+/-14,210	6.3%	+/-0.1	26,258,585	+/-102,998	13.2%	+/-0.1
High school graduate (includes equivalency)	59,297,691	+/-130,963	27.2%	+/-0.1	5,124,904	+/-31,826	28.1%	+/-0.2	54,172,787	+/-129,884	27.1%	+/-0.1
Some college or associate's degree	63,068,687	+/-110,051	28.9%	+/-0.1	6,815,732	+/-33,249	37.3%	+/-0.1	56,252,955	+/-105,530	28.2%	+/-0.1
Bachelor's degree or higher	68,086,717	+/-188,626	31.3%	+/-0.1	5,166,383	+/-37,207	28.3%	+/-0.2	62,920,334	+/-176,696	31.5%	+/-0.1
POVERTY STATUS IN THE PAST 12 MONTHS												
Civilian population 18 years and over for whom poverty status is determined	242,019,008	+/-32,024	(X)	(X)	18,164,281	+/-67,118	(X)	(X)	223,854,727	+/-63,398	(X)	(X)
Income in the past 12 months below poverty level	30,137,574	+/-129,712	12.5%	+/-0.1	1,248,910	+/-19,271	6.9%	+/-0.1	28,888,664	+/-131,682	12.9%	+/-0.1
Income in the past 12 months at or above poverty level	211,881,434	+/-146,543	87.5%	+/-0.1	16,915,371	+/-67,603	93.1%	+/-0.1	194,966,063	+/-143,579	87.1%	+/-0.1

2016 American Community Survey S2101: VETERAN STATUS

[https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_16\\_1YR\\_S2101&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S2101&prodType=table)

The total 2016 Texas population consist 92.9% non-veterans and 7.1% veterans. Female veterans are 10.3% of the general population compared to male veterans who are 89.7%. The female veteran population in Texas is greater than the percentage living in the United States.

## Veterans Social & Economic Characteristics In Texas

Subject	Texas											
	Total		Percent		Veterans		Percent		Nonveterans		Percent	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
POPULATION												
Civilian population 18 years and over	20,481,578	+/-5,918	(X)	(X)	1,460,627	+/-20,030	7.1%	+/-0.1	19,020,951	+/-19,247	92.9%	+/-0.1
GENDER												
Male	10,031,970	+/-7,153	49.0%	+/-0.1	1,309,502	+/-18,556	89.7%	+/-0.4	8,722,468	+/-18,603	45.9%	+/-0.1
Female	10,449,608	+/-6,086	51.0%	+/-0.1	151,125	+/-6,828	10.3%	+/-0.4	10,298,483	+/-7,705	54.1%	+/-0.1
MEDIAN INCOME IN THE PAST 12 MONTHS (IN 2016 INFLATION-ADJUSTED DOLLARS)												
Civilian population 18 years and over with income	28,474	+/-237	(X)	(X)	41,547	+/-399	(X)	(X)	27,203	+/-128	(X)	(X)
Male	(X)	(X)	(X)	(X)	41,945	+/-365	(X)	(X)	33,077	+/-490	(X)	(X)
Female	(X)	(X)	(X)	(X)	36,430	+/-1,418	(X)	(X)	22,374	+/-138	(X)	(X)
EDUCATIONAL ATTAINMENT												
Civilian population 25 years and over	17,722,153	+/-11,133	(X)	(X)	1,438,817	+/-19,549	(X)	(X)	16,283,336	+/-19,564	(X)	(X)
Less than high school graduate	3,035,462	+/-35,792	17.1%	+/-0.2	82,623	+/-4,649	5.7%	+/-0.3	2,952,839	+/-35,858	18.1%	+/-0.2
High school graduate (includes equivalency)	4,468,541	+/-37,963	25.2%	+/-0.2	328,414	+/-10,230	22.8%	+/-0.6	4,140,127	+/-37,069	25.4%	+/-0.2
Some college or associate's degree	5,103,008	+/-35,037	28.8%	+/-0.2	587,448	+/-14,804	40.8%	+/-0.8	4,515,560	+/-34,117	27.7%	+/-0.2
Bachelor's degree or higher	5,115,142	+/-37,192	28.9%	+/-0.2	440,332	+/-10,235	30.6%	+/-0.6	4,674,810	+/-35,916	28.7%	+/-0.2
POVERTY STATUS IN THE PAST 12 MONTHS												
Civilian population 18 years and over for whom poverty status is determined	19,965,522	+/-5,614	(X)	(X)	1,427,525	+/-19,524	(X)	(X)	18,537,997	+/-19,156	(X)	(X)
Income in the past 12 months below poverty level	2,641,063	+/-39,931	13.2%	+/-0.2	93,300	+/-5,650	6.5%	+/-0.4	2,547,763	+/-39,606	13.7%	+/-0.2
Income in the past 12 months at or above poverty level	17,324,459	+/-40,823	86.8%	+/-0.2	1,334,225	+/-18,864	93.5%	+/-0.4	15,990,234	+/-42,203	86.3%	+/-0.2

2016 American Community Survey S 2101: VETERAN STATUS

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### Veterans Social & Economic Characteristics In TX CD 8

Subject	Congressional District 8 (115th Congress), Texas											
	Total		Percent		Veterans		Percent		Nonveterans		Percent	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
POPULATION												
Civilian population 18 years and over	612,186	+/-8,049	(X)	(X)	47,688	+/-4,950	7.8%	+/-0.8	564,498	+/-8,847	92.2%	+/-0.8
GENDER												
Male	309,539	+/-4,822	50.6%	+/-0.4	44,685	+/-4,515	93.7%	+/-2.3	264,854	+/-6,146	46.9%	+/-0.6
Female	302,647	+/-4,561	49.4%	+/-0.4	3,003	+/-1,204	6.3%	+/-2.3	299,644	+/-4,664	53.1%	+/-0.6
MEDIAN INCOME IN THE PAST 12 MONTHS (IN 2016 INFLATION-ADJUSTED DOLLARS)												
Civilian population 18 years and over with income	31,188	+/-965	(X)	(X)	40,092	+/-5,179	(X)	(X)	30,648	+/-1,027	(X)	(X)
Male	(X)	(X)	(X)	(X)	40,567	+/-4,306	(X)	(X)	41,344	+/-1,386	(X)	(X)
Female	(X)	(X)	(X)	(X)	34,776	+/-21,827	(X)	(X)	22,827	+/-1,442	(X)	(X)
EDUCATIONAL ATTAINMENT												
Civilian population 25 years and over	534,499	+/-6,966	(X)	(X)	47,196	+/-4,912	(X)	(X)	487,303	+/-7,612	(X)	(X)
Less than high school graduate	69,101	+/-5,702	12.9%	+/-1.0	2,864	+/-840	6.1%	+/-1.7	66,237	+/-5,457	13.6%	+/-1.1
High school graduate (includes equivalency)	148,220	+/-7,533	27.7%	+/-1.4	13,171	+/-2,125	27.9%	+/-3.5	135,049	+/-6,910	27.7%	+/-1.4
Some college or associate's degree	155,971	+/-7,871	29.2%	+/-1.4	18,131	+/-3,139	38.4%	+/-4.7	137,840	+/-7,846	28.3%	+/-1.5
Bachelor's degree or higher	161,207	+/-7,784	30.2%	+/-1.4	13,030	+/-2,302	27.6%	+/-4.4	148,177	+/-7,796	30.4%	+/-1.5
POVERTY STATUS IN THE PAST 12 MONTHS												
Civilian population 18 years and over for whom poverty status is determined	583,871	+/-8,487	(X)	(X)	45,002	+/-4,824	(X)	(X)	538,869	+/-9,664	(X)	(X)
Income in the past 12 months below poverty level	64,972	+/-6,983	11.1%	+/-1.2	2,761	+/-1,156	6.1%	+/-2.4	62,211	+/-6,905	11.5%	+/-1.3
Income in the past 12 months at or above poverty level	518,899	+/-10,434	88.9%	+/-1.2	42,241	+/-4,656	93.9%	+/-2.4	476,658	+/-11,159	88.5%	+/-1.3

2016 American Community Survey S2101: VETERAN STATUS

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### QUESTIONS WE WERE UNABLE TO ANSWER

In addition to the original research question 1 (refined research question 11) regarding the financial implications of the VHA, we were unable to answer the following refined research questions and sub questions:

Question 2: While we were able to find the process to become a VCA-approved community provider and the reimbursement rate for providers seeing veterans through the VCA we were not able to determine the total number of VCA-approved community providers for the 8th Congressional District, the state of Texas, or the nation.

Question 3: We were not able to obtain data on who, from the 8th Congressional District of Texas, the state of Texas, or the nation, has utilized the VCA.

Question 4: We were not able to determine the number of veterans obtaining care through the VCA nor the number of veterans who have previously obtained care through the PC3 program; thus we are unable to provide a comparison of the effectiveness and utilization of the two community care programs.

Question 6: While our team was able to acquire information on wait times at the Conroe CBOC, we were not able access any financial information or budgets for the Conroe CBOC and could not address the second part of this question, “How do they [wait times] related to health expenditures (services offered, planning and resource management)?”

Sub Question 7.1: We were provided this information in an elite interview, however, we were unable to access any information that confirmed or supported the stated percentage of female veterans who utilize the Conroe CBOC.

Sub Question 7.2: We were unable to get any financial information from the Conroe CBOC and thus were unable determine how much is spent or budgeted on top line item services. We were not provided any demographic information regarding usage of services at the Conroe CBOC.

Sub Question 7.3: While it was requested, we were never provided with information on the number of female veterans from the 8th Congressional District who are using the WHC at DeBakey in Houston.

Sub Question 7.4: Regarding the question “How much of the Conroe CBOC has received this training?,” we were informed that a list of providers who have completed gender-specific training does exist, however, we were not provided any way to confirm this.

Question 8: Information for rural and urban dwelling veterans access to mental health care in the 8th Congressional District, Texas, and Nation were not available.

Sub Question 8.2: Information for specific demographics of veterans attending the Conroe CBOC were not available.

Sub Question 8.3: Information for rural veterans wait times for mental health appointments attending the Conroe CBOC was not available.

Sub Question 8.4: Information for gender-specific veteran utilization of mental health benefits was not available.

Sub Question 9.1: General statistical information was obtained but data sets were not available for the number of female and male veterans who screened for MST.

Sub Question 9.2: Actual data sets for comparisons between how many veterans screened for MST and were homeless was not available. Information was obtained from review of scholarly literature.

Question 11: Because we were not able to find specific financial information related to the Conroe CBOC and were not able to fully address this question.

We have submitted FOIA requests for additional information pertaining to the questions we were unable to answer. These requests can be viewed in Appendix 5 and 5.1.

## CHAPTER 4: DISCUSSION AND IMPLICATIONS

Our discussion and implication of themes (dual usage, Veterans Choice Program, wait times, female veteran healthcare, rural populations, homelessness and suicide) was led by our collection of data through elite interview, action research, content analysis of peer-reviewed literature and review of applicable, publicly available data. The research and data collection phase of our capstone project allowed our team to examine the information available and assess the themes as they relate to the refined research questions, as well as determine issues that cut across multiple themes.

Access to care is a recurring topic across themes. We identified struggles with VCA accessibility, female care proportionality, services specific to rural veterans, and prevention of homelessness and suicide. For each of these unique groups, accessing care from the VA is challenging. While the VCA emphasizes veteran community care, it is questionable how accessible such care truly is without hard data to analyze. Also, without a tracking mechanism for dual users or a system in place to facilitate VA and non-VA communication there are many negative side effects of expanded access to community care.

Female veterans are growing at a disproportionate rate to male veterans across the nation, especially in the 8th Congressional District of Texas, yet it appears that services for females are not growing at the same rate in the Conroe CBOC. Female veterans frequently experience a lack of support and services offered specific to their needs when utilizing the VA. Similarly, rural veterans experience higher risks from lack of access to VA care. From 2010 - present, the VA, along with other governmental and local community entities, put in place initiatives to prevent and help end homelessness, suicide, and mental health issues. There is current data (dated 2014) with national and state comparisons among veterans who are experiencing homelessness, suicide ideation, and mental health issues but limited information concerning veterans within the 8th Congressional District of Texas.

Additionally, team members faced challenges with access and availability of data across all themes. This was intensified by the near complete lack of information specific to the 8th



Congressional District of Texas. While national data is collected on VCA providers and users it was inaccessible by our team even after multiple attempts through many channels. Wait time information is available on the VA access to care website, or through the VA open data site, however, this information is not reliable. Also, while they have created a site that is intuitive for veteran users, our search to access this information on the VA open data site did not follow an intuitive path. Access to data for homelessness, suicide, mental health, and rural veterans was limited. Information regarding rural veteran populations was limited because the information is only accessible and tracked if the veteran signs up for VA services. Because of this, we were unable to look at the full population of rural-dwelling veterans and could not determine the number of rural veterans living in the 8th Congressional District of Texas.

While our team was able to find population projections for female veterans in the nation, state, and district, we were unable to determine if the Conroe CBOC is servicing female veterans at a proportionate rate to male veterans. We requested past financial information for services performed at the Conroe CBOC and were informed by the Chief Financial Officer that they did not have this information. We were able to gather information regarding training for gender-specific care, but were unable to confirm if providers at the Conroe CBOC were meeting the gender-specific training requirements.

Our discussion of themes examines the data and research available, and takes note of the story that the missing information tells. Veterans face many challenges in accessing VA care. Similarly, in researching each theme, our team was faced with challenges to access information regarding the topics we were tasked with examining. While this is only a single example, it mimics the challenges faced by veterans daily to access equitable health care. Further extensive analysis of each theme is detailed below.

### DUAL USE AND COMMUNICATION

Much overlap was discovered within the topics of dual use of healthcare systems and lack of communication between health systems for those veterans who are dual users. Therefore, findings regarding VCA refined research question one, “Is there a tracking mechanism to track dual usage of healthcare systems among veterans in the 8th Congressional District? If not, can we look at studies done in other areas to extrapolate data?” and five, “How are the VA and non-VA providers currently communicating regarding the VCA-approved community visits? How can communication be improved between the VA and non-VA providers?” will both be included in this section.

Overall, access to community care for veterans can potentially allow them to be seen faster for emergent conditions. However, scholarly, peer-reviewed literature uncovered many negative effects stemming from dual use of healthcare systems including care fragmentation and lack in the continuity of care, conflicting diagnosis, and duplication of services, and higher rates of exposure to PUMs (potentially unsafe medications) (Gellad, 2016; Lacoursiere, 2016; Suda, 2017; Thorpe, 2017; West and Charlton, 2016.) For example, “75,000 veterans with dementia showed higher rates of PUM prescribing for those receiving prescriptions from both VA and Medicare providers; the prevalence of exposure to PUMs was high overall (44%), but was particularly high in dual users (59%) than VA-only users (39%)” (Thorpe 2017, 160). In another relevant example of the dangers of dual use, Suda found that “although the odds of opioid overlap decreased for VA pharmacies from 2007 to 2009, the odds of Medicare Part D reimbursed pharmacies and cross-system overlap increased” (2017).

Through review of scholarly, peer-reviewed literature many negative effects stemming from lack of communication between different health systems were discovered. These negative effects include documents scanned into the VA EMR (electronic medical record) from community providers not being queried in the same way as VA medical records (Gellad 2016, 154); much of the burden of communicating complex medical history being placed on veterans and their family

members (this issue is exacerbated when veterans are mentally-ill or cognitively impaired [i.e. suffering from dementia]) (Thorpe 2017, 161;) and, outside providers not being able to follow the VA's formulary guidelines for prescriptions because 1) they don't know them and 2) cannot use the same ordering system (Gellad 2016, 153; Thorpe 2017, 161). In their study of the lack in communication specific to homeless veterans between the VA and homeless service providers, Lacoursiere noted, "several participants were concerned that communication problems jeopardized patient safety by increasing the likelihood of dangerous medication duplication and drug-drug interactions when homeless veterans receive prescriptions from both the VA and a non-VA organization. Medication reconciliation was recognized as an important activity between HCH program sites and the VA, but was usually not possible" for lack of access to the VA EMR (2016, 5). West and Charlton found increased danger for rural dual use veterans and stated that "ensuring that rural dual users are identified in primary care should enable better access and care coordination" (2016, 396).

Although there are some systems in place to facilitate tracking of dual usage among veterans, the limited research we were able to find about them were generally consistent with the scholarly literature. First, the Joint Legacy Viewer (JLV) is limited to communication between the Department of Defense and the Department of Veteran Affairs. This system is designed to help transfer active military records into the VA system, but has nothing further to do with facilitating community care communication between providers. The DeBakey Medical Center does not currently utilize the JLV at all (Dyman, phone call with team, October 3, 2017.)

Second, the Virtual Lifetime Electronic Record (VLER) is a tool which "gives VA and participating community care providers secure access to certain parts of your electronic health record" (Virtual Lifetime Electronic Record, 2013). This system may help VA providers communicate with non-VA community providers and assist dual-using veterans with negating some of the negative effects usually associated with simultaneous use of two health systems. However, no non-VA health system in or near the 8th Congressional District of Texas utilizes the VLER.

Third, the VA has the “Blue-Button” tool. With this tool, veterans are able to print VA medical records off for hand-delivery to non-VA providers from their individual web health profiles on MyHealtheVet.com, however this tool does not facilitate communication from the non-VA provider back to the VA. Our team confirmed during a visit to the Conroe CBOC on December 4, 2017 that they are not utilizing the “Blue-Button” tool.

The JLV, VLER, and Blue-Button tool appear to be small steps toward ameliorating the problem of untracked dual use and ineffective communication between health systems—but none of these solutions are currently widespread or making much of a dent in the issues associated with dual use. Thus far, through each of these tools, attempts at facilitating communication between VA and non-VA providers has been fragmented and ineffectual; especially in the 8th Congressional District of Texas. DeBakey VAMC does not utilize the JLV, no non-VA health system nearby subscribes to the VLER, and trainings for and usage of the Blue-Button tool is non-existent.

The inability to track veteran dual use of healthcare systems both within the 8th Congressional District of Texas and other areas throughout the country is significant to our project as untracked dual use has resulted in veterans not receiving the best possible care and being subject to the negative effects inherent in untracked dual use. With current VA policies like the Veterans Choice Act increasing veterans’ ability to obtain community care, more veterans than ever are being subjected to the aforementioned downfalls of dual use and communication errors inherent in dual use when there is not a tracking system in place. Implications of this moving forward are that the VHA should consider taking steps to better understand where and how veterans receive care in addition to that provided by the VA.

We did identify one best practice. One study tracking dual use in veterans less than 65 years of age in New Hampshire (NH) appears to have been successful. However, this tracking was only possible because of New Hampshire’s mandatory insurance claims database system which collects common identifiers for patients such as social security number and date of birth. This enabled researchers to cross-reference known NH resident veterans to the claims database (although this was only after following a painstaking process.) A state-level, mandatory

insurance claims database, as is set-up in New Hampshire, may be helpful in the endeavor to track commercial insurance usage and VA claims and care (West and Charlton, 2016.)

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#### VETERANS CHOICE ACT- APPROVED COMMUNITY PROVIDERS

VCA refined research question two addresses “How many VCA-approved community providers already exist within the 8th Congressional District compared to Texas and the nation? What is the current process to become a VCA-approved community provider? Is there a financial incentive for a community provider to become VCA-approved?”

As noted in the results and limitations sections of this report we were not able to ascertain the total number of VCA-approved community providers within the 8th Congressional District but were able to identify the current process to become a VCA-approved community provider and the reimbursement rate for providers agreeing to see veterans through the VCA.

The process to become a VCA-approved community provider appears straightforward. However, there does not appear to be much incentive for community providers to see VCA patients as they must accept the standard Medicare reimbursement rate for their area, type of care, and level of malpractice insurance. While the process to become approved might be uncomplicated, the extra barrier of going through the approval process with minimal returns may be significant enough to deter providers from taking the steps to become VCA-approved.

Available data was severely lacking on the number of VCA-approved community providers within any given area. This lack of information makes it ultimately unverifiable that data is being collected by the VA to ensure VCA-approved providers are located where needed. Also, because of this lack of data we do not know how many providers are actually available for veterans to see in order to utilize the VCA. We are also not able to report if the 8th Congressional District is high, low, or average in regard to their saturation of VCA-approved community providers in comparison to Texas and the nation as we had hoped. Because we are not able to tell if VCA-approved community providers exist at the level needed in the 8th Congressional District or how

the area compares to Texas or the nation it is difficult to assess whether the VCA has been successful at improving veterans access to care. Implications for this are that Congressman Brady and other decision makers will be asked to vote to extend the VCA policy at some point with very little information regarding how the funds allocated to that program are being spent or how available providers actually are for veterans. Without further information, a vote for the VCA will be based solely on principles, not on sound policy.

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#### VETERANS CHOICE ACT UTILIZATION

VCA refined research question three and four are “who has utilized the VCA in the 8th Congressional District, and how does it compare to Texas and the nation?” and “has the number of veterans using VA-approved community care increased since the passing of the VCA in the 8th Congressional District, and how do these numbers compare to the state and the nation? What is the comparison to number of veterans who had access to VA-approved community care through Patient-Centered Community Care (PC3,) the predecessor program to the VCA, and those who now have access using VCA?”

Both of these questions necessitated finding specific quantitative data on the number of veterans who have utilized either the VCA or PC3 program. Data on the number of unique VCA and PC3 users does exist on a national level through the VHA Support Service Center (VSSC) but this database is not publicly available (Dyman, phone call with team, October 3, 2017.)<sup>9</sup>

The lack of available data regarding VCP usage calls into question whether data is being collected, aggregated, and analyzed at all. Policy-wise this lack of data prevents our team from determining if the VCP is a widely utilized program that should be sustained through further allocation of funds, or if it is an underutilized program that should be discontinued. Further, this lack in data prevents holistic program evaluation and so, asks decision makers including Congressman Brady to blindly vote to extend or discontinue the VCA with little knowledge as to

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<sup>9</sup> Note: A FOIA request was sent to the FOIA contact at the VA, listed as Stephanie Graham. See Appendix 5 and 5.1.

how well the program is actually running and improving healthcare choice for veterans within the community.

## II. WAIT TIMES, FEMALE VETERAN HEALTHCARE, AND RURAL VETERAN POPULATION

### WAIT TIMES

Our results in testing wait times<sup>10</sup> of the Conroe CBOC to those of Texas and the nation were consistent with the scholarly literature: there was no significant difference. We conclude, therefore, that the Conroe CBOC is doing as well as other clinics in regards to managing wait times. However, we believe wait times for mental health appointments should be statistically less. This statement is supported by our findings from our literature review, which expressed rural veterans experience challenges in accessing care, especially services related to mental health, which puts them at higher risk. The rural nature of the 8th Congressional District, coupled with the increased importance of rural veterans access to mental health appointments causes us to conclude that the Conroe CBOC should be working towards reducing wait times to 0 days. During a visit to the Conroe CBOC on December 4, 2017, team members were informed by Leon that the Conroe CBOC would be hiring 7 additional mental health providers, which is a positive step towards decreasing wait times for mental health appointments.

Through action research, our team came across a best practice for veterans determining wait times and proximity to care through the VA access to care website (<https://www.accesstocare.va.gov/>). This website allows veterans to search by service and location, wait times, and how other veterans have rated VA hospitals and clinics. The website was designed to be easily utilized by veterans looking for specific services with the lowest wait times. This interactive tool is user friendly and intuitive. Clifford stated that the next “tool” they were hoping to provide on this website was VA providers by location.

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<sup>10</sup> All wait time data should be interpreted cautiously, as there is concern that wait times recorded are not accurate (Robbins 2012).

***“Each VA medical facility must ensure that eligible women Veterans have access to high-quality, equitable, comprehensive medical care which includes but is not limited to primary care, mental health, specialty care, spiritual and pastoral care, residential care, and urgent/emergent care in an environment that provides privacy, dignity and security. It is everyone’s responsibility in a VA medical facility to care for all Veterans including women Veterans” (VHA Directive 1330.01(1) 2017, 5).***

In the past decade, the number of female veterans in the VA system has doubled (Brooks, Dailey et al. 2016, 1). Female veterans are outgrowing male veterans in the 8th Congressional District. The percent of female veterans residing in the 8th Congressional District will double by 2035 and by 2045 they will surpass the state and the national averages. The growth of female veterans in the 8th Congressional District will be an important consideration for the Conroe CBOC, as the needs of female veterans differ from those of male veterans.

Female veteran healthcare needs differ from the needs of male veterans beyond basic medical services (i.e. obstetrics, gynecology, mammogram, etc.) and access to equitable care is a recurring concern for female veterans. There are more female mental health conditions than men, and it is notable that one in four women screened in a VA facility report military sexual trauma (MST) (Koblinsky, Schroeder, Leslie 2017, 122). Recovery from brain trauma and mental illness looks very different for female veterans than it does their male colleagues, and women more



often had worse outcomes than men (Rogers, Smith et al. 2014, 1406-7). The VA is perceived as being male oriented, and female veterans report that they do not feel deserving of treatment because they are frequently not viewed as a veteran (Brooks, Dailey et al. 2016; Koblinsky, Schroeder, Leslie 2017).

***“For practitioners to begin to understand how they can most effectively work with female veterans, it is essential to have some insight into not only who they are as individuals, but who they are as service members and veterans.” (Reppert, Buzzetta, and Rose 2014.80)***

Female veterans struggle to receive equitable treatment within the VA because their needs are overlooked by the system when deemed “not urgent” and there is limited opportunity for support among female veterans within the VA System (Koblinsky, Schroeder, Leslie 2017). The VHA is working to address these issues through directives aimed towards providing equitable healthcare to female veterans.

VHA Directive 1330.01(1), Health Care Services for Women Veterans, goes into great detail regarding the tools and steps involved to provide equitable healthcare to female veterans. They stress that healthcare for female veterans should be accessible, high-quality, equitable and comprehensive and done in a manner and environment that is sensitive to female veterans. This directive states that the VA is responsible to serve all veterans, including female veterans and that each facility much continually look at and work to rectify “deficiencies and environmental barriers to care for women Veterans” (VHA Directive 1330.01(1) 2017, 6).

Challenges and barriers faced by female veterans when accessing medical care are frequently resolved when VHA’s have a Women’s Health Clinic (WHC). These clinics provide preventative care as well as life spanning care, including primary care physicians specifically

trained, and only seeing female patients. This creates a safe and engaging environment designed specifically for women (Reddy, Rose et al. 2016, 649). Previous researchers have concluded WHC have a positive impact on meeting the needs of female veterans using the VA. “In the VHA and other American health care systems, previous research suggests WHCs are associated with higher patient satisfaction” (Reddy, Rose et al. 2016, 653).

*“VHA policy requires that the full scope of primary care is provided to all eligible Veterans. Therefore, regardless of the number of women Veterans utilizing a particular health care system, all sites that offer primary care services must offer comprehensive primary care to women Veterans. The Women’s Health Program works in close collaboration with primary care, mental health, and specialty and acute care to ensure equal access to high-quality health care services in all sectors for women Veterans, and that such care is provided in a sensitive environment. All necessary gender-specific primary care services must be available at every site of care in the health care system (Directive 1330.01(1) 2017, 12).”*

At present, the Conroe CBOC does not have a women’s health clinic, nor does it have services specific for female veterans needs. All services provided at the Conroe CBOC are accessible to both male and female veterans, and female veterans can receive an annual exam from a primary care physician at the Conroe CBOC if they so choose (Leon, email to Hare, September 12,

2017). According to VHA Directive 1330.01(1), care for female veterans should be performed in a space dedicated for female veterans. It is recommended by this directive that sites that are smaller and do not have the demand or space for a WHC, can select to have a “separate but shared” space, meaning the space can be used “part-time” for female healthcare services, including primary care visits (VHA Directive 1330.01(1) 2017, 15-16).

The closest location for female veterans in the 8th Congressional District to visit a WHC is at DeBakey in Houston. Dyman stated that DeBakey sees around 13,000 female veterans (timeframe was not specified) and they have “quite a few” female veterans that come from the 8th Congressional District to the DeBakey Women’s Health Clinic (we were not provided with any numerical data regarding the exact number of women seen overall or from the 8th Congressional District) (Phone call with Team, October 3, 2017). According to Leon, 10% of veterans seen at Conroe CBOC are female, however we could not verify this information. The percentage quoted by Leon exceeds the percentage of female veterans living in the 8th Congressional District (8.5%). We were unable to verify the numbers of female veterans utilizing the Conroe CBOC and were unable to determine how much is spent per service provided to female veterans. Without this information we cannot determine if the Conroe CBOC is proportionately serving the veteran constituents within the 8th Congressional District.

Worth mentioning is the data we have requested in order to analyze this issue, but never received. This included:

Q7, Sub Question 1: Number of female veterans are utilizing the Conroe CBOC- We were provided information in the form of an elite interview, but were unable to access any information that confirmed or supported the information given to us.

Q7, Sub Question 2: Amount spent/budgeted on top line item services at the Conroe CBOC; and percentage of female veterans utilizing these services compared to male veterans- We were unable to get any financial information from the Conroe CBOC and thus were unable to determine how much is spent or budgeted on top line item services. We were not provided any demographic information regarding usage of services at the Conroe CBOC.

Q7, Sub Question 3: Number of female veterans from the 8th Congressional District utilizing the DeBakey WHC in Houston- While we requested this information and provided the appropriate zip codes to DeBakey for comparison, we did not receive any information.

Q7, Sub Question 4: The number of providers at Conroe CBOC who have received gender-specific training- We were informed there is a list of providers who have completed the requirements for gender-specific training, however we were not provided any information to confirm this statement.

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#### POPULATION OF RURAL VETERANS:

Through our literature review we found that rural veterans have limited access to care and while rural veterans have greater health needs than those living in urban areas, they also have the largest gaps in care of veteran populations (Johnson, Ruth, et al. 2015; West, Weeks, Charlton 2017). Rural dwelling veterans have higher instances of suicide risks, substance abuse, domestic violence and depression (additional information on MST, suicide and homelessness is examined later in this paper) (Johnson, Ruth, et al. 2015, 245). With the large number of veterans living in the 8th Congressional District being rural, access to care for these veterans is a vital issue to consider. The VA is making attempts to reduce these gaps through the Office of Rural Health, whose sole purpose is to increase rural veterans access to care (Office of Rural Health 2017). They work to do so through two programs: Rural Promising Practices, and Collaborative Rural Access Solutions.

Rural Promising Practices are aimed specifically towards VA medical centers. These practices are working to improve access to care for rural veterans, and provide partnerships and mentorships to other VA medical centers. The goal of Rural Promising Practices is to implement best practices in reducing the gap in access to care for rural veterans (Rural Promising Practices 2017). VA medical centers can easily access information on how to be a part of Rural Promising Practices, either to be a mentor or mentee, through their website.

Collaborative Rural Access Solutions is aimed towards rural veterans themselves, instead of the medical centers. The 43 organizations and programs that are a part of Collaborative Rural Access Solutions create solutions to meet the specific needs of rural veterans, including (but not limited to) transportation services, telemedicine, and specific training of medical providers in areas where rural veterans are located (Collaborative Rural Access Solutions 2017). While you can find this information on the VA's website, you cannot access the different service's websites, nor is there a way to find out where these services are offered around the country from the Collaborative Rural Access Solutions page on the VA website. This lack of accessibility creates an issue for the rural dwelling veterans in the 8th Congressional District seeking assistance. Further discussion of the importance of rural veteran access to care is examined in wait times and the sections below.

### III. MENTAL HEALTH, MST, HOMELESSNESS, AND SUICIDE AMONG VETERANS

***“Mental illness and substance use disorders among newly returned military service members pose challenges to successful reintegration into civilian life and in extreme case, may lead to outcomes such as incarceration, homelessness, and suicide (Brignone et al. 2017).”***

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#### RURAL VETERANS

Rural veterans have limited access to mental health care, but they can access services for peer counseling, local community resources, and telemedicine therapy through the TexVet.org website which is a veteran online mental health resource directory maintained by the Department of State Health Services (DSHS) and Texas A&M University Health Science Center.

Another helpful collaboration between agencies is the DSHS and Texas Veterans Commission (TVC) partnership with the Veterans of Foreign Wars (VFW) that exists “with a goal to train at least one peer counselor to provide basic mental health support at every VFW post in Texas. DSHS and TVC have also partnered with the Texas Department of Criminal Justice (TDCJ) to provide counseling and peer support to incarcerated veterans and services to those in veteran treatment courts (<http://www.dshs.texas.gov/mhsa/Mental-Health-Program-for-Veterans.aspx>).” Peer counseling has a proven success rate among veterans and mental health providers.

Allocating funds for future needs of rural veterans can take the form of grants that help connect local community resources with VA services. One type of grant that has been effective to combine resources is the Rural Veterans Coordination Pilot (RVCP) grant provided by The VHA Office of Rural Health which “will fund \$10 million in grants to support Veterans and their families residing in rural and/or underserved areas of the country. This new grant program will provide \$2 million dollars over a two-year period to each grantee for outreach activities specifically geared towards rural Veterans and their families who are transitioning from military to civilian life. The five selectees in 2015 were Maine Department of Labor – State Entity; Westcare Washington, Inc. – (Washington State to include Oregon) - Non-Profit Organization; Volunteers of America North Louisiana – Non-Profit Organization (part of the VISN 16); New Mexico Department of Veterans’ Services – State Entity; and Nebraska Association of Local Health Directors – Non-Profit Organization.”

After the 2-year pilot program the RVCP resulted in establishing:

1. Local partnerships with medical and mental health professionals, conducted outreach events, established service sites, and referrals for veterans and family members.
2. The purpose of the RVCP is to establish access to care for rural veterans so they will have the following services without driving over 50 miles.
  - a. Tele-Intensive Care Units
  - b. Tele-Med Mental Health Hubs
  - c. Social workers added into Rural Patient Aligned Care Team (PACT)
  - d. Rural Transportation Service

- e. Rural Health Training and Education Initiative that provides rural health care delivery experience to health profession trainees (pre- and post-graduation)
- f. Remote, telephone-based delivery of cardiac rehabilitation  
(<https://www.ruralhealth.va.gov/rvcp.asp>).”

Bringing local community agencies together with VA services can only enhance the outreach to rural veterans in order to improve access to mental health care.

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#### MENTAL HEALTH AND MST AMONG VETERANS

In 2009, the Department of State Health Services (DSHS) and the Veterans Affairs (VA) set goals concerning mental health services for veterans and their families. In 2013, funds were assigned for extended programs such as “Peer Counseling, access to licensed Mental Health Professionals, Training for Peers and Veteran Jail Diversion Services” and working collaboratively with local services. “In 2015, the 84th Legislature added new initiatives for women and rural veterans.” The concept was to use community mental health centers to “recruit, train, and organize peer counseling services” and other related mental health services for veterans. The initiative was to reach rural veterans within their communities so they would have access to mental health services ([www.mentalhealth.va.gov/msthome.asp](http://www.mentalhealth.va.gov/msthome.asp)).

“National data revealed that about 1 in 4 women and 1 in 100 men respond “yes,” to the MST questionnaire, when screened by their VA provider. Although rates of MST are higher among women, because there are so many more men than women in the military, there are actually significant numbers of women and men seen in VA who have experienced MST ([www.mentalhealth.va.gov/msthome.asp](http://www.mentalhealth.va.gov/msthome.asp)).”

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#### VETERANS AT RISK OF HOMELESSNESS

The US Department of Housing and Urban Development (HUD) requires that Continuums of Care (Local Homeless Coalitions) conduct an annual count of homeless persons who are in emergency shelters, transitional housing, and unsheltered on a single night in January which is

called the “Point-in-time” (PIT) count. Data provided from this one-night count of homeless individuals gives an insight into a community’s homeless population and service gaps. The counting process is done by volunteers so there is potential for errors.

Specific data on homeless veterans living in the 8th Congressional District of Texas was not accessible but locating the subpopulation of veterans within the TX BoS CoC, which services small and rural communities and includes Walker, Montgomery, Houston, San Jacinto, Grimes, and Madison lead our team to conclude that the 8th Congressional District of Texas also experienced a decline in the homeless veterans population. Information concerning homeless veterans within the northern parts of Harris County and southern part of Leon County were not available.

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#### SUICIDE AMONG VETERANS

“Star Behavioral Health Providers (SBHP) is a resource for veterans, service members, and their families to locate behavioral health professionals with specialized training in understanding and treating military service members and their families.” Those listed in this registry have completed a series of trainings that are intended to make them better able to understand, assess and counsel members of the military. SBHP began in Indiana and is now offered in multiple states such as Oregon, California, Utah, Georgia, South Carolina, Ohio, Indiana, Michigan, and New York. SBHP’s approach is to provide “civilian behavioral health providers and other related professionals with training in evidence-based treatment options, as well as training which raises their awareness and sensitivity of the unique challenges faced by military affiliated people” (<https://www.starproviders.org/>). We conclude that providing key training tools for community-based providers will benefit military service members and their families. The increase of suicides and attempted suicides among veterans has especially affected women veterans. The high-risk factors for suicide and attempts are Substance Abuse Disorder and Adjustment Disorders. “From a prevention perspective, understanding the context of the transition from active duty military service to civilian status may provide opportunities for mitigating risk for negative post-discharge trajectories” (Brignone et al. 2017.557).



## CHAPTER 5: RESEARCH LIMITATIONS AND RECOMMENDATIONS

### RESEARCH LIMITATIONS

On August 25, 2017, Hurricane Harvey made landfall as a category four hurricane onto the Texas Gulf Coast with the eye over Rockport, TX. Hurricane Harvey caused numerous tornadoes, torrential rains, massive flash flooding and storm surges along the 250 mile coast from Corpus Christi to Houston. Southeast Texas experienced between 20 to 50 inches of rain which included 58 counties. The Hurricane first affected team member Castro and her family who lived in the direct pathway of Hurricane Harvey. They evacuated and were displaced from August 25 - September 28. Team member Willis and husband who live 140 miles north of Rockport along the coast evacuated August 26 - August 28 due to the storm surges and again on August 30 due to flash flooding resulting from 35 inches of rain in the area. At the time of the completion of this project (December 2017,) Willis was still living in temporary housing.

The majority of counties within the 8th Congressional District of Texas were devastated with flood waters from the 35 - 50 inches of rain. All VA facilities were closed through September 5 along with Houston schools and surrounding areas; they resumed operation on September 11. The DeBakey Medical Center and the Conroe CBOC, just like many businesses along the coast, were running at half-capacity with limited staff following Hurricane Harvey's devastation. Normal operations resumed the last week of September which is when this research project was able to obtain their first sets of data.

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### DATA LIMITATIONS

Our literature review examined limitations and concerns of wait time data gathered by the VA. Wait times are incentivized and hospital administration bonuses are based, in part, on these numbers. According to the Department of Veteran Affairs Office of Inspector General, "these numbers are unreliable and frequently 'gamed'" (Robbins 2012). Another concern addressed in Campbell's 2016 article, "Reducing waits for VHA services through use of tools of governance" was the concern that this is a highly political matter and while public information is a useful tool

to share what is happening in the VAs in relation to wait time, dissemination of this information is complicated (Campbell 2016, 80-83). Data should be interpreted cautiously, as there is concern that wait times recorded are not accurate (Robbins 2012). It would be beneficial to further study how wait times are recorded and the individuals involved in that process to further guarantee the accuracy of the wait time analysis provided in this paper.

We were not able to obtain budget data differentiating expenses aggregated male/female. In order to determine the relationship proportionality between female veterans and the services offered, we need financial information regarding the top services offered. We also have no data that indicates that 10% of the veterans served at the Conroe CBOC are female beyond the statement provided by Leon. Since we cannot confirm this data, we cannot affirm with certainty that this is an accurate statement. We did not receive additional information on the number of female veterans from the 8th Congressional District utilizing the DeBakey WHC. Our team was unable to find VHA Directive 1330.01(1) through our original research; it was provided to the team by Sanders on November 21, 2017. This directive contains a great deal of information on female healthcare within the VHA, and opens up additional questions that, given the time constraint of the project, the team was unable to answer.

Data comparisons prior to 2012 will be skewed due to redistricting within the 8th Congressional District. Redistricting in Texas occurs every 10 years, most recently in 2011. Texas districts should have equal populations and should not discriminate based on race or ethnicity. Prior to 2012, the 8th Congressional District of Texas included seven other counties, Liberty, Hardin, Orange, Polk, Tyler, Jasper, and Newton.

We did not have access to the comprehensive database (VSSC) concerning VCA users and providers. Had we had access to this we would have been able to provide further analysis of VCA usage and accessibility and further insight into the policy implications of the VCA.

There is a lack of data specific to the 8th Congressional District of Texas. We were not able to obtain data on the rural veterans living in the 8th Congressional District, and the data we were able to acquire through the VA website is not a complete list of rural dwelling veterans. Because

of this, we are unable to determine an exact number of rural veterans in the county, and we are unable to analyze the rural veterans living in the 8th Congressional District. We were unable to find an alternate way to gather this data because living location is self-reported when a veteran registers for services with the VA. We could not break down census data of Montgomery County into rural dwelling versus urban dwelling, nor could we separate data regarding living location of veterans in Leon County and Harris County, both of which are not fully located within the 8th Congressional District.

Data sets pertaining to specific number of rural dweller veterans utilize mental healthcare at the CBOC, rural versus urban dweller veterans wait times for mental health care, and female veterans utilization of their mental health benefits were not available.

#### RECOMMENDATIONS

Based on our research, we have compiled the following comprehensive list of recommendations for Congressman Brady, the VA, and the Conroe CBOC. Ultimately, we are making recommendations we hope will build on the existing strengths of the Conroe CBOC and continue to improve accessibility, resource allocation, and accountability for the veterans of the 8th Congressional District of Texas.

1. Moving forward, the DeBakey Medical Center and health systems in the surrounding areas including the Conroe CBOC should consider adopting usage of JLV and VLER. These systems are both currently in place by the VA to track dual usage and facilitate communication between the VA and non-VA providers.
2. The Conroe CBOC should consider requiring the usage of the Blue-Button tool for their dual-using veterans and educate veterans on how to utilize this system. Integration of the Blue-Button tool could become part of the routine of VA medical visits. Upon admission to the system the veteran could be assisted in setting up their online profile and login information; then, after each visit the VA office staff could make it routine to print a Blue-Button report for the veteran to take with them. This would allow the veteran to always have the most current VA medical information at their fingertips in case they see a non-VA provider in between VA visits. It takes the burden of record-keeping off of

the veteran and their family members while ensuring that exact medical records are communicated from VA to non-VA providers.

3. The VA should set up protocols to ensure the effective transmission of information between themselves and outside providers. According to Thorpe, “policymakers should consider implementing electronic health information exchanges and additional medication therapy management services across systems to keep pace with recent policies designed to expand veterans' access to non-VA providers and protect vulnerable patients from risks associated with dual-system use” (2016, 162). With the issue of dual use the VA should consider allowing limited access to the VA Electronic Medical Record (EMR) for VCA-approved community providers. Giving VCA-approved community providers a limited access log-in could enable them to input notes on patient visits in the system in a way that is queryable in the same manner as VA records. Further, their access could be restricted to the records of VA patients that they treat so they could have two-way communication between the system- inputting as well as viewing information. TriWest and Health Net, the contractors running the VCA program for the VA, could be held accountable for setting up such tracking. Once this system is put in place, the contractors can be removed as the communication middle-men which would allow the providers to ensure better continuity in care for veterans by seamlessly integrating non-VA communication with the VA system. The VLER appears to be a significant first-step in ameliorating this problem—but it is only one way (from the VA to community providers) and it is currently not widespread or well-utilized.
4. A potential long-term solution for better tracking of dual-using veterans may be to launch a mandatory insurance claims database in Texas like exists in New Hampshire. This would facilitate information gathering of health system utilization by veterans when using community care (whether VCA-approved or not) and VA care simultaneously. With such a system, providers could easily check if a prescription or test had recently been performed for the same person so as to not duplicate services.
5. The VA should consider producing VCA usage-rate reports and make information regarding the utilization of the VCP publically available so veterans, taxpayers, and decision makers, including Congressman Brady, are able to verify that it is a useful policy that should be extended.

6. For safety reasons, further study regarding access and usage of the VCA is recommended before making extension decisions about the policy. With the current lack of accessible data on its impact it stands to reason that increasing dual usage among veterans through the VCA without further safeguards in place to track dual usage or increase communication between health systems, may actually be detrimental.
7. The VA should consider amending the VCA-community provider search tool to query VCA-approved community providers in various ways. For research and accountability purposes it would be helpful to have the ability to search for the total number of providers in an area or a specialty. Currently the system is able to search for certain types of providers but the results are only shown in a list format with no totals. For ease of use by veterans, the search tool could be amended to ensure that no provider entries are duplicated and that it is simple to print the list of relevant providers once located.
8. Providing some type of financial incentive for providers to become part of the Veterans Choice Program should be considered. Currently the reimbursement rate for providers seeing veterans through the VCP is on par with the Medicare reimbursement rate which is quite low. Further incentives for rural or specialty providers who are VCA-approved should also be considered as the need for such doctors is especially relevant among veteran communities.
9. As the VHA re-strategizes, suggestions mentioned in the literature review summary above regarding a VHA restructure should be considered. Instead of trying to provide every health service at every VA-sponsored location (for example gynecologic oncology) it may be most efficient to encourage veteran use of community care for specific types of health needs the VA does not specialize in and those that are routine needs (i.e. sinus infection or allergy prescription refill.) This would free the VA to focus on war-related injuries and trauma such as traumatic brain injuries, limb amputations, and psychological issues stemming from war which plague veterans at a much higher rate than the general population.
10. In a meeting with Leon at the Conroe CBOC Monday, December 4, 2017, Leon stated that they were working to hire 7 additional mental health providers. We recommend that the wait times for mental health appointments be reexamined in a year to determine if the

addition of mental health providers has caused a statistically significant reduction in the wait times for mental health appointments.

11. The Conroe CBOC should be compliant with VHA Directive 1330.01(1), Health Care Services for Women Veterans, and ensure they are providing healthcare to female veterans that is accessible, high-quality, equitable, comprehensive and done in a manner and environment that is sensitive to female veterans. The Conroe CBOC should continually look at and work to rectify “deficiencies and environmental barriers to care for women Veterans” (VHA Directive 1330.01(1) 2017, 6).
12. With the percentage growth of female veterans in TX-08 over the next 29 years surpassing that of the state and the nation, it is important that the district fully understands the needs of female veterans in the district. We recommend that Congressman Brady survey eligible female veterans in the district. This survey should include questions regarding the needs of female veterans, including, but not limited to mental health, primary care, and community/emotional support.
13. Recommendations are based on the culture of rural dwellers who are described as self-reliant and tend to depend on their community for support. “They place a high value on individuality and self-sufficiency” (Adler, Pritchett, Kauth, and Mott 2015. 51).
  - a. Conduct outreach events such as community fairs or symposiums just for veterans (in hopes to attract rural veterans) and their families. The key is to broadcast resources in a format to those who are not tech savvy.
  - b. The TexVet.org site contains resources for homelessness, suicidal tendencies, and other adjustment and behavioral health disorders.
14. Set up Tele-Med Mental Health Hubs and provide training to local community partners especially for veteran health and behavioral care.
15. Provide training for “Peer Counseling” and “Veteran Jail Diversion Services” by working collaboratively with local nonprofits who can provide support and tangible services to make this possible.
  - a. Set up peer counseling in places such as the VFW or other known sites that are visited by veterans.
16. Utilize case managers (or Veteran Coordinators) to continue creating partnerships with local medical and mental health professionals within the TX CD-8.

17. Continue to maintain an updated referral list for veterans and family members to seek tangible and intangible resources.
18. Establish Tele-Med Mental Health Hubs with local community agencies in order to provide complete care and services for veterans.
19. Examine how to create a Rural Transportation Service for veterans who live too far from the Conroe CBOC so they can receive access to health and behavioral care.
20. Substance Abuse Disorders and Adjustment Disorders are the two key risk factors for suicide and attempted suicide among veterans. Train local behavioral health providers and other professionals on the unique issues that plague our military.
  - a. SBHP's approach is to provide "civilian behavioral health providers and other related professionals with training in evidence-based treatment options, as well as training which raises their awareness and sensitivity of the unique challenges faced by military affiliated people."
21. We recommend the Congressman supports the transparency of financial information and financial investments.

#### RECOMMENDATIONS FOR FUTURE RESEARCH

Through our action research, our team determined there is additional research needed on these topics that we were unable to cover based on the lack of available data within in the time frame of our project. These recommendations are organized into the categories of access to care, resource allocation and accountability.

##### Access to Care:

1. Telemedicine is an increasingly popular option for VA-sponsored care that decreases the need for coordination between separate health systems. In telemedicine, VA providers can "meet" veterans where they are (most often at their closest CBOC) when specialized providers are not available near them. This type of system has a proven track record of effectively serving rural veterans and those with specific needs (Perdew et al, 2017; Powers et al, 2017.) The Conroe CBOC is currently utilizing telemedicine in their clinic. Further research is recommended to examine the effectiveness of telemedicine at the

Conroe CBOC and how telemedicine can further be used to meet the needs of veterans living in the 8th Congressional District.

2. Further research regarding VLER (Virtual Electronic Lifetime Record) and JLV (Joint Legacy Viewer) would allow for examination of current tools accessible to reduce negative effects of dual usage and the lack of communication between health systems. Specific research questions could include:
  - a. How can the VLER (Virtual Electronic Lifetime Record) be better utilized? How can more health systems be drawn to subscribe to its usage? Is it effective for those health systems who do utilize it? Why aren't all VAMCs, CBOCs, and subsidiary VA facilities required to utilize it? Does its usage lower the impact of the negative effects of dual use and lack in communication between health systems?
  - b. How can the JLV (Joint Legacy Viewer) be better utilized? Is it an effective tool for communication between the DoD and VA? Why aren't all VAMCs, CBOCs, and subsidiary VA facilities required to utilize it? Does its usage lower the impact of the negative effects of dual use and lack in communication between health systems?
3. Further research is suggested to examine the following questions related to the VCP: How well is the VCP utilized? What are the number of VCP users? Is it more or less than the number of veterans who accessed community care through the former community care program (PC3)? Should the VCA policy be renewed and further funded?
4. We recommend further research to study how wait times are recorded and the individuals involved in that process (including, but not limited to what the benefits are for VA employees when wait times are low, and what are the consequences for high wait times).
5. Research regarding benefits of WH-PACT's and female support groups is recommended.
6. Future research on Texas homelessness, specifically in 8th Congressional District.
7. Future research on community-based nonprofits to utilize their expert knowledge in providing assistance to rural veterans.

Allocation of Resources:



1. Data specific to Congressional Districts, specifically the TX-08, is limited, and frequently nonexistent. Further research regarding ways to collect data by Congressional District is recommended so that data can be compared across district as well as state and nation.
2. Further research should be done to determine the needs of female veterans living in the 8th Congressional District. This should include (but is not limited to) the following questions: Are female veterans utilizing VA medical services? Would they use VA medical services if they could access the services need? What do female veterans need from the VA? What services do female veterans currently use at the Conroe CBOC? What services can female veterans not currently access at the Conroe CBOC that are needed? Do female veterans feel supported by the VA? What emotional and community support would female veterans like to see provided? What do female veterans think about the current motto of the VA?
3. Research what the most needed services are specific to the veteran constituents of TX-08, and examine ways to continue to improve allocating VA funds to the most needed services specific to the veteran constituents of TX-08.
4. Research the success rate of the Rural Veterans Coordination Pilot (RVCP) grant that provides financial resources to local agencies who are currently assisting rural veterans and their families.

Accountability:

1. Further research examining proportionality of female care at the Conroe CBOC is recommended.
2. We recommend that research is continued on the original research question provided by Congressman Brady and his team, “What are the financial impacts of VA health expenditures?,” as well as our refined research question eleven, “What is the cost allocated per veteran in the 8th Congressional District, and how does it compare to Texas, and the nation? What is the cost spent per veteran in the 8th congressional district, and how does it compare to Texas, and the nation? What are the top line items in the 8th Congressional District, and how do they compare to Texas, and the nation?” Further, we recommend additional research be done on financial expenditures related to female usage of services at the Conroe CBOC and gender-specific training.

## CONCLUSION

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### DUAL USAGE/ LACK OF COMMUNICATION

There are definite negative effects for dual users as noted in the results section of this report including higher exposure to potentially unsafe medications (PUMs) and duplication of care, tests, and prescriptions. Everything that Castro located in additional research concurred with these initial findings from our literature review. Authors did note some benefits to dual usage such as faster treatment for emergent conditions, but overall there are significant risks to long-term dual usage without additional safeguards and communication mechanisms being put into place between VA and non-VA health systems.

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### VETERAN CARE ACT

Preliminary conclusions regarding VCA providers are that it is difficult to search for VCA-approved community providers by any factor other than proximity to a certain location. Also, there does not seem to be much pull for providers to become VCA-approved as there is not much financial incentive to see veterans through the Veterans Choice Program.

Lack of data regarding VCA access and usage inhibit our team from making solid conclusions regarding implications of the Veterans Choice Act. More data should be collected regarding provider access and veteran utilization of the VCA.

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### WAIT TIMES

While our research indicates that there is no statistical difference between wait times for services provided at the Conroe CBOC for established and new patients, and wait times for the same services at clinics in the state and in the nation, we believe that given the rural nature of the 8th Congressional District, and the links between rural veteran lack of access to mental-health care, wait times for mental health appointments at the Conroe CBOC should be statistically less. Research shows the reliability of wait times is questionable. In a meeting with Leon on

December 4, 2017, he noted that the Conroe CBOC would be adding seven mental health providers to their current staff. We recommend that wait times for mental health appointments be reexamined in a year to determine if the additional of mental health providers has statistically reduced the wait time for mental health appointments at the Conroe CBOC. We also recommend further research to study how wait times are recorded and the individuals involved in that process in order to guarantee the accuracy of the wait time analysis provided in this paper. The VA access to care website is a simple tool for veterans to utilize in order to find VA hospitals and clinics based on proximity and compare wait times between facilities.

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#### FEMALE HEALTHCARE

Over the next 29 years, the growth of female veterans is disproportionate to the growth of male veterans. The rate at which female veteran populations will grow in the 8th Congressional District is also larger than the rate of female veteran growth in the state and the nation. Research indicates that female veterans have different healthcare needs than male veterans and that the VHA is working to create high-quality healthcare for female veterans that is accessible, comprehensive, equitable and provided in a manner that meets the needs of female veterans (VHA Directive 1330.01(1) 2017). We are unable to prove proportionality of services offered at the Conroe CBOC to the number of female veterans in the 8th Congressional District. Similarly, we are unable to determine how many female veterans are utilizing services at the Conroe CBOC or how many female veterans from the 8th Congressional District are utilizing the WHC at DeBakey VA Medical Center. There is great opportunity for further research on the topic of female veteran healthcare.

***“Understanding the community, building trust, developing cultural competency, and knowing formal and informal community resources are important to effective rural practice (Adler, Pritchett, Kauth, and Mott 2015. 51).”***

Rural culture among veterans are self-reliant, dependency on self, and trust in local community. “This rural culture can prevent homeless veterans from access to mental and behavioral health services, lack of affordable housing and transportation options. The VA established Community Based-Outpatient Clinics (CBOC) for the rural veterans in mind. The limitations of the CBOCs that is one case worker per four CBOCs and the need of non-health services. CBOC staff members are uniquely situated to provide rich perspective in these domains given that they are not only knowledgeable about the services available to rural veterans, but also, as a result of their contact with rural homeless veterans, have firsthand knowledge of these veterans’ needs and their barriers to care (Adler et al. 2015, 47-48).”

The role of the case manager within the CBOCs are to be key advocates for the veterans who are seeking health and mental care. “They help to build rapport, trust, and good communication, which in turn facilitates engagement and encouragement among veterans (Ganzer 2016.38).”

In 2012, all veteran suicide attempts and deaths started to be reported by the VHA to the Suicide Prevention and Application Network (SPAN). From 2012 -2015, national data presents an increase of suicides among post-deployed veterans; the highest risk of suicide and attempted suicide were among veterans who were diagnosed with substance abuse disorder and adjustment disorder. Nationally, suicides and attempted suicides by veterans has steadily escalated since 2012.

Case managers and veteran coordinators are the initial access point at the VA for veterans. Screening for mental health, MST, suicide, and homelessness is the first step to reaching veterans.

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## VETERAN HOMELESSNESS

The risk factors to homelessness for veterans who are transitioning from military to civilian life due to the lack of preparedness (reintegration issues), loss of employment and relationship complications, mental and behavioral health issues, childhood trauma and lifetime of poverty syndrome, and substance use disorder (SUD) are factors that are related to veterans becoming homeless (Creech et. al 2015, 620; Metraux et al. 2017). Research found that there are “45.7% of veterans with chronic homelessness reported having both SUD and mental health issues. Homelessness can become a barrier to gaining employment, treatment for SUD and mental health” (Cox, Malte, and Saxon 2017. 208).

In 2013, all VA centers were instructed to screen all veterans eligible for VA healthcare for eminent risk of homelessness and to connect veterans to support services. This was the beginning of a shift in the mindset at the VA, not just to assist homeless veterans but how to prevent veterans from becoming homeless by identifying those who are at risk of homelessness. This new shift established case managers and veteran coordinators as the access point for veterans seeking tangible and intangible resources.

Collaboration between local community agencies and VA centers has been an effective tool that has reduced veteran homelessness by 47% nationally and 70% within Texas.

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## FINANCIAL ACCOUNTABILITY

Without reliable financial data, our team was unable to answer research questions pertaining to the financial impacts of VA health expenditures. Because of this, we are unable to determine cost allocated or spent per veteran in the district, state or nation, and cannot determine how the Conroe CBOC is performing financially compared to other clinics across Texas and the nation. Similarly, we are unable to disaggregate and analyze cost per service by gender, investment

priorities driven by local demographics, and by risk factors. Without transparency of financial information, there is no accountability of the funds being spent, and future comparisons of efficiencies (by services, CBOCs, or veteran demographics) will not be possible. Because of this, Congressman Brady is unable to see if the Conroe CBOC is investing in services most needed by his veteran constituency. For example, the Conroe CBOC is in the process to open a dental clinic. Without information regarding the funds being spent to operate this clinic, we cannot determine if the Conroe CBOC is paying more for services performed or per veteran compared to other VA dental clinics.

## BIBLIOGRAPHY

### WORKS CITED

2016. Mental Health. August 3. Accessed October 2017.
- Adler, Geri, Lonique R. Pritchett, Michael R. Kauth, and Juliette Mott. 2015. "Staff Perceptions of Homeless Veterans' Needs and Available Services at Community-Based Outpatient Clinics." *Journal of Rural Mental Health* 39 (1) (01):46-53.
- Arksey, H., & O'Malley, L. 2007. "Scoping studies: Towards a methodological framework." *International Journal of Social Research Methodology* 8(1): 18-32.
- Asch, Steven M., and Eve A. Kerr. 2016. "Measuring what Matters in Health: Lessons from the Veterans Health Administration State of the Art Conference." *Journal of General Internal Medicine* 31 Suppl 1 (04):1-2.
- Balshem, Howard, Vivian Christensen, Anais Tuepker, and D Kansagara. 2011. "A Critical Review of the Literature Regarding Homelessness among Veterans." VA-ESP Project #05-225 *Department of Veteran Affairs HSR&D* 1-56.
- Bartel, Michael, Douglas Robertson, and Heiko Pohl. 2016. "Colonoscopy Practice for Veterans within and Outside the Veterans Affairs Setting: A Matched Cohort Study." *Gastrointestinal Endoscopy* 84 (2):272-8.
- Bossarte, Robert M., John R. Blosnich, Rebecca I. Piegari, Lindsay L. Hill, and Vincent Kane. 2013. "Housing Instability and Mental Distress among US Veterans." *American Journal of Public Health* 103 (12/02):S213-6.
- Brignone, Emily, Jamison Fargo, Rebecca Blais, Marjorie Carter, Matthew Samore, and Adi Gundlapalli. 2017. "Non-Routine Discharge from Military Service: Mental Illness, Substance use Disorders, and Suicidality." *American Journal of Preventive Medicine* 52 (5):557-65.
- Brignone, Emily, Adi V. Gundlapalli, Rebecca K. Blais, Marjorie E. Carter, Ying Suo, Matthew H. Samore, Rachel Kimerling, Jamison D. Fargo, and Ying Suo. 2016. "Differential Risk for Homelessness among US Male and Female Veterans with a Positive Screen for Military Sexual Trauma." *JAMA Psychiatry* 73 (6) (06):582-9.

- Brooks, Elizabeth, Nancy K. Dailey, Byron D. Bair, and Jay H. Shore. 2016. "Listening to the Patient: Women Veterans' Insights about Health Care Needs, Access, and Quality in Rural Areas." *Military Medicine* 181 (9) (09):976-81.
- Byrne, T., Nelson, R. E., Montgomery, A., Brignone, E., Gundlapalli, A. V., & Fargo, J. D. (2017, January 23). Comparing the Utilization and Cost of Health Services between Veterans Experiencing Brief and Ongoing Episodes of Housing Instability. (T. N. Medicine, Ed.) *Journal of Urban Health*, 94, 54-63. doi:10.1007/s11524-016-0110-5
- Campbell, Colleen. 2016. Reducing waits for VHA services through use of tools of governance. *Human Service Organizations: Management, Leadership & Governance* 40 (1) (Jan): 74-85.
- Carter, Andrea, Sonya Borrero, Charles Wessel, Donna Washington, Bevanne Bean Mayberry, Jennifer Corbelli, Bryan Batch, et al. 2016. "Racial and Ethnic Health Care Disparities among Women in the Veterans Affairs Healthcare System: A Systematic Review." *Women's Health Issues* 26 (4):401-9.
- Charlton, Mary, Michelle Mengeling, Jennifer Schlichting, Lan Jiang, Carolyn Turvey, Amal Trivedi, Kenneth Kizer, and Alan West. 2016. "Veteran use of Health Care Systems in Rural States: Comparing VA and Non-VA Health Care use among Privately Insured Veterans Under Age 65." *The Journal of Rural Health* 32 (4):407-17.
- "Collaborative Rural Access Solutions," VA.gov. Last Modified September 12, 2017.
- "Conroe VA Outpatient Clinic." 2016. Houston Veterans Affairs.  
[https://www.houston.va.gov/locations/Conroe\\_VA\\_Outpatient\\_Clinic.asp](https://www.houston.va.gov/locations/Conroe_VA_Outpatient_Clinic.asp) (June 13, 2017).
- Cox, Koriann B., Carol A. Malte, and Andrew J. Saxon. 2017. "Characteristics and Service Utilization of Homeless Veterans Entering VA Substance use Treatment." *Psychological Services* 14 (2) (05):208-13.
- Creech, Suzannah K., Erin Johnson, Matthew Borgia, Claire Bourgault, Stephen Redihan, and Thomas P. O'Toole. 2015. "Identifying Mental and Physical Health Correlates of Homelessness among First-Time and Chronically Homeless Veterans." *Journal of Community Psychology* 43 (5) (07):619-27.
- Dittrich, Kristina A., M. N. Lutfiyya, Catherine J. Kucharyski, John T. Grygelko, Cassandra L. Dillon, Taylor J. Hill, Matthew P. Rioux, and Krista L. Huot. 2015. "A Population-Based



- Cross-Sectional Study Comparing Depression and Health Service Deficits between Rural and Nonrural U.S. Military Veterans." *Military Medicine* 180 (4) (04):428-35.
- Doyle, Jamie M., and Robin A. Streeter. 2017. "Veterans' Location in Health Professional Shortage Areas: Implications for Access to Care and Workforce Supply." *Health Services Research* 52 (02/02):459-80.
- Ducharme, Lori, Redonna Chandler, and Alex H. S. Harris. 2016. "Implementing Effective Substance Abuse Treatments in General Medical Settings: Mapping the Research Terrain." *Journal of Substance Abuse Treatment* 60:110-8.
- Evans, Tracee. 2017. "U.S. Congressman Kevin Brady of the Woodlands announces service academy appointments." Woodlands Online. June 12, 2017.  
<http://www.woodlandsonline.com/npps/story.cfm?nppage=59506>
- Fairfax, Colita N., and Marvin D. Feit. 2015. "How Policy Improves Health." *Social Work in Public Health* 30 (5) (Aug):410-22.
- Finley, Erin, Polly Noël, Michael Mader, Elizabeth Haro, Nancy Bernardy, Craig Rosen, Mary Bollinger, Hector Garcia, Kathleen Sherrieb, and Mary J.V. Pugh. 2017. "Community Clinicians and the Veterans Choice Program for PTSD Care." *Medical Care* 55:S61-70.
- Finley, Erin P., Polly H. Noël, Shuko Lee, Elizabeth Haro, Hector Garcia, Craig Rosen, Nancy Bernardy, Mary J. Pugh, and Jacqueline A. Pugh. 2017. "Psychotherapy Practices for Veterans with PTSD among Community-Based Providers in Texas." *Psychological Services* (03/16).
- Fletcher, Carol, Allison Mitchinson, Erika Trumble, Daniel Hinshaw, and Jeffery Dusek. 2017. "Providers' and Administrators' Perceptions of Complementary and Integrative Health Practices Across the Veterans Health Administration." *Journal of Alternative and Complementary Medicine* 23 (1):26-34.
- Ganzer, Christine A. 2016. "Veteran Women: Mental Health--Related Consequences of Military Service." *American Journal of Nursing* 116 (11) (11):32-40.
- Gellad, Walid F. 2016. The veterans choice act and dual health system use. *Journal of General Internal Medicine* 31 (2) (02): 153-4.
- Giroir, Brett P., and Gail R. Wilensky. 2015. "Reforming the Veterans Health Administration -- Beyond Palliation of Symptoms." *The New England Journal of Medicine* 373 (18) (Oct 29, 2015):1693-5.

- Grant, M., & Booth, A. 2009. "A typology of reviews: An analysis of 14 review types and associated methodologies." *Health Information Library Journal* 26:91-108.
- Hamilton, Alison B., Ines Poza, and Donna L. Washington. 2011. "Homelessness and Trauma Go Hand-in-Hand: Pathways to Homelessness among Women Veterans." *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health* 21 (4) (07/20):S203-9.
- Health Care Services for Women Veterans VHA Directive 1330.01(1) (2017).
- "Health Benefits." 2014. *Veterans Eligibility - Health Benefits*.  
<https://www.va.gov/HEALTHBENEFITS/apply/veterans.asp> (August 12, 2017).
- "How to become a Veterans Choice Program." 2016. VA Health Care. October 28, 2017.
- Holder, Kelly Ann. 2017. "Veterans in Rural America: 2011 - 2015" American Community Survey Reports. United States Census Bureau. January 2017.
- Johnson, Christopher E., Ruth L. Bush, Jeffrey Harman, Jane Bolin, Gina E. Hudnall, and Ann M. Nguyen. 2015. "Variation in Utilization of Health Care Services for Rural VA Enrollees with Mental Health-Related Diagnoses." *Journal of Rural Health* 31 (3) (Summer 2015):244-53.
- Johnson, Erin E., Matthew Borgia, Jennifer Rose, and Thomas P. O'Toole. 2017. "No Wrong Door: Can Clinical Care Facilitate Veteran Engagement in Housing Services?" *Psychological Services* 14 (2) (05):167-73.
- Jordan, Jay R. 2015. "New Conroe VA Clinic Open for Veterans Monday." Nov. 22, 2015.  
<https://kevinbrady.house.gov/news/documentsingle.aspx?DocumentID=399416>
- Kehle-Forbes, Shannon, Eileen M. Harwood, Michele R. Spoont, Nina A. Sayer, Heather Gerould, and Maureen Murdoch. 2017. "Experiences with VHA Care: A Qualitative Study of U.S. Women Veterans with Self-Reported Trauma Histories." *BMC Women's Health* 17 (05/30):1-8.
- Kelly, Pamela, Ravi Chinta, and Gregory Privitera. 2015. "Do Centers of Excellence Reduce Health Care Costs? Evidence from the US Veterans Health Administration Centers for Epilepsy." *Global Business & Organizational Excellence* 34 (6) (Sep):18-29.
- Kertesz, Stefan G., Erika L. Austin, Sally K. Holmes, Aerin J. DeRussy, Deusen L. Van, and David E. Pollio. 2017. "Housing First on a Large Scale: Fidelity Strengths and Challenges in the VA's HUD-VASH Program." *Psychological Services* 14 (2) (05):118-28.

- Kirchner, JoAnn E., Mary S. Farmer, Valorie M. Shue, Dean Blevins, and Greer Sullivan. 2011. "Partnering with Communities to Address the Mental Health Needs of Rural Veterans." *Journal of Rural Health* 27 (4) (09):416-24.
- Koblinsky, Sally A., Allison L. Schroeder, and Leigh A. Leslie. 2017. "'Give Us Respect, Support and Understanding': Women Veterans of Iraq and Afghanistan Recommend Strategies for Improving their Mental Health Care." *Social Work in Mental Health* 15 (2) (Mar):121-42.
- Lacoursiere Zuccherro, T. (1,2), McDannold, S. (2,3), and McInnes, D.K. (2,3). 2016. "Walking in a maze": Community providers' difficulties coordinating health care for homeless patients. *BMC Health Services Research* 16 (1) September 2007.
- Lee, Jennifer, Gina Capra, and Thomas Klobucar. 2016. "Forging New Paths to Integrate Rural Veterans' Care Nationwide." *The Journal of Rural Health* 32 (4):374-6.
- Liu, C. F., M. K. Chapko, M. W. Perkins, J. Fortney, and M. L. Maciejewski. 2008. "The Impact of Contract Primary Care on Health Care Expenditures and Quality of Care." *Medical Care Research and Review* 65 (3):300-14.
- Logan, Joseph, Amy Bohnert, Erica Spies, and Mary Jannausch. 2016. "Suicidal Ideation among Young Afghanistan/Iraq War Veterans and Civilians: Individual, Social, and Environmental Risk Factors and Perception of Unmet Mental Healthcare Needs, United States, 2013." *Psychiatry Research* 245:398-405.
- Mankowski, Mariann and Joyce E. Everett. 2016. "Women Service Members, Veterans, and their Families: What we Know Now." *Nurse Education Today* 47 (12):23-8.
- Mattocks, Kristin, Michelle Mengeling, Anne Sadler, Rebecca Baldor, and Lori Bastian. 2017. "The Veterans Choice Act." *Medical Care* 55:S71-5.
- McCarthy, John F., Frederic C. Blow, Rosalinda V. Ignacio, Mark A. Ilgen, Karen L. Austin, and Marcia Valenstein. 2012. "Suicide among Patients in the Veterans Affairs Health System: Rural-Urban Differences in Rates, Risks, and Methods." *American Journal of Public Health* 102 (Mar):S111-7.
- McInnes, D. K., Gemmae Fix, Jeffrey Solomon, Beth Petrakis, Leon Sawh, and David Smelson. 2015. "Preliminary Needs Assessment of Mobile Technology use for Healthcare among Homeless Veterans." *Peerj* 3:e1096.

- “Mental Health Program for Veterans.” 2017. Texas Health and Human Services.  
<http://www.dshs.texas.gov/mhsa/Mental-Health-Program-for-Veterans.aspx> (June 13, 2017).
- Metraux, Stephen, Meagan Cusack, Thomas H. Byrne, Nora Hunt-Johnson, and Gala True. 2017. "Pathways into Homelessness among Post-9/11-Era Veterans." *Psychological Services* 14 (2) (05):229-37.
- Montgomery, Ann E., and Thomas H. Byrne. 2014. "Services Utilization among Recently Homeless Veterans: A Gender-Based Comparison." *Military Medicine* 179 (3) (03):236-9.
- Montgomery, Ann E., Melissa E. Dichter, Arwin M. Thomasson, Xiaoying Fu, and Christopher B. Roberts. 2015. "Demographic Characteristics Associated with Homelessness and Risk among Female and Male Veterans Accessing VHA Outpatient Care." *Women's Health Issues* 25 (1) (01):42-8.
- Nathaniel, Alvita K., and Lisa Hardman. 2017. "Caring with Honor: A Grounded Theory of Caring for Veterans within the Veterans Health Administration." *Grounded Theory Review* 16 (1) (06):15-9.
- n.d. "National Center for Veterans Analysis and Statistics." U.S. Department of Veteran Affairs. Accessed July 15, 2017. <https://www.va.gov/vetdata/glossary.asp>.
- Nuti, Sudhakar V., Li Qin, John S. Rumsfeld, Joseph S. Ross, Frederick A. Masoudi, Sharon-Lise T. Normand, Karthik Murugiah, Susannah M. Bernheim, Lisa G. Suter, and Harlan M. Krumholz. 2016. "Association of Admission to Veterans Affairs Hospitals Vs Non-Veterans Affairs Hospitals with Mortality and Readmission Rates among Older Men Hospitalized with Acute Myocardial Infarction, Heart Failure, Or Pneumonia." *Jama* 315 (6) (Feb):582-92.
- “Office of Rural Health,” VA.gov. Last Modified February 17, 2017.
- Palladino, B., A. E. Montgomery, M. Sommers, and J. D. Fargo. 2017. "Risk of Suicide among Veterans with Traumatic Brain Injury Experiencing Homelessness." *Journal of Military & Veterans' Health* 25 (1) (Jan):34-8.
- Pear, Robert. 2017. “A Key Republican Demands Subsidies to Calm Insurance Markets.” The New York Times, June 8, 2017. [https://www.nytimes.com/2017/06/08/us/politics/kevin-brady-republican-insurance-subsidies.html?\\_r=0](https://www.nytimes.com/2017/06/08/us/politics/kevin-brady-republican-insurance-subsidies.html?_r=0)

- Pedersen, Eric R., Nicole K. Eberhart, Kayla M. Williams, Terri Tanielian, Caroline Epley, and Deborah M. Scharf. 2015. "Public-Private Partnerships for Providing Behavioral Health Care to Veterans and Their Families." Rand Corporation. 1-32
- Perdew, Cassie, Katie Erickson, and Jessica Litke. 2017. Innovative models for providing clinical pharmacy services to remote locations using clinical video telehealth. *American Journal of Health-System Pharmacy* 74 (14) (07/15): 1093-8, <http://lib-ezproxy.tamu.edu:2048/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=syh&AN=124004048&site=eds-live>.
- Powers, Becky, Marcia Homer, Natalia Morone, Natali Edmonds, and Michelle Rossi. 2017. Creation of an interprofessional teledementia clinic for rural veterans: Preliminary data. *Journal of the American Geriatrics Society* 65 (5): 1092-9.
- Rand Corporation – Veterans Research. [www.rand.org/research/veterans.html](http://www.rand.org/research/veterans.html)
- Reddy, Shivani, Danielle Rose, James Burgess, Martin Charns, and Elizabeth Yano. 2016. "The Role of Organizational Factors in the Provision of Comprehensive Women's Health in the Veterans Health Administration." *Women's Health Issues* 26 (6):648-55.
- Reppert, Meghan L., Mary Buzzetta, and Tim Rose. 2014. "Implications for Practice: Assisting Female Veterans in their Career Development." *Career Planning & Adult Development Journal* 30 (3) (Fall 2014):80-91.
- Robbins RA. 2012. VA administrators gaming the system. *Southwest Journal of Pulmonary & Care* 4: 149-54.
- Rogers, Thea J., Bridget M. Smith, Frances M. Weaver, Shanti Ganesh, Karen L. Saban, Kevin T. Stroupe, Rachael N. Martinez, Charlesnika T. Evans, and Theresa L. -. Pape. 2014. "Healthcare Utilization Following Mild Traumatic Brain Injury in Female Veterans." *Brain Injury* 28 (11) (Oct):1406-12.
- "Rural Promising Practices," VA.gov. Last Modified September 12, 2017. [https://www.ruralhealth.va.gov/providers/promising\\_practices.asp](https://www.ruralhealth.va.gov/providers/promising_practices.asp)
- "Rural Veterans by State," data.va.gov. Last Modified April 6, 2015. <https://www.data.va.gov/dataset/rural-veterans-state-2014>
- Shay, Kenneth, and Thomas T. Yoshikawa. 2010. "Overview of VA Healthcare for Older Veterans: Lessons Learned and Policy Implications." *Generations* 34 (2) (Summer 2010):20-8.

- Sherman, Michelle, Jessica Larsen, and Lynne Borden. 2015. "Broadening the Focus in Supporting Reintegrating Iraq and Afghanistan Veterans: Six Key Domains of Functioning." *Professional Psychology, Research and Practice* 46 (5):355-65.
- Shulkin, David. 2017. "Understanding Veteran Wait Times." *Annals of Internal Medicine* 167 (1):52-5.
- Suda, Katie, Bridget Smith, Lauren Bailey, Walid Gellad, Zhiping Huo, Muriel Burk, Francesca Cunningham, and Kevin Stroupe. 2017. Opioid dispensing and overlap in veterans with non-cancer pain eligible for Medicare part D. *Journal of the American Pharmacists Association* 57 (3): 333,340. e3.
- Teich, Judith, Mir M. Ali, Sean Lynch, and Ryan Mutter. 2017. "Utilization of Mental Health Services by Veterans Living in Rural Areas." *Journal of Rural Health* 33 (3) (Summer 2017):297-304.
- Texas Health and Human Services. Texas Department of State Health Services. Mental Health Program for Veterans. March 30. Accessed October 14, 2017.  
<http://www.dshs.texas.gov/mhsa/Mental-Health-Program-for-Veterans.aspx>
- Thorpe, Joshua M., Carolyn T. Thorpe, Walid F. Gellad, Chester B. Good, Joseph T. Hanlon, Maria K. Mor, John R. Pleis, Loren J. Schleiden, and Courtney Harold Van Houtven. 2017. Dual health care system use and high-risk prescribing in patients with dementia: A national cohort study. *Annals of Internal Medicine* 166 (3) (02/07): 157-63.
- Tsai, Jack, Thomas O'Toole, and Lisa K. Kearney. 2017. "Homelessness as a Public Mental Health and Social Problem: New Knowledge and Solutions." *Psychological Services* 14 (2) (May):113-7.
- Turek, Maggie E. 1. 2017. "To Care for Him Who Shall have Borne the Battle: Expanding the Choice Card Program to Provide for those Who Serve." *Kansas Journal of Law & Public Policy* 26 (2) (Spring 2017):215-35.
- U.S. Department of Veterans Affairs – National Center for Veterans Data and Statistics.  
[www.va.gov/VETDATA/index.asp](http://www.va.gov/VETDATA/index.asp)
- “V.A. History in Brief.” U.S. Department of Veterans Affairs.  
[https://www.va.gov/opa/publications/archives/docs/history\\_in\\_brief.pdf](https://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf) (November 11, 2017).

Vandenberg, Patricia, Linda R. Bergofsky, and James F. Burris. 2010. "The VA's Systems of Care and the Veterans Under Care." *Generations* 34 (2) (Summer 2010):13.

"Veterans Access, Choice and Accountability Act of 2014 ("Choice Act")." va.gov. <https://www.va.gov/opa/choiceact/documents/choice-act-summary.pdf> (June 13, 2017).

"Veterans Health Administration- Review of the Implementation of the Veterans Choice Program." 2017. va.gov. <https://www.va.gov/oig/pubs/VAOIG-15-04673-333.pdf> (June 13, 2017).

Veteran Services. <http://www.tricountyservices.org/veteran-services> (June 12, 2017).

Virtual Lifetime Electronic Record (VLER) Enterprise Program Management Office (EPMO). 2013. "VLER Health." VLER Health Home. (October 28, 2017).

West, Alan, and Mary Charlton. 2016. Insured veterans' use of VA and non-VA health care in a rural state. *The Journal of Rural Health* 32 (4): 387-96.

West, Alan, William Weeks, and Mary Charlton. 2017. "Differences among States in Rural Veterans' use of VHA and Non-VHA Hospitals." *The Journal of Rural Health* 33 (1):32-40.

---

#### WORKS CONSULTED

2016. Office of Public and Intergovernmental Affairs (OPIA). July. Accessed October 2017.

Atkins, David, Amy Kilbourne, and David Shulkin. 2017. "Moving from Discovery to System-Wide Change: The Role of Research in a Learning Health Care System: Experience from Three Decades of Health Systems Research in the Veterans Health Administration." *Annual Review of Public Health* 38 (1):467-87.

"Brady Backs America's Veterans" Press Release. March 17, 2017. <https://kevinbrady.house.gov/news/documentsingle.aspx?DocumentID=400361>

Center for New American Security. [www.cnas.org/research/military-veterans-and-society](http://www.cnas.org/research/military-veterans-and-society)

Chuan-Fen Liu, Michael Chapko, Chris L. Bryson, James F. Burgess, John C. Fortney, Mark Perkins, Nancy D. Sharp, and Matthew L. Maciejewski. 2010. "Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics." *Health Services Research* 45 (5) (10):1268-86.



- Conforte, A. M., DeLeon, P. H., Engel, C. C., Ling, C., Bakalar, J. L., & Tanofsky-Kraff, M. (2017, May/June). Identifying Policy Implications and Future Research Directions Regarding Military Community Support and Child Psychosocial Adjustment. *Military Medicine*, 182(5/6), 1572-1580.
- Ellsworth, Meagan. 2016. "Conroe Courier: Veterans Commend expanding Conroe VA Clinic 1 Year Later." December 17, 2016.  
<https://kevinbrady.house.gov/news/documentsingle.aspx?DocumentID=400153>
- Frayne, S. M., W. Yu, E. M. Yano, L. Ananth, S. Iqbal, A. Thrailkill, and C. S. Phibbs. 2007. "Gender and use of Care: Planning for Tomorrow's Veterans Health Administration." *Journal of Women's Health* (15409996) 16 (8) (10):1188-99.
- Institute of Military and Veterans Families. <https://ivmf.syracuse.edu/research/data-tools/veteran-strategic-analysis-research-tool/>
- Lehavot, Keren, Claudia Der-Martirosian, Tracy L. Simpson, Jillian C. Shipherd, and Donna L. Washington. 2013. "The Role of Military Social Support in Understanding the Relationship between PTSD, Physical Health, and Healthcare Utilization in Women Veterans." *Journal of Traumatic Stress* 26 (6) (12):772-5.
- "Make the Connection." Make the Connection. <https://maketheconnection.net/> (June 13, 2017).
- National Association of County Veteran Service Officers. [www.nacvso.org](http://www.nacvso.org)
- National Association of State Directors of Veterans Affairs. <http://www.nasdva.us/>
- Riley, Nathan, Kelley Withy, Kevin Rogers, Ragan DuBose-Morris, and Tiffany Kurozawa. 2017. Comparison of primary care physician reimbursement rates in the united states. *Hawai'i Journal of Medicine & Public Health* 76 (3 Suppl 1): 24.
- Rivera, Stacie, and Treva Lutes. 2016. Eureka! VA doctors use secure web-based tool to better serve veterans. *Vantage Point* (12): 8.
- Slabodkin, Greg. 2015. DOD-VA EHR viewer falls short, congressman says. *Healthdatamanagement.Com* (12): 2.
- "Veterans Choice Program Law Changes." 2017. [va.gov](https://www.va.gov/opa/choiceact/documents/Choice-Extension-Fact-Sheet-FINAL-April-2017_508.pdf).  
[https://www.va.gov/opa/choiceact/documents/Choice-Extension-Fact-Sheet-FINAL-April-2017\\_508.pdf](https://www.va.gov/opa/choiceact/documents/Choice-Extension-Fact-Sheet-FINAL-April-2017_508.pdf) (June 13, 2017).



## APPENDICES

### APPENDIX 1: LIST OF CONTACTS

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Kate Machado, VP Business Development - Atlas Research

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# SERVING VETERANS IN THE 8TH CONGRESSIONAL DISTRICT OF TEXAS: A HYBRID LITERATURE REVIEW

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PSAA 675

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Submitted for grading: 7/30/2017

Amended to include foreword: 11/11/2017

## FOREWORD

This literature review has been amended as of November 11, 2017 to omit research and analysis completed by J. Williams who was a member of this capstone team for the first semester of our project but not the second. For this reason the team decided to omit the section of the literature review completed by Williams in an attempt to avoid taking credit for his work. Also, upon further analysis (post literature review) little data was located pertaining to the topics covered by Williams (financial impact) and thus, his section of the literature review is of minimal relevance to our capstone project's ultimate results.

## ABSTRACT

This capstone project is working to provide sound academic research to U.S. Congressman Kevin Brady and his staff to enable evidence-based decision making to promote the interests of veteran constituents in the 8th Congressional District of Texas. In order to do this, we conducted a hybrid literature review that consisted of a scoping study and then a search of scholarly, peer-reviewed articles focusing on the themes of Veterans Health Administration (VHA) health expenditures, the Veterans Choice Act, veteran homelessness and suicide, and healthcare.

According to our research findings, veterans have unique and different needs when seeking medical care than non-veterans. Also, subpopulations of veterans, such as female veterans and those living in rural areas, have more specific needs that are not readily met by the VHA.

An attempt to alleviate the wait times was executed through passing of the Veterans Access, Choice and Accountability Act of 2014. The Veterans Access, Choice and Accountability Act of 2014 (Veterans Choice Act or VCA) is necessary to bridge the gap in care for rural and women veterans, however, the VCA was implemented far too quickly. An overhaul of the VHA system was recommended so that the VA can focus on veteran-specific healthcare needs. It is important that the VHA creates measurable performance goals that are patient centered (Shulkin 2017, 53).

Another important finding from our research is that the VA has a mandate to focus on veteran homelessness and suicide among veterans. This fell into three basic risks factors: substance use

disorder (SUD), mental health, and unemployment (Cox, Malte and Saxon 2017; Creech et al 2015; Metraux et al. 2017). Studying papers on these topics led to further discussion on women veterans, rural dwelling homelessness, suicide ideation, Military Sexual Trauma (MST) and the implications of multiple deployments.

Through the information found in our scholarly, peer-reviewed research, we were able to refine the focus of our research questions. In the next phase of our capstone project we will work on developing hypotheses based on our modified research questions. We will then investigate our refined research questions through the use of quantitative data analysis and further examination of scholarly literature.

## BACKGROUND

The modern VA healthcare system was developed during the 1950s and 1960s as a result of the increased population of wounded from the US involvement in Vietnam; the model's foundation was in hospital-based inpatient care, medical specialization, and high technology (Vandenberg, et.al., 2010). Post-conflict increase in the veterans' population in the 1990's forced a realignment in veterans' healthcare process and systems. The VA medical system adapted to the evolving healthcare environment across the nation and the ever-changing needs of veterans spanning generations from WWI to the Gulf War. The transformation was supported through medical advances and technological innovations, and healthcare economics (Vandenberg, et.al, 2010).

The VA strategic plan desires to meet the unique needs of veterans. 1995 brought about a huge organizational shift as the VA moved from "largely autonomous units" into twenty-two veterans integrated service networks (VISN.) Vandenberg et. al. explains that "a typical VISN incorporates seven to ten medical centers, a few dozen ambulatory care sites, four to seven nursing homes, one or two residential rehabilitation treatment programs, and ten to fifteen vet centers" (2010.) All enrolled veterans who live within a certain geographic area are to be serviced by their particular VISN; each VISN usually services about 250,0000 veterans annually (Vandenberg et. al., 2010.)

In 1999 the VA revamped their eligibility guidelines and currently has eight priority groups that veterans are assigned to when they enroll (Health Benefits.) Eligibility for benefits is determined by the VA through a variety of factors but does not have to re-enroll once they are initially enrolled in the VHA system (Vandenberg et.al., 2010.)

This research project is being conducted to understand the economic impact the VHA has on veteran constituents, the economy, and the community at large in the 8th Congressional District of Texas. The 8th Congressional District of Texas is located within the service area of VHA VISN-16 Healthcare Network.

#### PURPOSE OF LITERATURE REVIEW

The final requirement to complete the Executive Masters of Public Service Administration program at The Bush School is to complete a capstone research project. Our team will be working with our client, Congressman Kevin Brady from the 8th Congressional District of Texas and his staff. The Bush School received an original proposal for the research project from the Congressman and his staff outlining their needs. The focus of their proposal highlighted the 8th Congressional District's current lack of information surrounding the needs of veterans living in their district, specifically as it relates to healthcare.

Therefore, the purpose/mission of this capstone project is to provide sound academic research to Congressman Brady's office to enable evidence-based decision making to promote the interests of veteran constituents in the 8th Congressional District of Texas. The initial part of this project is a review of the existing literature. As we examine existing research, we will attempt to narrow down the initial research questions provided by the client to drive the second phase of our capstone: original research.

#### RESEARCH QUESTIONS

After receiving and reviewing the original proposal, our team met with staff member Tracee Evans, Director of Communications for United States Representative Kevin Brady, on June 27,

2017. After this meeting, our team created a scope of work that included a summary of the proposed research project (including data required, budget, and themes needed to be researched), the expected deliverables and timeline of the project, and the expectations of our capstone team and that of the client. Both our team and the Congressman's staff agreed to the initial research questions as follows:

1. What are the financial impacts of VA health expenditures in the 8th congressional district?
2. What are policy implications of the Veterans Choice Act?
3. What information exists about veteran homelessness and suicide within the 8th Congressional District?

## METHOD

To answer initial research questions, we conducted a hybrid literature review. Our hybrid review consists of two reviews. The first is a scoping study. We chose to initially conduct a scoping review because we anticipated finding minimal scholarly research specific to the 8th Congressional District in Texas. Grant and Booth (2009), recommend a scoping study to assess potential size and choice of available research. Furthermore, Arksey and O'Malley (2005), stated scoping studies may be used to "identify research gaps in the existing literature" base "where no research has been conducted" (21). Once we identified the wider, non-scholarly resources, we then conducted a narrative, thematic scholarly review. The details of the steps we took are described in the following sections.

## SEARCH STRATEGY

The purpose/mission of this hybrid literature review is to review the existing literature and to narrow down the initial research questions provided by the client. To review, those questions were:

- What are the financial impacts of VA health expenditures in the 8th congressional district?

- What are policy implications of the Veterans Choice Act?
- What information exists about veterans homelessness and suicide within the 8th Congressional District?

In order to adequately review the literature and investigate those research questions, our team developed a search strategy. This strategy included the following steps:

1) Conducting an initial scoping review in which we utilized information taken from, *Scoping Studies: Towards a Methodological Framework* by Arksey and O'Malley as directed by our capstone advisor, Dr. Catherine Cole. We summarized 24 non-scholarly articles including newspaper articles, web pages, press releases and academic journal articles. The information gathered and its significance to our research project is outlined in the scoping study section of this document below.

3) After our initial scoping review we utilized our time on the Texas A&M campus during residency week to break down our agreed-upon three research questions to more specific sub-questions. From our sub-questions we created lists of keywords to utilize in our scholarly literature search. For each keyword or phrase identified we worked to include other descriptors that could result in more thorough search criteria. For example, if we identified "what are the health care needs specific to women veterans?" we brainstormed further descriptors such as "rural women veterans," or "in Texas" in order to use the most narrow search parameters possible.

4) After the creation of our keyword list we worked to categorize each keyword phrase. We were able to narrow our keyword list into four themes. These themes are 1) health expenditures, 2) Veterans Choice Act, 3) homelessness and suicide, and 4) healthcare. Upon this categorization we assigned each individual team member to a theme.

5) Each team member then embarked upon a search for scholarly, peer-reviewed literature that pertained to their theme. We utilized Texas A&M University (TAMU) library database system to search for articles that include our key words. TAMU library simultaneously searches approximately 950 databases. The number of articles located specific to each theme as well as how many were utilized in our literature review will be outlined in the following pages.

6) Upon finding relevant articles, eligible citations were exported to RefWorks for data organization and documentation.

## INCLUSION/EXCLUSION CRITERIA

The inclusion/exclusion criteria for our scoping study was extremely broad. We included all information regarding the 8th Congressional District of Texas and the three initial research questions. This included newspaper articles, websites, government reports, etc.

After our scoping review, which allowed us to cast a wide net in order to gather information about the 8th Congressional District of Texas, we focused our efforts on a scholarly narrative and thematic review. In this review we included:

- 1) Scholarly, peer-reviewed articles
- 2) Research published in English
- 3) Research published in the last ten years (between 2007-2017)
- 4) Research conducted in the United States

We selected this ten-year window so that we could focus our research on the most current information. This ten-year window gives us background to the issues and framework of the themes being reviewed and allows us to examine changes that have been made over the last ten years.

## THE SCOPING STUDY

### SIGNIFICANCE TO RESEARCH

Our project team's scoping study served the purpose of familiarizing our team with Congressman Brady, the 8th Congressional District of Texas, veterans resources, policies, and issues and existing opinions on the topic. Through this familiarization we were able to narrow the research questions given to us by the Congressman and his staff into keyword search phrases to utilize in our scholarly literature review. As we narrowed our research questions we were able to identify the four themes on which we based our scholarly literature review.



Our scoping study was also integral in helping us identify the information gap that exists in regards to material specific to the veterans within the 8th Congressional District of Texas. We discovered additional research limitations regarding finding data specific to our district and realized we will need to use general veteran information for our project.

## FINDINGS

Our scoping study included sources from newspaper articles, press releases, corporation, non-profit, and government-sponsored websites, and opinion pieces. Research reviewed was limited to the last five years. We identified five main topics of interest to the project. These included:

- 1) Information on Congressman Brady and his policy interests
- 2) Veteran-centered data and statistics sources
- 3) Resources already available within the 8th Congressional District of Texas
- 4) The Veterans Choice Act, its implementation and extension
- 5) Suggestions that upfront VA expenditures may reduce overall healthcare costs.

## SCHOLARLY LITERATURE REVIEW

Our scholarly narrative review is presented by themes as mentioned previously. After each theme's title is the search strategy utilized for that theme, characteristics found in the literature on that theme, significance of those findings to our project, and finally implications of those findings for our project moving forward.

### THEME 1- FINANCIAL IMPACT OF VA HEALTH CARE EXPENDITURES

As noted in the foreword above, this section of the literature review has been removed.

### THEME 2- POLICY IMPLICATIONS OF THE VETERANS CHOICE ACT OF 2014

Using Texas A&M University databases I initiated my scholarly research using the keywords Veterans Choice Act which produced 1,302 articles, "Veterans Choice Act" which produced 12

articles, “Veterans Access, Choice, and Accountability Act of 2014” which produced 5 articles, and added the further descriptor of “implementation” which produced two articles. I utilized the option to only allow searches from scholarly (peer-reviewed) journals in each attempt.

I saved 36 articles in my RefWorks account, read 24 articles in their entirety, and found 20 that were of use to our project. 12 unique articles will be cited in the following literature review detailing the Veterans Access, Choice and Accountability Act of 2014.

Articles in this section are recently published since the Veterans Access, Choice, and Accountability Act was just passed in 2014. The data they are reviewing comes from 2015 and the beginning of 2016. Since the peer-review and research process takes so long, it is possible changes have been made in the implementation of the policy between this research and present day.

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#### CHARACTERISTICS

VCA implemented too quickly. The first notable finding from my literature review regarding the Veterans Access, Choice and Accountability Act of 2014 (VCA) is that the Act was implemented far too quickly with underdeveloped community provider networks— “Although Congress mandated that VCA must begin within 90 days of passage of the legislation, no guidelines were provided in the legislation to ensure that Veterans had access to an adequate number of community providers across different specialties of care or distinct geographic areas, including rural areas of the country” (Mattocks 2017, s71). 90 days was far too little time for all of the necessary communication channels to be established and a solid community provider network to be set-up.

As a sub issue of this finding, dangers already inherent in dual use of healthcare systems such as care fragmentation and duplication of services are amplified since the VCA was not given proper planning prior to implementation to allow for necessary communication channels for the VA and non-VA community-based providers to correspond about veterans who may be accessing both systems. “The VA must develop a more effective way to integrate non-VA data for VA

providers, perhaps by requiring laboratory, imaging, and provider notes from outside VA to be seamlessly embedded with VA data in the relevant sections of the EMR (electronic medical record)” (Gellad 2015, 2). However, at this point, non-VA doctors “do not have access to the VA’s EMR and ordering systems, leading to risks of duplication of services, errors, and inefficient care” (Gellad 2015, 1).

Currently the VA holds contracts with two subcontractors, TriWest and Health Net, who approve veterans for Veterans Choice Card usage and then set up appointments for approved veterans with community providers (Finley 2017, s61). As Turek explains, “when scheduling appointments with non-VA providers, VA schedulers unnecessarily play middleman. Making an appointment with a non-VA provider could be a simple process that the veteran could handle alone, but is not able to with the current system” (2017, 223). The middleman role that the subcontractors play is bogging down the process—“ Veterans experienced substantial delays while waiting for their non-VHA appointments through Choice, and often, these wait times were longer than the VHA waiting time would have been had their appointment remained in the VHA” (Mattocks 2017, s74).

As a bright spot, community providers already approved as part of the VA’s Patient Centered Community Care (PC3) program were automatically enrolled as VCA-approved providers. However, other community providers interested in becoming VCA approved have faced a challenge. Finley et. al. reported “low satisfaction with the process of VCP authorization and referral among the few providers who had attempted to join the program” as well as little awareness of the Veterans Choice Program among providers in Vermont and Texas (2017, s67).

VA providers produce high-quality care. The second finding to report from my literature review of the VCA is the quality of VA care as compared with non-VA providers. In fee-based (non-VA) versus VA colonoscopies there was a lower adenoma detection rate (ADR) among the non-VA providers which is generally accepted in the medical community to mean that the doctors took less time and were less thorough at screening for precancerous polyps. Bartel concluded, “lower ADRs raise concern that referring veterans outside the VA system may impact colonoscopy quality” (2016, 1). Older men (65 and up) who suffered acute myocardial

infarctions (heart attacks,) heart failure or pneumonia and were hospitalized at VA facilities versus non-VA facilities had “lower 30-day risk-standardized all-cause mortality rates” (Nutti 2016, 1). For those seeking care for PTSD from non-VA community providers “only 15.0% of providers reported regularly conducting psychotherapy for PTSD following a treatment manual, and fewer than half reported any use of evidence-based psychotherapies (EBPs) for PTSD with patients” (Finley 2017, 1). In each of these studies, the medical care provided by the Department of Veterans Affairs was as good, if not better than, the care provided by non-VA services.

Reasons given for the VA’s comparatively high performance were their understanding of veterans and veteran issues (Lacoursiere Zuccherro 2016, 6). The VA is a leading provider for issues more prevalent in veterans such as PTSD and understand the “military culture” better than general community providers.

Rural and women veterans face significant challenges to access VA care. The third finding from my review of literature regarding the VCA is that rural veterans and women veterans face significant challenges when attempting to access general VA care because of wait times, distance and special needs. Rural veterans, regardless of gender, face difficulties when accessing healthcare for various reasons. Lee refers to these issues as “innate challenges of rural care delivery [which] include provider shortages, geographic barriers, lack of transportation options and rural community hospital closures (2016, 374).

Health professionals are lacking in rural communities for both VA and non-VA care. In a study attempting to pinpoint locations within the U.S. that are health professional shortage area counties, Doyle found that “of the 21 million total Veterans and the approximately 9 million VHA enrollees in the [U.S.] between 23 and 24 percent live in Shortage Area Counties. Similarly, about one-quarter of veterans older than 65 years live in Shortage Area Counties while about 22 percent of women veterans live in these areas” (2017, 465).

When there are VA facilities nearby they may not have specialists needed to treat certain conditions. As Mattocks noted in her qualitative examination of VCA implementation “Many staff and providers at rural VAMCs noted that the availability of specialty providers across the

state or region was low to begin with, particularly for highly specialized fields like gynecologic oncology.” She further detailed that “As a result, many veterans who may have had to wait 35 days for care in the VA were being shifted to the community, where wait times could approach 3–6 months for certain specialty services (2017, s73).

The VA has begun to implement mental healthcare via telemedicine at VA facilities that do not have such services on staff but Lee suggests “[the VA] should strive to extend VA telehealth links beyond the walls of the VA, into community hospitals, clinics and patients’ homes, making care even more accessible and convenient to rural veterans” (2016, 376). But, even when there are VA facilities and specialists available, the VA may not be a place conducive to all populations. For example, “among those with a military sexual assault history, was the perception that VHA’s environment was unwelcoming; being ‘surrounded by men’ yielded emotions ranging from discomfort and mistrust to severe anxiety” (Kehle-Forbes 2017, 1). Suggestions offered to ameliorate these feelings include private waiting areas for women for primary care appointments, women-only mental health groups, and teletherapy in order to unite women from different areas with a specialized provider (Kehle-Forbes 2017, 6).

Overhaul of the VHA. Finally, three pieces of literature were reviewed that suggest the Veteran Health Administration (VHA) completely overhaul their organization. These recommendations were for the VHA to focus on their large medical centers and treatment of service-connected wounds and disorders while allowing other VA-care eligible veterans to see community-based providers for regular check-ups and routine issues—“veterans who have a cold, need allergy medication, or have a sore back should be able to go to an approved primary care provider location instead of scheduling an appointment at a VA facility. This would allow VHA to clear up waiting rooms, shorten wait times, and provide more intensive and focused care for veterans with more serious medical needs” (Turek 2017, 226). VHA would play the “payer” role as private insurance companies do for these community-based visits instead of trying to see all VA-care eligible veterans themselves. By doing this, the VA would rein back their commitment to smaller VA health facilities in satellite locations and limit their staff. This could provide a prime opportunity for the VA to share some of their evidence-based best practices with the community providers veterans access, as well as learn from them— “As VHA becomes more of a payer as

well as a provider of health care under the Veterans Choice Act, there will be more opportunities and motivations for studying cross-system coordination and comparisons of implementation contexts” (Ducharme et. al. 2015, 116).

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## SIGNIFICANCE

My first finding, that the VCA was implemented too rapidly with inadequate community provider network building, is significant to our project as it raises the question of whether or not necessary changes have been made since this research to make the VCA a worthwhile policy. As we study the policy implications of the VCA, keeping in mind its upcoming fund depletion, we must know whether the flaws from the Act’s infancy have been improved so we know whether to advise extension or non-extension of the VCA to the Congressman and his staff.

My second finding, that VA care is often similar in quality or better than that of non-VA providers is significant to our project as it raises the question of whether the VA should partner with community providers to care for veterans at all as the quality of care may be less than they receive at VA facilities. As we continue to study the policy implications of the VCA we must consider the idea that VA care is best for veterans and that the VCA and policies like it may actually lower the quality of care for veterans.

My third finding, that rural and women veterans face significant challenges when attempting to utilize VA care is significant to our project as we must keep these populations in mind when making recommendations about the future of the VCA. VCA was enacted with the goals of reducing wait times and accessibility obstacles (such as distance) at VA facilities, and thus, even as we acknowledge the negatives about the policy as detailed above, it is a step in the right direction for populations with special needs because of wait times, distance and unique health concerns.

Lastly, the finding that recommendations exist for the VHA to totally overhaul their structure is significant to our project as we must ensure we do not consider the VCA and its policy implications as the only option for expansion of community-based provider services to VA-care

eligible veterans. It is important for the Congressman and his staff to hear all viable options from us in order to best decide how the veterans of the 8th Congressional District should be served.

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## IMPLICATIONS

Even though VA care may be just as good as non-VA care or better it does veterans no good if they are not being seen because of long wait times, great distance to VA facilities, or special needs not met by the VA. Implications stemming from our research on the Veterans Access, Choice and Accountability Act of 2014 (VCA) are that even with all of its flaws, it does what it can to bridge the gap between what veterans need and VA care by utilizing community-based providers. However, the VA must do a better job moving forward to build a strong community-based provider network and streamline the process to become a VCA-approved provider. Also, the VA must plan for and build communication channels to simplify interactions between community-based VCA approved providers and the VA—as Lee advised “as more veterans access care in their local communities, integration and care coordination of VA and community health care services will become even more important” (2016, 374).

The VA must also reevaluate their use of subcontractors to run the VCA process—as it is currently set up the VCA process is taking longer than the VA wait times veterans are using the VCA to avoid. Recommendations that the Veterans Health Administration (VHA) consider a complete overhaul of their operating system must also be considered as an alternative to the VCA.

## THEME 3: HOMELESSNESS AND SUICIDE AMONG VETERANS

I began my study of homelessness and suicide among veterans by conducting a word phrases search of homeless veterans, homeless veterans and suicide, homeless female veterans, women veterans and homelessness and suicide, homelessness in rural areas and veterans, rural homelessness and veterans, housing instability and veterans and housing for veterans and homeless within 940 unduplicated data bases available through the Texas A&M University

library system using EBSCOhost. I narrowed the scope of my research to scholarly journals found between 2011 – 2017 and later refined my search to 2014 – 2017 reviewing 65 of those that pertained to access to healthcare, thirty were appropriate, for my literature review section on homelessness and suicide among male and female veterans living in rural areas because they met my criteria.

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## CHARACTERISTICS

Risk factors for homelessness among veterans and those dwelling in rural areas. The commonality throughout my study that homelessness causation falls into three basic risks which are substance use disorder (SUD), mental health (behavioral health), and unemployment (financial instability) (Cox, Malte and Saxon 2017; Creech et al 2015; Metraux et al. 2017). There were unique risks that appear several times such as Post Traumatic Stress Disorder (PTSD), Military Sexual Trauma (MST), and Traumatic Brain Injury (TBI) that are in relationship to homelessness and rural living among veterans that were imperative to my study towards access to healthcare (Brignone et al. 2016; Kirchner et al. 2011).

Risk factors for homelessness among women veterans. Homelessness or the risk of homelessness is not gender bias but there are unique challenges for women veterans such as reintegration after post-deployment (Reppert, Buzzetta, and Rose 2014) with mental health and relationship issues relating to MST (Hamilton, Poza and Washington 2011). There is a potential for further research on the topic of homelessness and suicide rates of women veterans and their access to healthcare in the postmodern era as they experienced more combat time than their counterparts in earlier history (Mankowski and Everett 2016).

Risk factors for suicide among veterans. Suicide and attempted suicide risk factors among veterans are mental illness due to the reluctance to seek care or scarcity of providers (Thorne et al. 2017,42), and mental fatigue due to multiple deployments (Ganzer 2016, 33) and the stigma of a “non-routine” discharge (Brignone et al. 2017, 557).



Housing stability for veterans. Ending homelessness among veterans is a priority of the Veteran Affairs (VA), Housing and Urban Development (HUD), and for the last three administrations. For my study the definition of homelessness is further defined and categorized by the VA and HUD using the Homeless Emergency and Rapid Transition to Housing (HEARTH) criteria which is the key to housing stability (Balshem et al. 2011) and access to care for homeless veterans who face the challenges of SUD, mental and behavioral health, financial instability, and suicide ideation.

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#### SIGNIFICANCE

I found during my research that during the Bush Administration the VA began the mandate to end homelessness. “The government began requiring communities to conduct and report annual Point-In-Time (P.I.T.) counts of homeless individuals on one designated night in January.” In 2016, the P.I.T. count estimated over 550,000 individuals as homeless. The greatest number of homeless being male, single, and middle aged but recently there has been a shift in homeless women and families who present unique needs. The P.I.T. count currently showed a decrease of 47% in Veteran homelessness nevertheless there still continues to be a homeless problem among our veterans today (Tsai, O’Toole, and Kearney 2017, 113 - 114).

“Beginning in 2001, the Global War on Terrorism has been the longest war in our nation’s history, drawing upon unprecedented numbers of National Guard and Reserve personnel, involving multiple, repeated deployments for many service members, and entailing a unique kind of warfare (Sherman, Larsen and Borden 2015, 355).” Veterans face unique risk factors for homelessness and suicide. The risk factors to homelessness for veterans are transitioning from military to civilian life due to the lack of preparedness (reintegration issues), loss of employment and relationship termination, mental and behavioral health issues, childhood trauma and lifetime of poverty, and substance use disorder (SUD) are factors that are related to veterans becoming homeless (Creech et. al 2015, 620; Metraux et al. 2017). Research found that “45.7% of veterans with chronic homelessness reported having both SUD and mental health issues.

Homelessness can become a barrier to gaining employment, treatment for SUD and mental health (Cox, Malte, and Saxon 2017,208).”

Women are not the only victims of Military Sexual Trauma (MST) but men in the military also face the same trauma but never report the incident or incidents until years later. “Recent research by Brignone et al. (2016) suggest that MST may be a determinant in several factors associated with post deployment homelessness (582).” In 2004, the VA began screening Operation Enduring Freedom (OEF)/ Operation Iraqi Freedom (OIF) veterans for MST. The research conducted found that “MST was significantly associated with homelessness with men compared to women (585).” This could be because most men in the military do not report incidents of this nature until years later after seeking assistance with homelessness and other mental and physical issues surface.

There is a difference in rural and urban homeless veterans and how they access care. First, a need to understand the unique culture of rural dwellers which they are “self-reliant and self-sufficient” (Adler et al. 2015, 49). They are more likely to depend on family or community support and less likely to seek outside services beyond what they are familiar within their community. The key to understanding the rural culture is to get to know the community as a whole, know the resources within the community, begin to build trust, and build a cultural competency which takes time. (Adler et al. 2015, 51). Rural culture can prevent homeless veterans from access to mental and behavioral health services, lack of affordable housing and transportation options (Adler et al. 2015, 47). The VA established Community Based-Outpatient Clinics (CBOC) for the rural veterans in mind. The limitations of the CBOCs that is “1 case worker per 4 CBOCs and the need of non-health services (Adler et al. 2015, 48).” The findings from the study done by Dittrich et al. (2015), findings indicated that rural veterans had higher odds of being currently depressed when compared to their nonrural counterparts. This was also the case for lifetime depression (428).” Depression is also a barrier in obtaining employment. In 2011, Iraq and Afghanistan veterans aged 18 to 24 experienced an unemployment rate of 30.2% compared to 16.1% of same-aged civilian (433).” Consequently, the study “suggested that mental health care might be improved through community outreach efforts in rural areas (433).” In 2007, the VA established the Office of Rural Health for veterans who dwell in the rural areas so they can have

access to physical and mental health care. Research by Kirchner et al. (2011), “indicated that 1 in every 4 – 5 veterans will return from war with some serious mental illness, most commonly depression (14%), Post Traumatic Stress Disorder (PTSD) (14%), or Traumatic Brain Injury (TBI) (19%) and these illnesses are often complicated by substance abuse. They found a way to form a link between these informal care networks and the formal care system is essential for providing care in the rural areas.” They identified community facilitators as clergy, postsecondary educators, and criminal justice personnel as those who are mainly significant for OEF/OIF veterans in rural areas. They identified community facilitators as clergy, postsecondary educators, and criminal justice personnel as those who are mainly significant for OEF/OIF veterans in rural areas (Kirchner 2011, 417). These three collaborates working together have been the key to rural veterans getting the help they needed. A study done by McInnes et al. (2015) revealed that there are “49,900 homeless veterans which comprise 11% of the U.S. homeless population.” The research “indicated that information technologies (IT) such as mobile phones may improve access and utilization to health care by homeless veterans especially those who dwell in the rural areas(2).” With the use of mobile phones and the current technology veterans can easily access their records, doctors, etc. and vice versa the doctors and nurses can have access to the patient.

There are over 14,000 female veterans compared to the 127,000 male veterans. Female veterans represented 9.8% of the homeless veterans population. “Recently, homeless female veterans' needs appear to be related to physical health problems whereas recently homeless male veterans needs appear to be related to substance abuse and emergent care (Montgomery and Byrne 2014, 237).” The shift in the mindset of the VA is not to assist homeless veterans but to prevent the risk of homelessness and homelessness among veterans. Risk factors that cause homelessness among female veterans are the incidents that cause them to “flee from violence or abuse as the primary precursor to homelessness. The other risk factors for female veterans at risk of homelessness are women who are 35 – 55 yrs. old, adolescent childbearing, low-wage employment or unemployment, lack of an affordable housing, disability, poor health, PTSD, or anxiety disorder.

Programs that enable veterans to remain in housing, affordably, as their needs increase may increase their housing stability (Montgomery et al. 2015 42 – 47).” It is estimated that female

veterans will increase by 17% over the next two decades and roles in the military will steadily be evolving (Montgomery and Byrne 2014; Reppert 2014). Continued research is needed on risk factors and prevention of at risk of homelessness and homelessness among female veterans. Female veterans face unique challenges in transitioning back into civilian life. To better understand female veterans, you would have to understand the military culture in general and the specific branch they served in. Career advancements, lower rate of promotions are just a few of the limitations women face in the military. Barriers for female veterans are decreased social support and increase family responsibility due to them being single with children when they enter the military. Women have the tendency to remain silent about their gender related health concerns as a result they do not seek health care due to wanting to appear strong (Reppert 2014). Hamilton, Poza, and Washington (2011) found that a predominant root of homeless women veterans is a pattern of victimization of those who prior to military service were abused and again experienced military sexual trauma (MST). Revictimization damages self-esteem and sense of safety among women (s207). For women veterans reentering civilian life and the lack of affordable housing has created a new subpopulation of women homeless veterans. “Safety concerns among VHA homeless programs, noting the prevalence of sexual harassment and assault reports and the lack of segregated housing for women with children. Recognizing the marginal resources of community based agencies caused by dwindling budgets and increased needs, and coupling this with the unique needs of post deployed homeless women veterans creates a perfect storm of unintended consequences and inadequate service provision for women veterans and their children (Mankowski and Everett 2016, 26).”

Veterans have demonstrated signs of fatigue due by “multiple deployments of unusually long duration, leaving less “dwell time,” the amount of time service members spent at their home stations between deployments. Dwell time affords service members a mental and physical break from combat and gives them time to reconnect with family. There is evidence linking dwell time to post deployment mental health (Ganzer 2016, 33).” Suicide has increased in the past ten years among military service members. There are “five mental health disorders found to be predictive of post enlistment first suicide attempts: pre-enlistment panic disorder, pre-enlistment PTSD, post-enlistment depression, and both pre and post en-listment intermittent explosive disorder. Female soldiers were at significantly higher risk for suicide than male soldiers (Ganzer 2016,

36).” Research studies “indicated that VA patients in rural areas had more physical comorbidities and worse health-related quality of life than those in suburban or urban areas and that they had reduce access to health services and fewer alternatives to VA care (McCarthy et al. 2012, S111).” Barriers are “continuity of care” and “greater access to firearms” which might contribute as a risk factor of suicide among male veterans but the most common suicide method by female veterans is poisoning (McCarthy et al. 2012, S112).” The research conducted by Schuman and Schuman revealed that suicide is the second leading cause of death for U.S. service members (2016, 538). The stigma of seeking mental health prevent those who are facing suicide ideation, anxiety disorders, PTSD, and other diagnosed and undiagnosed mental disorders. This very common among veterans who live in rural areas due to the anonymity or the lack of in a small town (Thorne 2017, 43). The study by Thorne et al. (2017) “found that 34% of individuals with long-term suicidal ideation make a suicide plan and, of those who plan, 72% attempt suicide. Further, 26% of individuals with long-term suicidal ideation who do not make a suicide plan will still make a suicide attempt (44).” Veterans who have been diagnosed with Traumatic Brain Injury (TBI) have been linked to having a high risk of suicide ideation. “TBI is a type of acquired brain injury that occurs as a result of a blow, jolt, or bump to the head or a penetrating injury that disrupts brain function. TBI has been diagnosed among more than 333,000 service members since 2000. Repeated Traumatic Brain Injury (rTBI) can result in damage to the cerebral axons and lead to symptoms such as impaired judgment and impulse control, memory loss, confusion, aggression, and depression (Palladino, Montgomery, and Fargo 2017, 34).” Thorne et al. (2017) correlates Posttraumatic Stress Symptoms (PSS), rural living and suicide risks factors such as “reluctance to seek mental health care, scarcity of mental health providers, poor provider quality of mental health care, and increase access to firearms (42).”

Another vulnerable subpopulation of veterans, are those who have been “non-routine discharged” who have experienced a causal pathway to homelessness and suicide. There are 126,631 veterans out of 443,360 who had a non-routine discharge due to disqualifications, misconduct, mental health, SUD, or suicidality (Brignone et al. 2017, 557). The non-routine discharge creates a stigma and hinders their reintegration into civilian life. They possible carry with them mental and physical trauma due to combat but do not qualify for healthcare due to their non-discharged status. Risk factors that set Veterans and civilians apart are drug problems

and perceptions of unmet mental health care. These predictors can be critical to screening for suicide and other suicide preventions efforts for veterans of recent conflicts (Logan 2016, 403).”

“The solution to housing instability is to have an increased awareness of housing status and proactive referral to housing services may provide opportunity to decrease risk of psychological distress and suicide ideation associated with loss or threat loss of housing (Bossarte 2013, 205).” Researchers found that providing homeless veterans “stable housing improves health outcomes among homeless and enhances engagement in mental health care, addiction treatment and chronic disease management (Johnson et al. 2017, 167).” The VA has been delivering permanent housing solutions and letting go of historically dominant approaches based on “housing readiness (Kertesz 2017, 128).” The VA defines “Housing First (HF) combines permanent supportive housing and supportive services for homeless individuals and removes traditional treatment-related preconditions for housing entry. The U.S. Department of Veterans Affairs (VA) has transitioned to an HF approach in a supportive housing program serving over 85,000 persons (Kertesz 2017, 118).” Finding supportive services after housing homeless has been successful but improvement in accessing care and increasing the number of affordable housing units are still needed. (Kertesz 2017, 128).

The sense of community and belonging is key to self-esteem, with that comes a stable housing environment. The VHA is the first stop most homeless veterans seek help they should also be the first to give referrals to supportive services. A holistic approach to helping veterans is a collaborative effort from community support in housing, financial, and emotional stability for veterans.

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## IMPLICATIONS

1. In 2013, the VA began to screen all vets eligible for VA healthcare for eminent risk of homelessness and connecting veterans to support services. (Bossarte 2013, 215)
2. Since 2004, new rules of screening for MST for potentially early markers for homelessness began. (Brignone 2016, 583)

3. 2012, Department of Defense (DoD) and the Veterans Affairs (VA) combine efforts to prevent the risk of suicide by working on a Suicide Prevention Campaign. A new standardize reporting process was implemented, Suicide Prevention and Application Network (SPAN) as a national database on all individual suicide events and deaths are reported by the VHA. (Schuman and Schuman 2016)

#### THEME 4 - HEALTHCARE

I began my study of Veteran Healthcare by searching through the Texas A&M Library EBSCO Database using the search term “Veteran Healthcare.” I followed this with a search of “Veteran Healthcare Access” which produced 6,272 results. These articles spanned veteran healthcare for other countries outside of the United States, and the subject matter of the papers was specified to a certain type of disease or location. To narrow the field, I added “rural” in my search, and was able to find 5 articles to be included in our literature review. The next search I performed was “Veteran Healthcare Women,” which produced 7,453 scholarly articles, and “Veteran Healthcare Female,” producing 4,504 results. An initial view reveals there is overlap in these two lists. After these searches, I made the decision to move away from specific terms (“access,” “rural,” “female”) and searched “Veterans Healthcare Administration.” This search produced 91,619 scholarly, peer reviewed articles written in the last ten years. My final search was on “VHA Wait Times.” 176 articles were available in the A&M Library database. Of these results, I exported 29 scholarly, peer reviewed articles to RefWorks for further analysis and review. 21 of the 29 articles read are pertinent to our study, and of those 16 are included below in my findings.

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#### CHARACTERISTICS

Through my literature review, I identified three characteristics that are important to note when discussing veteran’s healthcare. The first item of importance is that veterans have different needs when seeking medical attention compared to non-veterans and personalized, patient centered care is vital. It is important the VHA has performance measures in place that they are working towards. Second, female veterans have needs that are different from male veterans, and there are

opportunities for improvement to meet these unique needs. The third characteristic of importance is understanding how rural and aging veterans use the VHA system.

Performance measures of the VHA. Veterans have different needs when seeking medical attention compared to non-veterans. “Through their military experience, Veterans become ingrained with shared values, beliefs and attitudes that characterize their everyday existence. Characteristics seen within the cultural group include positive qualities such as a strong sense of duty, honor, loyalty and commitment to fellow soldiers” (Nathaniel and Hardman 2017, 2). Veterans more frequently than non-veterans experience PTSD, brain and spine trauma, military sexual trauma (MST), and difficulty adjusting back to civilian life upon return, especially from war zones. These issues can cause veterans to feel guilt, and “and feelings of weakness for experiencing mental and physical needs” (Nathaniel and Hardman 2017, 2). For these reasons, it is vital that healthcare providers within the VHA system are offering timely, personalized, patient-centered medical care across many disciplines that meets the varying needs of each veteran (Shay and Yoshikawa 2010, 22) (Asch and Kerr 2016, 51).

How we understand if these needs are being met, or what the performance measures of the VHA are, is currently unclear. These performance measures have been inconsistently measured in the past, due in large part, to the inconsistency and lack of clarity on the governance structure of the VHA and who is accountable for these measures (Campbell 2016, 74). The goal that is most commonly noted among scholarly papers is “timely, patient centered care” (Shay and Yoshikawa 2010, 26-27) (Fletcher, Mitchinson, et al. 2017, 32) (Asch and Kerr 2016).

A clear example of inconsistent performance measures is the VHA wait time scandal. When the VHA scandal broke in 2014, and continued into 2015, it showed that the VA was not meeting the goals of its 2013-2018 published strategic plan to provide timely medical care to veterans (Campbell 2016, 75). Starting in 2014, VA wait times have been publicly posted, and the VA determined that wait times would be recorded for new patients when they request an appointment (Shulkin 2017, 52-53). There is concern that wait time numbers are unreliable, as hospital administration receives bonuses for lower wait times. The “integrity of the data may be called into question” (Robbins 2012).



In September of 2014, a MyVA Reorganization plan was launched with the intention of changing “the agencies process to allow for “top level customer service,” in alignment with the current strategic plan” (Campbell 2016, 77). This reorganization plan included stakeholders, nonprofits organizations, employees and veterans receiving medical services. “While the VHA strategic plan articulates that one of the three goals is the achievement of measurable improvements in health outcomes, there is no clarification within this tool for accountability” (Campbell 2016, 78-79). Since 2014, VA wait times have been publicly posted, and the VA determined that wait times would be recorded for new patients when they request an appointment (Shulkin 2017, 52-53). This was a first step in tracking measurable performance goals.

Female Veteran Needs. In the past decade, the number of female veterans in the VA system has doubled, and 40% of those women are racial and ethnic minorities (Brooks, Dailey et al. 2016, 1) (Carter, Borrero et al. 2016). In 2011, 65% of all VHA patients were women, making them the fastest growing patient group in the VHA (Reddy, Rose et al. 2016, 648). Research shows that, beyond basic difference in medical needs (obstetrics and gynecology, female cancer screening, etc.) there are more female mental health conditions than men, and it is notable that one in four women screened in a VA report military sexual trauma (MST) (Koblinsky, Schroeder, Leslie 2017, 122). Recovery from brain trauma and mental illness looks very different for women veterans than it does their male colleagues, and women more often had worse outcomes than men (Rogers, Smith et al. 2014, 1406-7).

Beyond the basic medical differences between male and female veterans, there are barriers preventing women from receiving equitable and quality care from the VHA. Women veterans do not feel that they deserve to be treated at the VA, and frequently when they do seek out medical care from the VA, they do not get viewed as a veteran. This increases the perceived stigma of not deserving treatment (Brooks, Dailey et al. 2016) (Koblinsky, Schroeder, Leslie 2017). This feeling is enhanced by the notion that when their needs are not “urgent,” and they feel overlooked in the VA system. Additionally, female veterans lack opportunities for social support among female veterans (Koblinsky, Schroeder, Leslie 2017). The VA is perceived as being male

oriented, and women need to feel safe and valued when receiving medical treatment (Brooks, Dailey et al. 2016).

Women's Health Clinics (WHC) provide specialized care to female veterans. These clinics are located within the VHA, and provide both preventive care as well as life spanning medical care. This create a safe and engaging environment specifically for women (Reddy, Rose et al. 2016, 649). However, not all VHA have WHC, as only larger VHA have budgets specific for women's health (Reddy, Rose et al. 2016, 649). Research shows that WHC have a positive impact on meeting the needs of female veterans using the VA. "In the VHA and other American health care systems, previous research suggests WHCs are associated with higher patient satisfaction" (Reddy, Rose et al. 2016, 653).

Rural and Aging Veterans. 40% of the veteran population are living in areas classified as rural, and 36.4% of veterans enrolled in the VA are living in rural areas (Johnson, Ruth, et al. 2015, 245). Overall, rural veterans have greater health needs than those living in urban areas however these individuals have the largest gaps in care of veteran populations and are most likely to be seen for urgent care issues in emergency rooms (Johnson, Ruth, et al. 2015) (West, Weeks, Charlton 2017). Rural dwelling veterans have higher suicide risks, substance abuse, domestic violence and depression (Johnson, Ruth, et al. 2015, 245).

While many rural dwelling veterans note that travel time is a barrier to receiving care, others state that it is economic factors that reduce their VA care usage (Koblinsky, Schroeder, Leslie 2017) (Teich, Mir et al. 2017, 298). Rural dwelling veterans are most likely to be dual VA and Medicare users, although they are seen less often in both VA and non-VA locations than their urban dwelling counterparts (West and Charlton 2016).

Aging veterans have unique issues of their own, as many of them live with multiple chronic medical issues (Shay and Yoshikawa 2010, 21). Aging veterans struggle with impediment to activities of daily living (ADL). 46.4% of veterans receiving healthcare through the VA are over the age of 65 and 13% of veterans enrolled in the VA are 85 years and older, and have 3 or more hindrances to ADL (Shay and Yoshikawa 2010, 22). There is a shortage of geriatricians that are

trained in multiple disciplines that can meet the many needs of this group of veterans. The VA maintains nursing homes and community living centers, however, these facilities have been used primarily for transitions, and not a permanent care; work is being done to improve and upgrade these facilities (Shay and Yoshikawa 2010, 25).

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## SIGNIFICANCE

The ability to access care that is patient centered, personalized and timely are key tenets of the strategic plan of the VHA (Campbell 2016). More importantly, the VHA must focus on what matters to patients and how they heal (Fletcher, Mitchinson et al. 2017, 32) As we look at the VHA expenditures and the utilization rates of their services in the 8th Congressional District, we need to determine if these performance measures are being tracked and met and where they are compared to state and national rates. We will need to look at the wait times tracked by the Conroe CBOC. Since we have an understanding of when wait times start being recorded, we can determine further who is eligible to participate in the VCA.

Women's Health Clinic (WHC) provide better quality care to female veterans since they are able to provide patient centered care that is unique to these patients. However, not all VHA's have access to have a WHC onsite. Larger VHA are given budgets specific to women's health (Reddy, Rose et al. 2016, 649). As we evaluate the Conroe CBOC and VHA in the 8th Congressional District, we will need to evaluate if there is a WHC available for the female veterans residing in the district. If not, this potential gap in services will be important to examine.

A great percentage of the 8th Congressional District is classified as rural. The needs of these veterans will need to be taken into great consideration as we further explore the expenditures of the VHA and usage by these veterans. Looking at dual usage between Medicare and VA will also help us better determine how constituents in the district are utilizing the CBOC.

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## IMPLICATIONS

Veterans have different needs when seeking medical care than non-veterans, and unique groups within veterans have more specific needs that are not always readily met by the VHA. It is challenging to compare what works in the private sector directly to the VHA, especially when looking at wait times, however, it is important that the VHA creates measurable performance goals (Shulkin 2017, 53). Campbell states that “personalized, proactive, patient driven healthcare” is a goal of the VHA and it should be healthcare that is “timely, high quality, personalized, safe, effective and equitable” (Campbell 2016, 77). This matches the suggestions brought forth at the VHA State of the Art Conference: patient preference and need should be at the center of treatment and the way it is measured, and these measures should be clear and transparent so all individuals involved can fully understand what they are and if they are being met (Asch and Kerr 2016) (Shulkin 2017, 53). These personalized care measures should be evaluated when looking at the VHA as a whole, but even more so as we look at meeting the needs of female veterans, those living in rural areas, and aging veterans.

## CONSOLIDATED FINDINGS

### GAPS IN RESEARCH

We have identified the following gaps in research:

1. Information specific to the 8th Congressional District. In general, there is a gap in scholarly research specific to the 8th Congressional District of Texas and its veteran residents.
2. Specific expenditures within the VA. Through our literature review, elite interviews, and action research we were not able to determine much money is going to each VAMC or how much goes to the CBOCs within each VAMCs service area. Of specific concern to us is, how much goes to the Conroe CBOC and by what method (allocation or reimbursement). We have also not been able to locate numbers on how much is spent on specialty care and other line-item expenditures.<sup>11</sup>
3. VA healthcare expenditures per capita. We have identified this as a gap in information as one can access Medicare expenditures per capita but not for the VA.

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<sup>11</sup> Note: A FOIA request was sent to the FOIA contact at the VA, listed as Stephanie Graham. See Appendix 5 and 5.1.

4. How many unique veterans are actually utilizing the Veterans Choice Card program. We assume there is information within the VA on these numbers since non-VA providers have to file claims with the VA but have not been able to access usage data (see assumptions).
5. Implementation of the Veterans Choice Act since 2015. Peer-reviewed research only covers the first year of implementation since the law was so recently enacted due to lag time in publication process.
6. Veteran homelessness and suicide scholarly research. Most of the studies we reviewed were completed in one state but did not compare to other states. Tracking for eminent risk of homelessness by the VA health facilities began in 2013 so prior documentation was sporadic. The Department of Defense and the VA tracked veteran suicides separately until 2012 when they combined efforts creating a national database, the Suicide Prevention and Application Network (SPAN).

#### CROSS-CUTTING LITERATURE REVIEW FINDINGS

Cross-cutting literature findings are as follows:

1. The VHA Strategic Plan was mentioned frequently in our research, however there is concern about the implementation of it due to the governance of the VHA and the lack of clear accountability. There are some suggestions of a complete overhaul of the VHA system.
2. Mental health is a significant issue for veterans, especially among OEF and OIF veterans.
3. Wait times remain a concern even after the implementation of the Veterans Choice Act. Appointment wait times continue to be lengthy for veterans who utilize the VCA and those who do not.
4. The VA is a leader in veteran-specific medical needs and often provides just as good, if not better healthcare than non-VA providers.
5. Telemedicine is becoming an increasingly available option to provide care to rural, aging, and female veterans. Telemedicine can “meet” rural and aging veterans at locations convenient to them. Telemedicine provides an opportunity for the VA to address female-specific mental health groups needs when the number of female veterans in one location is not high enough to merit gender-specific groups or facilities.

6. There are a high number of veterans who are “dual users,” and access two health systems at a time (VA and a private health insurance plan or VA and Medicare/Medicaid.) A major concern is how to achieve continuity of care when veterans utilize two systems. A major barrier to this continuity is non-VA providers do not have access to the electronic medical records (EMR) of the VA.
7. Female veterans have gender-specific medical needs that are not regularly being met by VA health care. VAMCs are described as uncomfortable and unwelcoming to female veterans.

## REFINED RESEARCH QUESTIONS

Our 11 refined research questions are listed:

1. Is there a tracking mechanism to track dual usage of healthcare systems among veterans in the 8th Congressional District? If not, can we look at studies done in other areas to extrapolate data?
2. How many VCA-approved community providers already exist within the 8th Congressional District compared to Texas and the nation? What is the current process to become a VCA-approved community provider? Is there a financial incentive for a community provider to become VCA-approved?
3. Who has utilized the VCA in the 8th Congressional District, and how does it compare to Texas and the nation?
4. Has the number of veterans using VA-approved community care increased since the passing of the VCA in the 8th Congressional District, and how do these numbers compare to the state and the nation? What is the comparison to number of vets who had access to VA-approved community care through Patient-Centered Community Care (PC3,) the predecessor program to the VCA, and those who now have access using VCA?
5. How are the VA and non-VA providers currently communicating regarding the VCA-approved community visits? How can communication be improved between the VA and non-VA providers?
6. What are the wait times in the 8th Congressional District compared to Texas and the nation? How do they related to health expenditures (services offered, planning and resource management)?
7. What services are offered to female veterans at the Conroe CBOC? What percentage of veterans in the district are female, compared to Texas and nation? What is the population of female veterans compared to male veterans in the 8th Congressional District, Texas and nationally?
8. What is the rural versus urban access to mental health care in the 8th Congressional District, versus Texas and the nation and/or are there differences between rural and urban access to mental health care?

9. What are the rates of MST per gender compared to homelessness? How many veterans report MST? How many veterans reporting MST are homeless?
10. What information exists on homelessness and suicide among veterans in the 8th Congressional District? How many veterans are at risk of homelessness? How many veterans have committed suicide, attempted suicide or report suicide ideation are homeless? What is the population of homeless female veterans compared to homeless male veterans in the 8th Congressional District, Texas and nationally.
11. What is the cost allocated per veteran in the 8th Congressional District, and how does it compare to Texas, and the nation? What is the cost spent per veteran in the 8th congressional district, and how does it compare to Texas, and the nation? What are the top line items in the 8th Congressional District, and how do they compare to Texas, and the nation?

#### LITERATURE REVIEW CONCLUSION

Through our hybrid literature review we were able to familiarize ourselves with the scholarly and non-scholarly research available, identify gaps in the research, and focus our initial research questions into 11 refined research questions.





### Consulting Capstone

## SCOPE OF WORK

### Executive Summary

Congressman Brady and his office are passionate for helping veterans living in the 8<sup>th</sup> Congressional District of Texas. It is important for the Congressman and his office to understand the needs of veterans, which of these needs are being met, and how they can reach veterans whose needs are not being met. Using a capstone project format, the Bush School EMPSA Nonprofit Capstone Team will be studying the following questions:

- What are the financial impacts of VA health expenditures in the 8th congressional district?
- What are policy implications of the Veterans Choice Act?
- What information exists about veteran's homelessness and suicide within the 8th Congressional District?

The capstone project, which is under the guidance of academic advisor Dr. Catherine Cole, will begin by gathering academic literature, case studies and secondary data. This information will be analyzed using content and comparative analysis, data analysis and regression analysis. The Capstone Team is committed to gathering information ethically and will not release information that is confidential in nature or that is not ready for public review.

The capstone team will provide two reports to the Congressman and his office. The first to be delivered in August with an update on the status of the project and a focused scope (to be determined by the academic literature review) of the questions presented above. The final report will be delivered in December. The Capstone Team and Congressman Brady's office will continue discussion regarding potential for a live presentation on the team's finding.

The Capstone Team will be working together to address the questions set forth by Congressman Brady's office. The team is committed to using the same passion and fervor in their research that the Congressman and his office have for meeting the needs of veterans in the 8<sup>th</sup> congressional district.

**Mission:** To provide sound academic research to Congressman Brady's office to enable evidence based decision making to promote the interests of veteran constituents in the 8<sup>th</sup> Congressional District of Texas.

**Vision:** To support an 8th congressional district where the needs of veterans are met through understanding and presentations of academic research and data analysis.

**Client Purpose:** To improve the lives of veterans.

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**Define the problem (or issue)**

**\*We expect these research questions to become more focused upon completion of our literature review**

**1) What are the financial impacts of VA health expenditures in the 8th congressional district?**

- How are VA healthcare facilities funded? (allocated vs. reimbursement/visit)
- How does the VA decide how much money the VHA distributes to VA facilities (VAMCs/CBOCs)?
- What are the trends of wait times for VA facility healthcare?
- What trends exist in expenditures per line item for last 10 years? (Conroe CBOC)
  - # of doctors available then versus today
  - # of nurses available then versus today
  - # of patients seen then versus today
  - # of specialties seen then versus today
- Where are patients coming to the CBOC from?
- Is the Montgomery County facility low or high in expenditures per vets in relation to national numbers?
- What is the veteran utilization rate for Conroe CBOC in relation to nationwide rates? Low/high/normal?
- How does the Texas 8th Congressional district compare to other TX districts?
- How does the Texas 8th Congressional district compare to all Congressional districts nationwide?

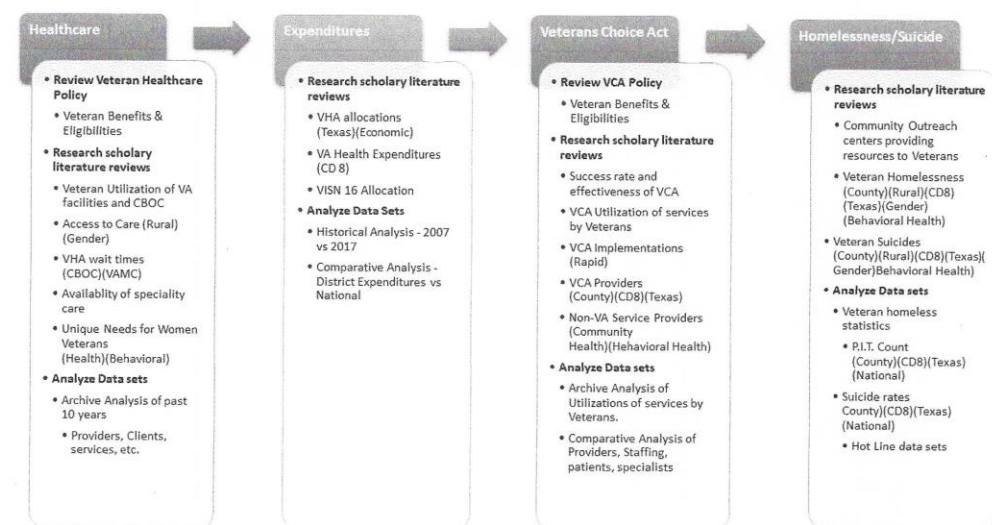
**2) What are policy implications of the Veterans Choice Act?**

- What money has been expended in TX-08 through the VCA?
- Out of total vets within our district who is actually eligible to use VCA? (based on distance to facility/ wait time)
- How many non-VA medical providers within our district have agreements with VA to accept VCA card?
- What percentage of veterans within TX-08 are being denied VCA access?
- Statistically, are more veterans being seen with the VCA versus without in TX-08?
  - Are more veterans being seen with the VCA versus without on a national level?

**3) What information exists about veteran's homelessness within the 8th Congressional District? How does this information relate to veteran suicide?**

- What are the current veteran homeless statistics within TX-08?
  - What are the current suicide statistics for TX-08?
  - Upon accessing veteran suicide data from our district, can we find out what medical/mental conditions they had prior to death?
  - What are the top trending topics for which veterans seek assistance?
-

## Project Road Map



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### **Data Requirements**

<b>Required Data</b> <i>(We have access)</i>	<b>Data Sources</b> <i>(Open Access)</i>	<b>Data Requirements</b> <i>(Request Needed for Access)</i>
<ul style="list-style-type: none"><li>•VHA Medical Expenditures by (TX-08)</li><li>•Total VHA Exenditures</li><li>•Total Unique patients in TX-08 (non-duplicated)</li><li>•Total veteran Poulation in TX-08</li><li>•% of Total VHA expenditure in TX-08</li><li>•MEDVAMC (Conroe CBOC) (# patient's served)</li><li>•Homeless VET Data (P.I.T. Counts) (County)</li></ul>	<ul style="list-style-type: none"><li>•va.gov/vetdata (GDX)</li><li>•Veteran population data</li><li>•Office of Budget &amp; Finance Data</li><li>•M.D. &amp; A - VHA line item</li><li>•AFR - VHA line item</li><li>•VA Audited Financial Statement's</li><li>•GDX of Medical Expenditures per county within TX-08</li><li>•# Unique patients served by MEDVAMC</li></ul>	<ul style="list-style-type: none"><li>•MEDVAMC - CBOC System Budget</li><li>•Conroe CBOC</li><li>•Operating Budget</li><li>•# veterans served</li><li>•# homeless veterans served</li><li>•# women veterans served</li><li>•P.I.T. Count of unsheltered &amp; Sheltered veterans in TX-08 (Counties)</li><li>•VCA DATA</li><li>•# patients eligible</li><li>•# patients utilizing VCA</li><li>•# patients denied VCA</li><li>•VCA Budget - MEDVAMC /CBOC (TX-08)</li><li>•Healthcare budget for homeless veterans within MEDVAMC network</li></ul>

### **Define the deliverables**

-**Scope of work:** Capstone team will complete document and get it to client by: EOB Thursday, 6/29

-**Weekly Updates:** Sent to Congressman's office each Friday after Thursday group meetings (bullet points and high-points fine.)

-**In Progress Report:** EOB August 11: to summarize the work of the first semester (literature review)

-**Final Client Report:** December, (paper, presentation) to summarize the work of second semester (data analysis)



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#### **Schedule the key meetings and presentations**

- **Thursday Team Meetings:** Each Thursday evening, 7 pm-Weekly Team Update
  - Call and Texts through Google Hangout
  - Call initiated by Mary Lu; will send reminder mid-day text
- **Friday Client Update:** Friday after Thursday group meetings, Weekly update sent to Congressman's office
  - bullet points and high-points fine. (Jeremy)
  - Approval from team and Dr. Cole before being sent
- **Thursday, 6/29, EOB-** Capstone team will complete scope of work and get it to client (Jeremy)
  - Jeremy will scan document in with signatures from Congressman's office
- **August 11, EOB:** will submit end-of-semester Progress Report to client summarizing the work of the first semester (literature review) (Jeremy)
- **December:** Final Report and Presentation
  - Deliverable 1) Final Report (Jeremy)
    - Include executive summary/abstract of report
  - Deliverable 2) Presentation (team) Congressman, 8th Congressional District Office, Chief of Staff.
    - In Person (via Skype if necessary)
    - TBD:Location of presentation; attendees of presentation

#### **Team Member Roles**

Project Advisor: Dr. Catherine Cole

Project Manager/Internal Point-Person: Mary Lu

External Communication: (nonprofit sector/ others as necessary/ FOIA requests): Terri

External Communication: (Congressman Brady's office/ VA knowledge): Jeremy

Secretary/Documentation: Bethany

#### **Client Roles and Expectations**

-Tracee Evans (Congressman's Communications Director,) main point of contact with Congressman Brady's office

-Todd Stephens (District Director) 2nd point of contact after Tracee, will be copied on any communication with the office

-Mary Cordes (Director of District Operations) 2nd point of contact after Tracee, will be copied on any communication with the office

#### **Expectations of Client's Office:**

- Client will assist with Congressional requests for information; Client will provide contact information for offices they work closely with that will be able to provide information to the capstone team.
  - Client will provide timely communication and feedback
  - Client and Capstone Team will renegotiate any changes to the scope of work after signing.
-

- Printing Funds (3 printed reports x \$150 = \$450,)
  - Postage (\$50)
  - **Trip to 8th Congressional District Office-**
    - \$500 (travel and meals)
  - **Trip to D.C.(potential):**
    - Flights (\$800 x 5= \$4000,)
    - 3 night accommodations (\$250/night x 3= \$750; \$750 x 5= \$3750,)
    - meal allotment (\$231 x 3= \$693; \$693 x 5= \$3465,)
    - ground transportation (\$200)
    - **Total for possible DC trip: \$11,415**
  - **Manpower:** to be tracked throughout the project
- Total Project Budget: \$12,415**

*By signing below, the Bush School MPSA Consulting team and the client indicate their agreement that this proposal accurately represents the purpose and goal(s) of the project, anticipated budget, and the plan to achieve them.*

**Client**

**Date**

Tracee L. Evans  
(Name and title) Tracee Evans  
Communications  
Director

7/10/17

**Bush School Team**

MARY LU SPREIER  
(Name of Team Member)

Mary Lu Spreier  
(Name of Team Member)

Jeremy Williams  
(Name of Team Member)

Jeremy Williams  
(Name of Team Member)

THERESA Willis  
(Name of Team Member)

THERESA Willis  
(Name of Team Member)

Bethany Castro  
(Name of Team Member)

Bethany Castro  
(Name of Team Member)

Catherine Cole

Catherine Cole

## APPENDIX 4: WAIT TIME HYPOTHESES AND ANOVA SINGLE FACTOR TESTING

### Wait Time Hypotheses and ANOVA Single Factor Testing

#### A. Audiology Wait Times

- a. **Null Hypothesis:** There is no difference in wait times for new audiology patients at the Conroe CBOC and average wait times for new audiology patients in Texas VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for new audiology patients at the Conroe CBOC and average wait times for new audiology patients in Texas VA Clinics.
- b. **Null Hypothesis:** There is no difference in wait times for new audiology patients at the Conroe CBOC and average wait times for new audiology patients in the Nation VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for established audiology patients at the Conroe CBOC and average wait times for established audiology patients in nation VA Clinics.

Anova: Single Factor

#### SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Conroe N. Aud	1	0	0	#DIV/0!
Nation N Aud.	263	5729	21.78327	220.4528
TX N Aud.	20	389	19.45	367.6289

#### ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	566.8966	2	283.4483	1.230222	0.293797	3.027898
Within Groups	64743.6	281	230.4043			
Total	65310.49	283				

- c. **Null Hypothesis:** There is no difference in wait times for established audiology patients at the Conroe CBOC and average wait times for established audiology patients in Texas VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for established audiology patients at the Conroe CBOC and average wait times for established audiology patients in Texas VA Clinics.

- d. **Null Hypothesis:** There is no difference in wait times for established audiology patients at the Conroe CBOC and average wait times for established audiology patients in Nation VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for established audiology patients at the Conroe CBOC and average wait times for established audiology patients in nation VA Clinics.

Anova: Single  
Factor

#### SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Conroe Est Aud	1	0	0	#DIV/0!
Nation Est. Aud	328	1558	4.75	44.38379
TX Est Aud	21	73	3.47619	18.2619

#### ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	53.8019	2	26.90095	0.627381	0.534593	3.021745
Within Groups	14878.74	347	42.87821			
Total	14932.54	349				

#### B. Mental Health Wait Times

- a. **Null Hypothesis:** There is no difference in wait times for new mental health patients at the Conroe CBOC and average wait times for new mental health patients in Texas VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for new mental health patients at the Conroe CBOC and average wait times for new mental health patients in Texas VA Clinics.
- b. **Null Hypothesis:** There is no difference in wait times for new mental health patients at the Conroe CBOC and average wait times for new mental health patients in the Nation VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for new mental health patients at the Conroe CBOC and average wait times for new mental health patients in the Nation VA Clinics.



Anova: Single Factor

#### SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Conroe New MH	1	5	5	#DIV/0!
Nation New MH	788	10961	13.9099	115.5815
Texas New MH	44	547	12.43182	61.97199

#### ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	168.9499	2	84.47495	0.748864	0.473223	3.006571
Within Groups	93627.4	830	112.8041			
Total	93796.35	832				

- c. **Null Hypothesis:** There is no difference in wait times for established mental health patients at the Conroe CBOC and average wait times for established mental health patients in Texas VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for established mental health patients at the Conroe CBOC and average wait times for established mental health patients in Texas VA Clinics.
- d. **Null Hypothesis:** There is no difference in wait times for established mental health patients at the Conroe CBOC and average wait times for established mental health patients in the nation VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for established mental health patients at the Conroe CBOC and average wait times for established mental health patients in the nation VA Clinics.

Anova: Single Factor

#### SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Conroe Est MH	1	2	2	#DIV/0!
Nationa Est. MH	873	2654	3.040092	15.40779
Texas Est MH	47	152	3.234043	8.226642

## ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	2.778978	2	1.389489	0.092337	0.911806	3.00553
Within Groups	13814.02	918	15.04795			
Total	13816.8	920				

## C. Optometry Wait Times

- Null Hypothesis:** There is no difference in wait times for new optometry patients at the Conroe CBOC and average wait times for new optometry patients in Texas VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for new optometry patients at the Conroe CBOC and average wait times for new optometry patients in Texas VA Clinics.
- Null Hypothesis:** There is no difference in wait times for new optometry patients at the Conroe CBOC and average wait times for new optometry patients in the nation VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for new optometry patients at the Conroe CBOC and average wait times for new optometry patients in the nation VA Clinics.

Anova: Single Factor

## SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Conroe	1	35	35	#DIV/0!
Nation New Opt.	201	6510	32.38806	428.7087
TX new Opt.	18	579	32.16667	416.8529

## ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	7.695929	2	3.847965	0.008995	0.991046	3.037472
Within Groups	92828.23	217	427.7799			
Total	92835.93	219				

- c. **Null Hypothesis:** There is no difference in wait times for established optometry patients at the Conroe CBOC and average wait times for established optometry patients in Texas VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for established optometry patients at the Conroe CBOC and average wait times for established optometry patients in Texas VA Clinics.
- d. **Null Hypothesis:** There is no difference in wait times for established optometry patients at the Conroe CBOC and average wait times for established optometry patients in the nation VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for established optometry patients at the Conroe CBOC and average wait times for established optometry patients in the nation VA Clinics.

Anova: Single Factor

#### SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Conroe	1	5	5	#DIV/0!
Nation Est. Opt.	204	1687	8.26960	54.1584
TX Est. Opt.	18	122	6.77777	36.6535
			8	9

#### ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	46.6814	5	23.3407	0.44201	0.64331	3.03689
Within Groups	11617.2	8	52.8058			
Total	11663.9	6	222			

#### D. Primary Care Wait Times

- a. **Null Hypothesis:** There is no difference in wait times for new primary care patients at the Conroe CBOC and average wait times for new primary care patients in Texas VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for new primary care patients at the Conroe CBOC and average wait times for new primary care patients in Texas VA Clinics.

- b. **Null Hypothesis:** There is no difference in wait times for new primary care patients at the Conroe CBOC and average wait times for new primary care patients in the nation VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for new primary care patients at the Conroe CBOC and average wait times for new primary care patients in the nation VA Clinics.

Anova: Single  
Factor

#### SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	1	16	16	#DIV/0!
Column 2	49	943	19.2449	100.1888
Column 3	789	16101	20.40684	211.8914

#### ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	81.09116	2	40.54558	0.197323	0.820963	3.006493
Within Groups	171779.5	836	205.4778			
Total	171860.6	838				

- c. **Null Hypothesis:** There is no difference in wait times for established primary care patients at the Conroe CBOC and average wait times for established primary care patients in Texas VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for established primary care patients at the Conroe CBOC and average wait times for established primary care patients in Texas VA Clinics.
- d. **Null Hypothesis:** There is no difference in wait times for established primary care patients at the Conroe CBOC and average wait times for established primary care patients in the nation VA Clinics. **Alternate Hypothesis:** There is a difference in wait times for established primary care patients at the Conroe CBOC and average wait times for established primary care patients in the nation VA Clinics.

Anova: Single  
Factor

#### SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	1	2	2	#DIV/0!
Column 2	50	190	3.8	5.877551
Column 3	808	2815	3.483911	8.691191

#### ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	6.958867	2	3.479434	0.407899	0.665175	3.006241
Within Groups	7301.791	856	8.530129			
Total	7308.75	858				

## APPENDIX 5: FOIA REQUEST 11.1.17

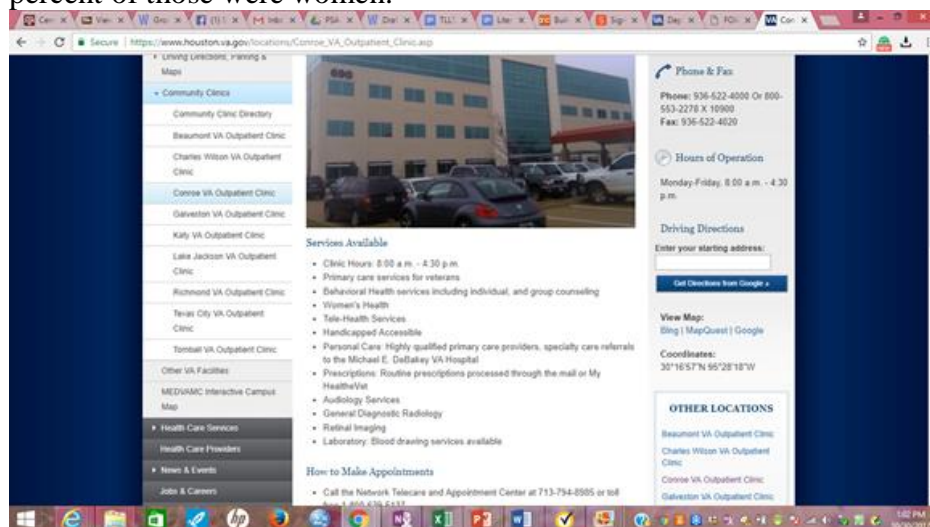
To: Stephanie Graham  
FOIA Contact  
(19F2) VACO

From: Catherine Cole, PhD  
catherinecole@tamu.edu  
512.771.7404  
208 N Bryan Ave. # 13  
Bryan TX 77803

Date: 11.1.2017

I am submitting a FOIA request for the following information:

1. Total dollars spent for the Conroe CBOC VA Outpatient Clinic per year for the years 2012-2016. NOTE: We attempted to get this information from Alisa Cooper (CFO DeBaKey ??) who stated she did not have financial information for Conroe nor did she direct us to the right person as requested (attachment A).
2. Total veterans served at the Conroe CBOC per year for years 2012-2016 and what percent of those were women.



3. Total dollars spent for “Women’s Health” as advertised on the Conroe CBOC website (4th bullet in picture above) (https://www.houston.va.gov/locations/Conroe\_VA\_Outpatient\_Clinic.asp) per year for years 2012-2016.
4. Total number of women served by “Women’s Health” services at the Conroe CBOC (4th bullet) per year for the years 2012-2016.
5. List of “Women’s Health” services offered at the Conroe CBOC (4th bullet) per year for the years 2012-2016.
6. Total dollars spent on “Primary Care” services at the Conroe CBOC (2nd bullet) per year for years 2012-2016.
7. Total number of veterans served per year with “Primary Care” services at the Conroe

CBOC (2nd bullet) for years 2012-2016 and what percent of those were women.

8. Total dollars spent per year on “Audiology” services at the Conroe CBOC (9th bullet) for years 2012-2016.

9. Total number of veterans served per year with “Audiology” services at the Conroe CBOC (9th bullet) for years 2012-2016 and what percent of those were women.

10. Total dollars spent per year on “Behavioral Health” services at the Conroe CBOC (3rd bullet) for years 2012-2016.

11. Total veterans served per year with “Behavioral Health” services at the Conroe CBOC (3rd bullet) for years 2012-2016 and what percent of those were women.

12. Total veterans served per year with “Retinal Imaging” and general optometry services at the Conroe CBOC (11th bullet) for years 2012-2016 and what percent of those were women.

13. Total dollars spent per year on “Retinal Imaging” and general optometry services at the Conroe CBOC (11th bullet) for years 2012-2016.

Thanks so much for your help.

Please call if I can clarify any of this information/requests.

Respectfully submitted,

Catherine Cole  
512.771.7404

## APPENDIX 5.1: FOIA REQUEST 12.6.17

To: Stephanie Graham

FOIA Contact

(19F2) VACO

From: Catherine Cole, PhD

*catherinecole@tamu.edu*

512.771.7404

208 N Bryan Ave. # 13

Bryan TX 77803

Date: 12.06.2017

I am submitting a FOIA request for the following information:

1. How is the Conroe CBOC funded? Is it an allocation process based on the number of eligible veterans in the service area, or is it a reimbursement process based on the number of veterans served?
2. The total number (and list of) VCA/VCP-approved (by TriWest Healthcare Alliance Services and or Health Net Federal) community medical providers for the zip code list (attachment A) per year for the years 2012-2016. NOTE: We made this request to Brenda Owens who said she did not have it but would forward request to supervisor – no response as of this date. NOTE: We attempted to get this information from the veterans choice provider locator: <https://www.va.gov/opa/apps/locator/>, however, we cannot get a full list.
3. The total number (and list of) VCA/VCP-approved (by TriWest Healthcare Alliance Services and or Health Net Federal) community medical providers for all of Texas excluding the zip code list (attachment A) for the years 2012 - 2016.
4. The total number (and list of) VCA/VCP-approved (by TriWest Healthcare Alliance Services and/or Health Net Federal) community medical providers for all of the nation excluding Texas.



5. The number of unique veterans, per year, who have used the PC3 program since 2012 (may be available through the VHS Support Service Center but we were informed we would not have access to this database). NOTE: Attempted to make contact and request through Sonia White (choice expert??) with no response as of this date.
6. The number of unique veterans, per year, who have used the VCP program since 2012 (may be available through the VHS Support Service Center but we were informed we would not have access to this database). NOTE: Attempted to make contact and request through Sonia White (choice expert??) with no response as of this date.
7. Total dollars spent, total hours of training provided, and total medical providers trained (for the Conroe CBOC) in gender-specific training that equips providers with skills to treat female veterans' specific needs per year for years 2012-2016 as required by VHA DIRECTIVE 1330.01(1) HEALTH CARE SERVICES FOR WOMEN VETERANS. NOTE: We requested this information from Dr. El-Serag, Medical Director Women's Health Program on Oct 25, 2017 with follow up on Oct 31, 2017. To date, no response.
8. Total number of female veterans from the zip code list that used the Michael E. DeBakey VA Medical Center - Houston, Texas per year for years 2012-2016.
9. Total number of veterans categorized as "rural" who have received care from the Conroe CBOC per year for years 2012-2016. NOTE: (It is our understanding this is mandated by the Open Door Policy and collected by veteran coordinators??)
10. Total number of HIPAA compliant authorizations to release medical information requested (and signed) by patients from the Conroe CBOC and processed by the DeBakey VA Medical Center – Houston releasing (and sending) medical information requested by Conroe CBOC patients to a non-VA provider for 2016.
11. The number of veteran suicides disaggregated by gender per year for the years 2012-2016 for the zip code list.
  - a. How many of these were homeless (sheltered/unsheltered)?
  - b. How many of these had been screened for military sexual trauma (MST) per gender and of those who reported MST?
  - c. How many of these had treatment for mental health issues?
  - d. How many were rural?

Thanks so much for your help.

Please call if I can clarify any of this information/requests.

Respectfully submitted,

Catherine Cole

512.771.7404

Attachment A– Zip Code List

<b>Zip Code</b>	<b>Texas Congressional District</b>
75835	8
75845	8
75847	8
75849	8
75850	8
75851	8
75852	8
75856	8
75858	8
75862	8
75926	8
77301	8
77302	8
77303	8

<b>Zip Code</b>	<b>Texas Congressional District</b>
77304	8
77306	8
77316	8
77318	8
77320	8
77331	8
77334	8
77340	8
77342	8
77354	8
77356	8
	8
77359	8
77362	8

<b>Zip Code</b>	<b>Texas Congressional District</b>
77364	8
77367	8
77378	8
77380	8
77381	8
77382	8
77384	8
77385	8
77386	8
77830	8
77831	8
77855	8
77861	8
77864	8

77876	8
77873	8
77872	8
77871	8 & 17
77868	8, 10 & 17
77865	8 & 17
77484	8 & 10
77447	8 & 10
77389	8 & 10
77388	8 & 2

77379	8 & 2
77377	8, 10 & 2
77375	8, 10 & 2
77373	8, 2 & 18
77372	8 & 36
77371	8 & 36
77365	8 & 2
77363	8 & 10
77357	8 & 2
77355	8 & 10

77339	8 & 2
75904	8 & 1
75831	8 & 17
75833	8 & 17
75839	8 & 5
75844	8 & 5
75846	8 & 17
77070	8, 10, & 2
77328	8 & 36

## APPENDIX 6: AT RISK OF HOMELESSNESS



# At Risk of Homelessness

CRITERIA FOR DEFINING AT RISK OF HOMELESSNESS	<b>Category 1</b>	Individuals and Families	<p>An individual or family who:</p> <ul style="list-style-type: none"> <li>(i) Has an annual income below <u>30%</u> of median family income for the area; <u>AND</u></li> <li>(ii) Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the “homeless” definition; <u>AND</u></li> <li>(iii) Meets one of the following conditions: <ul style="list-style-type: none"> <li>(A) Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; <u>OR</u></li> <li>(B) Is living in the home of another because of economic hardship; <u>OR</u></li> <li>(C) Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; <u>OR</u></li> <li>(D) Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; <u>OR</u></li> <li>(E) Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; <u>OR</u></li> <li>(F) Is exiting a publicly funded institution or system of care; <u>OR</u></li> <li>(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient’s approved Con Plan</li> </ul> </li> </ul>
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[https://www.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition\\_Criteria.](https://www.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition_Criteria.pdf)

pdf