



# Meeting The Healthcare Needs of United States Veterans: Texas 8th Congressional District



A project on behalf of the:

Bush School of Government and Public Service  
Executive Masters of Administration and  
Public Service Program

Capstone Advisor: Dr. Catherine Cole

**A REPORT BY:**

Adeline Fox, Jenny Huang, William Huffman, Leslie Krueger, and Jennifer White

Bush School of Government and Public Service Executive Masters

of Administration and Public Service Program

Capstone Advisor – Dr. Catherine Cole

Produced for our client:

The Honorable Kevin Brady of the 8th Congressional District



## TABLE OF CONTENTS

Introduction.....	6
Background.....	7
Problem Statement and Overview of Project Purpose.....	7
Significance of Research.....	8
Definitions and Key Terms.....	8
Assumptions.....	11
Delimitations.....	13
Original Research Design and Research Questions.....	13
Theme I: Comparative Analysis: Congressional Districts 8 And 31 And VA System In Each District And The Veterans Choice Act.....	14
Theme II: Overall Veteran Healthcare.....	22
Theme III: Veteran Women’s Healthcare.....	23
Theme IV: Military Sexual Trauma Among Veterans In The 8th District.....	24
Theme V: Substance Abuse Among Veterans In The 8th District.....	26
Theme VI: Homelessness Among Post-9/11 Veterans.....	27
Literature Review Summary.....	29
Introduction.....	28
Overview of Project Purpose and Methods.....	29
Research Questions Prompted By Literature Review.....	31
Theme I: Comparative Analysis.....	31
Focus Area: Demographics - Fewer Veterans Trending at State and Local Levels.....	31
Focus Area: Comparative Analysis - Congressional Districts 8 and 31 and VA system in Each District.....	31
Focus Areas: Access and Quality of Care Performance.....	31
Focus Area: Veterans Choice Act and Dual Use Implications.....	32
Theme II: Overall Veteran Healthcare.....	32
Theme III: Women Veteran’s Healthcare.....	33

Theme IV: Military Sexual Trauma Among Veterans In The 8th Congressional District.....	33
Theme V: Substance Abuse Among Veterans In The 8th Congressional District..	33
Theme VI: Homelessness Among Post-9/11 Veterans In The 8th Congressional District.....	34
Literature Review Findings.....	34
Theme I: Comparative Analysis: Congressional Districts 8 and 31 and VA system in Each District.....	34
Focus Area I: Demographics and Fewer Veterans Trending at State and Local Levels.....	35
Focus Areas II: Access and Quality of Care Performance.....	35
Focus Area III: Veterans Choice Act and Dual Use Implications.....	35
Theme II: Overall Veteran Healthcare.....	36
Theme III: Women Veterans Healthcare.....	36
Theme IV: Military Sexual Trauma Among Veterans In The 8th Congressional District.....	37
Theme V: Substance Abuse Among Veterans In The 8th Congressional District..	37
Theme VI: Homelessness Among Post-9/11 Veterans In The 8th Congressional District.....	38
Team Augmented Methodology.....	38
Priorities.....	38
Methodology.....	39
Data Limitations.....	39
Refined Research Questions And Related Data.....	40
Theme I: Comparative Analysis: Congressional Districts 8 And 31 And VA System In Each District And The Veterans Choice Act.....	40
Theme II: Overall Veteran Healthcare in Texas' 8th Congressional District.....	51
Theme III: Female Veterans' Healthcare.....	62
Theme IV: Military Sexual Trauma(MST) Among Veterans of the 8th Congressional District.....	67
Theme V: Substance Abuse Among Veterans of the 8 <sup>th</sup> Congressional District.....	69

Theme VI: Post-911 Veteran Population of Texas’ 8th Congressional District...	70
Findings.....	77
Theme I: Comparative Analysis: Congressional Districts 8 And 31 And VA System In Each District And The Veterans Choice Act.....	78
Theme II: Overall Veteran Healthcare in Texas’ 8th Congressional District.....	79
Theme III: Female Veterans’ Healthcare.....	79
Theme IV: Military Sexual Trauma (MST) and Substance Abuse Among Veterans of the 8th Congressional District.....	80
Theme V: Post-911 Veteran Population of Texas’ 8th Congressional District.....	80
Cross Cutting Themes.....	81
Post 9-11 Veterans.....	82
Age.....	82
Female Veterans.....	83
Deployment Attributed Issues.....	83
Barriers to Care.....	84
Poverty.....	84
Discussion & Implications.....	85
Recommendations.....	88
1. Comparative Analysis and the Veterans Choice Act.....	88
2. Overall Veterans Healthcare.....	88
3. Female Veterans Healthcare.....	89
4. Military Sexual Trauma (MST) Among Male Veterans and Substance Abuse of CD8 Veterans.....	89
5. Post-9/11 Veterans in CD8 and Post – 9/11 Veteran Demographics.....	89
Appendices.....	92
Appendix A.1: External Communication.....	90
Appendix A.2: Full Literature Review.....	97
Bibliography.....	177

## INTRODUCTION

Veterans of all ages utilize healthcare through the Veterans Health Administration (VHA), which is the medical branch of the United States Department of Veterans Affairs (VA). The VHA is “America’s largest integrated healthcare system” serving approximately 9-million veterans annually (VHA 2018). Thousands of medical centers, hospitals, clinics, and community based outpatient clinics offer healthcare services within the VA network. These facilities are found throughout the country with 12 VA hospitals/healthcare system facilities located in Texas alone (USDVA 2018). Our study area is specific to the Conroe Community Based Outpatient Clinic (CBOC). Even though the VHA currently serves 9-million veterans, approximately 20-million veterans live in the United States, meaning many veterans are either not utilizing VHA services, or they are getting their health needs from other facilities (VetPop 2016). The VA network offers countless services for veterans, but such an expansive medical framework comes with its limitations.

The 2017 nonprofit and public administration capstone team extensively researched financial impacts of veterans healthcare, impacts of the Veterans Choice Act (VCA), and veteran homelessness and suicide (Castro, Hare, and Willis 2017). The findings from last year’s team provided a window for more work to be done, which led our group to research much of the same subject matter through a different lens. We also continued working with Congressman Kevin Brady and his Conroe office staff. Our main task was to review gaps previously identified by the former team and to find even more specific information about veterans’ healthcare in the 8th congressional district (8th district).

Over the span of two semesters, our team researched secondary data, examined databases, analyzed results, and created recommendations. Each teammate focused on a specific theme based on priority issues identified by our client, as well as the previous report. We found new information relating to general performance ratings for the Conroe CBOC compared to the Cedar Park CBOC, additional information regarding access limitations to healthcare services for female veterans, and an overarching theme of veterans in the 18-34 age range being the most vulnerable to poverty and homelessness.

Our team presents our findings in the following order. We first discuss the background, problem statement, significance of research, findings, and overlap of information found within our themes. Next, we cover the discussion and implications of our findings. Lastly, we highlight future recommendations and future research topics. Our

external communications information and full literature review are available in the appendices section starting on page 90.

## **BACKGROUND**

Our capstone project was a continuation of the work done last semester by the 2017 capstone team. Based on their findings, we knew where possible limitations already existed. We dove into more detail with previous topics, as well as added our own priorities to this year's project. We know that Congressman Brady and his staff are dedicated to finding out more about health services provided to veterans in the 8th district and this mindset opened our scope further. The original literature review research question created by our team was:

- *“What literature exists in regards to issues with similar CBOCs, overall health, women's health, mental health, substance abuse, and homelessness in addition to what the previous capstone found?”*

Knowing that very little data specific to the 8th district existed, we increased the scope of subject matter studied. Each team member honed in on a specific theme and then we began researching. A brief scoping study was conducted for the comparative analysis theme because this particular subject had not been researched extensively in the previous report. We conducted a hybrid literature review by finding scholarly, peer-reviewed articles using the Texas A&M University library system. We only analyzed articles from 2011 to present, and we only evaluated veterans within the United States. Our team specifically researched similar CBOCs, overall health of veterans, women's health, substance abuse, and homelessness. We reviewed data collected from secondary sources and analyzed findings in the literature review to refine our research questions. After evaluating our data, we identified cross-cutting themes and extracted additional information we were not expecting to find. Our team developed 65 refined research questions based on findings from our literature review.

## **PROBLEM STATEMENT AND OVERVIEW OF PROJECT PURPOSE**

The 2017 capstone team identified research opportunities for us in their report. More research was needed for several themes in the previous report. For this reason, our team continued past research and filled in other subject gaps for our project. Additionally, Congressman

Brady and his staff needed more information regarding the status and performance of veterans healthcare in the 8th district.

### SIGNIFICANCE OF RESEARCH

Congressman Brady and his staff want veterans in the 8th district to have the best healthcare available, but before last year's report very little information was known about how services for veterans were performing in the district. Our project goes into additional performance-based analysis of veterans healthcare overall, as well as priorities specific to the 8th district.

The following subjects were researched and findings were analyzed.

- Comparative analysis of the Conroe CBOC and the Cedar Park CBOC
- Impacts of the Veterans Choice Act (VCA) and Veterans Choice Program (VCP)
- Performance and access to primary care facilities
- Healthcare expenditures by district, state and nation
- Current healthcare available and additional services needed for female veterans
- Rates of Military Sexual Trauma (MST) reported by male veterans
- Substance abuse services available
- Status of post-9/11 veteran population and services needed
- Services available to homeless veterans and programs that aim to prevent homelessness
- Veteran enrollment in the VHA services

Our team found some new information to report to Congressman Brady. However, many data gaps still exist when trying to find information specific to the 8th district veterans and services available to them. Limitations with transparency and access to information within the VA system was a common occurrence for all team members during this project. We are presenting the evidence-based research and data that was available, as well as reporting on information we were unable to verify in hopes of shedding more light on the needs of veterans living in the 8th district.

### 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.

**Food Inefficiency:** When a person and/or family is lacking food to have adequate supply for health and nutrition in all areas of life.

**Functional Zero:** Used in this context, is reached when the number of veterans who are homeless, whether sheltered or unsheltered, is no greater than the monthly housing placement rate for veterans (HUD 2016).

**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).

**Medicare:** Medicare is a federal health insurance program for individuals age 65 and older and those under age 65 with certain disabilities (National Center for Veterans Analysis and Statistics n.d.).

**Medicaid:** Medicaid is a state-administered health plan for individuals and families with low incomes and limited resources. Veterans who qualify for Medicaid do not pay copayments for VA health care (National Center for Veterans Analysis and Statistics n.d.).

**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.)

**National Center for Veterans Statistics and Analysis (NCVAS):** The National Center for Veterans Analysis and Statistics (NCVAS) leads the effort to implement corporate data governance and corporate data management in VA (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 United States 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.)

## ASSUMPTIONS

Assumptions for this study include:

### Comparative Analysis: Congressional Districts 8 and 31:

In the early stages of this research, it was assumed that the 31st district was a good comparison to the 8th district because of similar demographics. Another assumption included the similarities between the Conroe and Cedar Park CBOCs. Much of the assumptions for this portion of the research revolved around demographics data and performance information from government reports.

### Veterans Choice Act

The main assumption with the Veterans Choice Act (VCA) was that there would be very limited quantitative data about the VCA based on findings from last year's team.

### Healthcare of Veterans

Our assumption of healthcare of veterans is that veterans health care services are administered by the Veterans Health Administration (VHA). The program oversees the healthcare services provided to qualifying veterans. Eligible United States veterans access the program through various health care facilities including hospitals, clinics, CBOCs and counseling centers. Beneficiaries enjoy healthcare benefits for veterans, such as mental health care (emotional trauma, suicide prevention, substance abuse, PTSD treatment), women's health issues and other health and wellness services. Based on the limitations found from last year's team, we also assume that there would be limited quantitative and qualitative information and data about Conroe CBOC we could find and use.

### Female Veterans Healthcare

Because we do not have quantitative data to analyze the female veterans use of the Conroe CBOC or other sources, our research has relied on content analysis of peer-reviewed articles (additionally to our original literature review). The content of these articles focuses on a general overall healthcare atmosphere found among veteran females within the United States. There is a time delay associated with majority of scholarly article research and studies to allow for at least one to two years. Communication between the VA and other sources was limited and therefore we relied on information found within the web or available through public formats.

### Military Sexual Trauma

It was our assumption that male victims of Military Sexual Trauma report victimization at a lower rate than females. In analyzing the rate of unreported sexual assault and sexual harassment of male victims we researched electronic reference databases including the Texas A&M University library system and the JSTOR online journal storage system. We assume that the government reports and journal article data are accurate in reporting of MST issues.

### Veteran Substance Abuse

Substance abuse analysis of individual veterans in the 8th Congressional District has proven difficult due to a lack of information specific to the district. By using electronically available research databases via the Texas A&M University library system and the JSTOR online journal storage system we were able to locate general information on veterans across the United States. We assume that rates of treatment and success are relatively steady across the country.

### Homeless Veterans

The main assumption surrounding issues of veteran homelessness was that there would be significant research indicating the numbers of post-9/11 veterans experiencing homelessness was high. An additional assumption was that deployment would be a contributing factor to post-9/11 veteran homelessness and issues with readjustment to civilian life.

## DELIMITATIONS

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

1. We would study only those in the United States Armed Forces.
2. Research from 2011 – 2018 written in the English language would be considered.
3. Research on the homeless veteran population was based on PIT counts done by the Texas Homeless Network.
4. Scholarly peer-reviewed and verifiable database resources would be used.

## ORIGINAL RESEARCH DESIGN AND RESEARCH QUESTIONS

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

Using exploratory mixed research methods per theme, each member led the research on one theme. Fox led the research on comparative analysis of congressional districts 8 and 31, dual usage, and Veterans Choice Act. Huang led the research on overall veteran healthcare status within the 8th district. White led research on women veteran healthcare;

Huffman led the research on military sexual trauma and substance abuse, and Krueger led the research on veteran homelessness. Specific research designs are presented per theme:

**THEME I: COMPARATIVE ANALYSIS: CONGRESSIONAL DISTRICTS 8 AND 31 AND VA SYSTEM IN EACH DISTRICT AND THE VETERANS CHOICE ACT**

Team member Fox led research for the comparative analysis and Veterans Choice Act portions of the research. She looked for data from districts 8 and 31. During the fall 2018 semester, she will analyze quantitative data to test statistical significance of several findings from the literature review. The original research question for the comparative analysis portion of the literature review was “What literature exists in regards to issues with similar CBOCs?”

The following are 14 potential research questions to compare districts 8 and 31:

1. How are health care expenditures documented in each congressional district?
  - Sub question 1: Do district VA hospitals report this information to the VA or state? Both?
2. How does the Central TX VHCS improve services to veterans within the 31st district?
  - Sub question 1: Does the Central TX VHCS offer mental health education services for families?
  - Sub question 2: Are there more services available through this facility than in Debakey? If so, how are services different?
3. What kind of health services are the most prevalent in Conroe and Cedar Park?
  - Sub question 1: Are mental health illnesses being treated more frequently compared to other ailments?
  - Sub question 2: How are health services categorized by CBOCs and VA hospitals?
  - Sub question 3: Do CBOCs and VA hospitals use the same type of documentation process for mental health patients?
4. Are Katy and Beaumont seeing statistically more health patients? Is this service or location related?

5. Has the Conroe CBOC implemented recommendations made by the 2010 report?
  - Sub question 1: Has Conroe hired more staff to address limitations in women's health services?
  - Sub question 2: Has Conroe gotten worse in any of the evaluated categories?
6. Is the Cedar Park CBOC actually performing better than the Conroe CBOC?
  - Sub question 1: Do patients who visit Cedar Park CBOC suffer from recidivism in terms of treatment?
7. What are statistically significant demographic differences between the 8th district and TX/national averages?
8. What areas does Cedar Park CBOC perform in better as measured by having women's liaisons  
and having family education programs for veterans and their families?
9. What are the differences between Conroe and Cedar Park in terms of services? Are they statistically significant?
10. Do Conroe and Cedar Park see statistically more MH patients than the TX/national averages?
11. Do rural veterans receive statistically significant less care (as defined as services offered for  
mental health) than the TX/national averages?
12. What is the projected growth rate of the 8th district veterans as compared to the TX/national averages per sex. Age, etc.? Statistical significance?
13. What are average wait times for services in Conroe and Cedar Park and are they statistically significantly different?
14. Is Bell County Comparable to Montgomery County in terms of poverty rates?

## **METHOD**

To compare districts, qualitative and quantitative methods will be used. This may be considered a mixed method research approach. Many quantitative data sets were found and used to decipher congressional district and CBOC data. One goal is to identify measurable variables between the CBOCs in districts 8 and 31. One of these variables could relate to the family education programs for veterans dealing with mental health challenges. At this time, I do not know where to find data to compare specific family education programs by CBOC. I will also need to test if the population and expenditure figures for districts 8 and 31 are statistically significant. I will use t-tests to measure differences between collected data. Unfortunately, current data contains a limitation when it comes to qualitative data. At this time, it is not clear how the other focus areas will be incorporated into the final product.

## **DATA**

Data sets from the National Center for Veterans Analysis and Statistics will be used to examine districts. These include:

1. A Geographic Distribution of VA Expenditures to determine if there is a statistical significance between expenditures in districts 8 and 31  
([https://www.va.gov/vetdata/veteran\\_population.asp](https://www.va.gov/vetdata/veteran_population.asp))
2. Veteran population 115<sup>th</sup> to determine if there is a statistical significance between male and female veteran populations in districts 8 and 31  
([https://www.va.gov/vetdata/veteran\\_population.asp](https://www.va.gov/vetdata/veteran_population.asp))
3. Veteran Population Projection Model 2016 infographic to determine if projections for veteran populations in districts 8 and 31 are statistically significant compared to the national average.  
([https://www.va.gov/vetdata/docs/demographics/new\\_vetpop\\_model/vetpop\\_infographic\\_final31.pdf](https://www.va.gov/vetdata/docs/demographics/new_vetpop_model/vetpop_infographic_final31.pdf))

## **PROCEDURES**

### Conroe and Cedar Park CBOCs

1. Need to find alternative data sources beyond the Inspector General (IG) reports or find more IG reports with more information relating to Conroe or Cedar Park CBOCs.



2. Try to find raw data used in IG reports to then test statistical significance between mental health patients visiting Conroe versus Cedar Park.

#### Congressional districts

1. Will conduct a t-test to compare expenditures and demographics within districts 8 and 31.

### **CROSS CUTTING**

Much of the CBOC comparison section of research relates to mental health services because a large portion of our report addresses mental health and there was more mental health data available.

#### **Focus Area One: Demographics and Fewer Veterans Trending at State and Local Levels**

The demographics of veterans focus area is an extension of the research question relating to comparative analysis of districts and CBOCs. This focus area provides additional information about veteran population trends in Texas and the United States. The following four research questions relate to veteran demographics:

15. What is the VA currently doing to prepare for shifts in veteran demographics?
  - Sub question 1: How will pitfalls in the current system be improved before a demand shift?
  - Sub question 2: How will changing demographics influence the locations and number of CBOCs available?
16. Why are some areas of Texas seeing more veteran growth than others?

### **METHOD**

Information relating to veteran demographics supplements the comparative analysis theme. Data found in this subject matter is quantitative in nature. No research used for this section is qualitative. One limitation in this portion of the research is the conflicting veteran population numbers found from the United States Census Bureau versus the VA data. I will test the data found in the Amaral article with growth projections for districts 8 and 31.

## DATA

Quantitative data from the Amaral scholarly article, the United States Census Bureau, and the VA will be used to evaluate veteran population trends and potential demands on veteran health services.

1. United States Census Bureau data for the 115<sup>th</sup> Congressional Districts 8 and 31 to test current populations with national averages (<https://www.census.gov/mycd/>)
2. Veteran Population Projection Model 2016 infographic to determine if projections for veteran populations in districts 8 and 31 are statistically significant compared population projections provided by Amaral ([https://www.va.gov/vetdata/docs/demographics/new\\_vetpop\\_model/vetpop\\_infographic\\_final31.pdf](https://www.va.gov/vetdata/docs/demographics/new_vetpop_model/vetpop_infographic_final31.pdf)) Amaral scholarly article to compare projection numbers to the Veteran Population 2016 data (Amaral et. al, 2018).

## PROCEDURES

1. Utilize data found in the literature review phase to test statistical significance between population projections in districts 8 and 31 to the national average.
2. Search for new data sources to confirm or reject the hypothesis of growth projections in the San Antonio and Austin areas of Texas.

### **Focus Area Two: Access and Quality of Care Performance**

The access and quality of care performance focus area is an extension of the research question relating to comparative analysis of districts and CBOCs. This focus area provides additional information about performance of VA hospitals and CBOCs in general. The following nine research questions relate to access and quality of care:

17. Why are veterans utilizing more VA benefits?

- Sub question 1: Is the aging population of veterans qualifying more people for benefits?

18. Have more CBOCs hired women's health liaisons?

- Sub Question 1: Why didn't all 44 CBOCs evaluated in the CBOC review have one?

19. Does the Cedar Park or Conroe CBOC have a family education program?

20. Are rural veterans more at-risk in the 8th district than they are in the 31st district?

- Sub Question 1: Are there more services offered in Cedar Park than in Conroe?
- Sub Question 2: Are rural veterans missing out on helpful mental health services because of where they live?

21. What kind of support groups exist for families within the DeBakey and Central Texas networks?

22. Has something like the SAFE program been implemented into the DeBakey and Central Texas VA facilities?

23. What can be done to encourage veterans to seek help more quickly?

- Sub questions 1: Is the system broken or is this an attitudinal barrier of veterans?

24. How much coordination is going on between the federal departments within Texas?

- Sub Question 1: What is the state's role in managing services provided by these entities?

25. How have the DOD, DHHS and VA worked together in past programs?

## **METHOD**

Even though this section of research is related to the comparative analysis section, it contains more qualitative data for performance of CBOCs and VA hospitals. Throughout the research collection process, this focus area became its own because of the amount of valuable qualitative information available. Combining and refining this section's information with the quantitative data from the comparative analysis and demographics sections might be useful. More data needs to be found in terms of determining if family education, as well as support group programs are offered by the Conroe and Cedar Park CBOCs, as well as program effectiveness compared to the national average.

## DATA

Government reports and scholarly articles relating to performance in the VA system, CBOCs, and challenges in seeking care will be used to evaluate this section.

1. VA Utilization Profile 2016 to evaluate this source of data in more detail and potentially find data sets that are cited in the report to identify veteran utilization trends ([https://www.va.gov/vetdata/docs/QuickFacts/VA\\_Utilization\\_Profile.PDF](https://www.va.gov/vetdata/docs/QuickFacts/VA_Utilization_Profile.PDF))
2. Veterans Health Administration Characteristics: FY 2002 to FY 2015 will be used to determine characteristics/classifications of veterans seeking health. The date range of 2011 to 2018 would be the only admissible data in this report. (<https://www.va.gov/vetdata/Utilization.asp>)

## PROCEDURE

1. Identify data from current sources that could be used to test utilization between districts  
8 and 31 mental health services compared to the national average.
2. Find more data regarding veteran utilization of mental health services and programs.
3. Find more data regarding Conroe and Cedar Park CBOC mental health services and programs.

## CROSS CUTTING

The portions of this research relating to female veteran utilization data coincide with team member White's section which relates to veteran women's health. Most of my research questions are centered around districts 8 and 31. There is some overlap with team member White's research questions relating to female veterans' disability status in the 8th district. There is also potential for collaboration when it comes to rural and urban female veterans' health services both in the 8th district and nationally.

### **Focus Area Three: Veterans Choice Act and Dual Use Implications**

The Veterans Choice Act and dual use implications focus area is separate from the comparative analysis theme, but it does correlate with several themes discussed in the literature review. This focus area should be addressed but should not be its own focus area or

stand-alone theme. The following three research questions relate to the Choice Act and dual use:

26. How many veterans has the Veterans Choice Act helped?

27. How will the new legislation VA MISSION Act improve upon downfalls of the Choice Act?

28. How can dual use be a more efficient model for veterans?

## **METHOD**

This section of research is mostly quantitative, but qualitative information is included in government reports and some scholarly articles. This topic includes a mixed method approach because it contains quantitative and qualitative information.

## **DATA**

Government reports that are quantitative and qualitative will be used to evaluate this section. This is considered a mixed method approach. Scholarly, peer-reviewed articles were also used to evaluate the VA MISSION Act, which is a new veteran healthcare bill passed by President Donald Trump.

1. United States Government Accountability Office 2018 to further evaluate implications of the Veterans Choice Act  
(<https://www.gao.gov/assets/700/692271.pdf>)
2. Journal of General Internal Medicine regarding the Veterans Choice Act to utilize sources within the article from the VA

(<https://www.va.gov/opa/choiceact/documents/FactSheets/Progress-Report-March-2015-Fact-Sheet.pdf>) and the Health Services Research & Development Service  
([https://www.hsrd.research.va.gov/publications/internal/forum04\\_13.pdf](https://www.hsrd.research.va.gov/publications/internal/forum04_13.pdf))

## **PROCEDURES**

1. Evaluate current data sources with more detail.
2. Find more research relating to the Veterans Choice Act and its impacts.

## THEME II: OVERALL VETERAN HEALTHCARE

Team member Huang led research regarding the overall veteran healthcare within the 8th Congressional District. During the fall 2018 semester, Huang used a mixed, exploratory method conducting this research by using the Texas A&M University library system to store documents in RefWorks and used the Internet to open sources for quantitative and qualitative data, graphics, tables, and literature reviews.

The six research questions for this theme are:

29. What is the current VA healthcare situation?
30. What are the top three channels for veterans seeking care through VA system?
31. What are the governmental budget and expenditures for VA healthcare, and what is the impact?
32. What is the waiting time for general comparing with other non-veteran medical services?
33. What are the reasons veterans to choose other medical services more than VHA's CBOC?
34. What are the top three opportunities to improve the healthcare services in Conroe CBOC?

## METHOD

Driven by the six 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, especially for the CBOC and VA hospitals in congressional district 8. After few failed attempts at elite interviews and lack of accessible numbers and solid data, this section mainly relied on qualitative data.

## DATA

The secondary data analyzed was qualitative in nature and included additional peer-reviewed scholarly journal articles, governmental reports, and organizational and programmatic websites. This included reviewing and analyzing applicable, publicly available data in order to determine the population of rural dwelling veterans. Quantitative data was used in this

theme about the governmental budget and expenditures for VA healthcare to the nation, state and district 8, and it was also used for the quality of care about access to care for the veterans in this area. These information were collected from the VA open data website(  
<http://data.va.gov>)

## **PROCEDURE**

1. Identify data from current sources that could be used to test determine the budget and expenditures of government to the veterans' healthcare and the quality of care.
2. Using the available data regarding VA healthcare governmental budget and expenditures to work out and compare the average spending per patient based on a level of nation, state, and congressional district 8.
3. Determine top three channels for veterans seeking healthcare.
4. Identify data from the current sources that the government allocated certain amount of the total annual healthcare budget of veterans for the rural veterans.

## **CROSS CUTTING**

The portion of the research related to congressional healthcare expenditure documentation, and that regarding prevalent services provided in Conroe coincides with the research led by team member Fox. All team members will collaborate to determine statistical significance of demographic differences between the 8th district and Texas/national averages. We will also study the average wait times for services in Conroe, as well as the veteran population trends in Texas and the United States.

### **THEME III: VETERAN WOMEN'S HEALTHCARE**

The veteran women's healthcare, both in and outside of the VA, for the 8th district of Texas is discussed. After the 2017 study of female veteran healthcare, the scoping study, and scholarly literature review, we determined that additional research would be required to answer the following original questions:

35. How are the younger generations targeted for successful service when leaving the military?

36. What educational and/or targeted training are available for the clinicians and nurses (both within and outside of the VHA?) Are these trainings required or mandatory?
37. What nonprofit options are available for women veterans within the 8<sup>th</sup> district? What can be done to increase aide to these organizations to assist these veterans?

## **METHOD**

This section of research is mostly quantitative, but qualitative information is included in government reports and some scholarly articles. This topic includes a mixed method approach because it contains quantitative and qualitative information. We used internet resources to obtain graphics, maps, tables, and data to drive the answers to the quantitative information. Inductive research methods to gather data about the trends in growth of female veterans in the 8th district.

## **DATA**

1. Infertility and negative pregnancy outcomes are associated with deployment.
2. Gender-specific healthcare training is not mandatory.

## **PROCEDURES**

1. Evaluate current data sources with more detail.
2. Find additional research relating to women veterans' healthcare trends in the 8th district.
3. Determine what services are available as well as those that are lacking in the 8th district for women veterans.

## **CROSS CUTTING**

Work with team member Krueger on data and research to determine the influence had on homelessness of female veterans. Work with team member Fox on data retrieved about rural veterans and comparison information found for females, dual usage, and other information relative to geographical location.



The initial scoping study and scholarly literature review led team member Huffman to develop the following five questions related to Military Sexual Assault (MSA) and Military Sexual Trauma (MST):

41. What is driving the lower rate of reporting of MSA among male veterans?
42. Is there anything that can be done to encourage more veterans to report and then seek treatment?
43. What are the barriers to 8th district male veterans in completing outpatient treatment programs for both substance abuse and MST?
44. Is there a lower rate of MST among male veterans at the Conroe CBOC?
45. Is there a statistically significant difference between male veterans with hx of MST committing suicide and the TX/national average?

## **METHOD**

Driven by the research questions, we will perform further Internet searches of available literature and statistical data regarding the reporting of MST and MSA. Quantitative and qualitative studies will be conducted on any data discovered by the additional searches. Data will be requested regarding the number of patients reporting MST, methods of treatment, and number of patients completing treatment programs. If possible, elite interviews will be performed with mental health staff from the Conroe CBOC regarding MST and MSA reporting and treatment.

## **DATA**

The team was unable to identify datasets containing specific information regarding the CBOC or DeBakey VA Medical Center (VAMC) on MST.

## **PROCEDURES**

4. Evaluate current data sources with more detail.
5. Find additional research relating to MSA/MST, and the impacts.

6. Find research regarding male survivors of MSA/MST.
7. Determine what services are available in the 8<sup>th</sup> District for survivors of MSA/MST.

## **CROSS CUTTING**

Work with team members to compare data regarding the relevance of MSA/MST's impact.

### **THEME V: SUBSTANCE ABUSE AMONG VETERANS IN THE 8TH DISTRICT**

The initial scoping study and scholarly literature review led team member Huffman to develop the following three questions related to substance abuse among veterans in the 8th District.

46. What can be done to encourage veterans to complete substance abuse treatment programs?
47. How can the Conroe CBOC share information between VHA and Medicare/private healthcare providers to allow continuity of treatment?
48. Is there a difference between the 8th district veteran suicide rate and the national average?

## **METHOD**

Driven by the research questions, we will perform additional searches of available literature and statistical data. Qualitative and quantitative analysis will be performed on any data recovered. Specifically, the number of patients who begin treatment and who complete it. Information on number of repeat patients can be analyzed to determine recidivism rates.

Additional Internet research will be done into what, if anything, can be done to encourage veterans to complete substance abuse treatment. If possible, elite interviews will be performed with staff from the Conroe CBOC regarding substance abuse treatment.

## **DATA**

The secondary data analyzed was qualitative in nature and included additional peer-reviewed scholarly journal articles, governmental reports, and organizational and programmatic

websites. This included reviewing and analyzing applicable, publicly available data in order to determine scale of veteran substance abuse issues within the 8<sup>th</sup> District.

## **CROSS CUTTING**

Work with team members to compare data regarding the impact of veteran substance abuse on all other themes.

### **THEME VI: HOMELESSNESS AMONG POST-9/11 VETERANS**

The initial scoping study and scholarly literature review led team member Krueger to develop the following questions related to homelessness among post-9/11 veterans in the 8th District.

49. What resources are available in the 8th district that address veteran employment issues?
50. What percent of veterans in the 8th district is unemployed?
  - Sub Question 1: Of those, what percentage is OEF-OIF and/or female?
  - Sub Question 2: How long have these veterans been unemployed?
51. What percentage of post-9/11 veterans experience challenges obtaining and maintaining employment?
52. How does deployment impact employability for post-9/11 veterans?
53. What percentage of veterans who are literally homeless and those at imminent risk, request assistance from VA and/or community services?
54. How many veterans a year are homeless and/or at imminent risk of homelessness but do not receive services because they are not registered with the VA?
55. How is the VA working to remove barriers for female veterans seeking assistance for housing?
56. How is the VA working to make specialized services for female veterans seeking assistance?
57. What are the barriers to obtaining hudvash vouchers or housing assistance?

58. Number of veterans within the area participating in hudvash?
59. Are there any other permanent supportive housing assistance in the 8th district other than that provided by the VA?
- Sub Question 1: Is it being used?
  - Sub Question 2: Are there barriers to services?
60. Is the VA SSVF program provided in 8th district? Why, why not? Is it being used?
61. What if any, are the best practices/solutions to veteran homelessness in the 8th district?
62. What, if any, programs are specifically addressing veteran homelessness among post-9/11 female veterans in in the 8th district?

## **METHOD**

Driven by the research questions and sub questions, we used inductive methods to gather data and to determine incidence rates and risk factors for homelessness, based on post-9/11 veteran baseline data for military factors, demographic characteristics, rates of use for VA supportive housing services, and diagnoses of PTSD. Team member Krueger led the research regarding homelessness among veterans within the 8th district. Krueger 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, homelessness among post-9/11 veterans, social and economic characteristics of female veterans.

## **DATA**

Quantitative and qualitative data sources were used to validate findings. This included conducting elite interviews, examining publicly available datasets, and reviewing additional scholarly journal articles published between 2011 - 2017. collect a significant amounts of data can be collected from the 8th District's Homeless Continuum of Care, the VAs national database system, the American Community Survey, and other community database systems which can then be applied to the 8th district OEF-OIF and female veteran population for optimal analysis of services available and service recommendations.

## PROCEDURE

Team member Krueger collected qualitative and quantitative data from peer reviewed journal articles and reports on homelessness among post-9/11 veterans within the state of Texas, the nation, and in the 8th district. Krueger reached out to VA and local community programs and collect data to determine what services are available for veterans experiencing housing insecurity in 8th district. The qualitative and quantitative approach is based on content analysis gathered from archival data and examining publicly available datasets to analyze homeless veteran populations, social and economic characteristics of post-9/11 veterans.

## CROSS CUTTING

Work with all team members to compare data regarding shared issues relevant to the impact of veteran homelessness.

## LITERATURE REVIEW SUMMARY

### INTRODUCTION

This literature review completed phase one of two required capstone classes in the Bush School of Government and Public Service's Executive Master of Public Service and Administration (EMPSA) graduate program. The authors conducted a systematic, critical review of literature to assess and summarize existing publications, in addition to those found in the 2017 capstone, related to veteran health services in the United States 8th Congressional District (8th district). Additional reasons we conducted the review included familiarizing ourselves with the body of literature related to the 8th district, identifying variables to test for next semester, and formulating research questions. What follows is a summary of our literature review. This includes an overview of project purpose and methods, findings, limitations in research, refined research questions, and a conclusion. The full hybrid literature review can be located in Appendix A.2.

### OVERVIEW OF PROJECT PURPOSE AND METHODS

This capstone effort is a continuation of the 2017 capstone report titled *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* (Castro, Hare, and Willis, 2017). Research findings from last year, provided important information about the 8th district and its veteran health services, but findings also indicated a need for further research. Our team continued research from last year and added to the scope of subject matter. Previous research focused on financial implications of VA health expenditures, policy implications of the Veterans Choice Act, and veteran homelessness and suicide. Additional subject matter included 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, military sexual trauma (MST), and suicide.

Our mission is to provide the Honorable Kevin Brady with evidence-based information to help inform his decisions regarding services for veterans of the 8th district. Keeping the overarching team mission in mind, we aimed to report important findings regarding veterans' healthcare to the Honorable Kevin Brady that will serve as evidence to inform decision making regarding veteran healthcare within the 8th district.

Focusing on answering our original research question, "what literature exists regarding the following veteran issues: similar CBOCs, overall health, women's health, mental health, substance abuse, and homelessness in addition to what the previous capstone found?"; our team originally became familiarized the previous team's research, Congressman Brady, the 8th Congressional District of Texas, veteran resources, policies, issues and existing opinions on veteran issues. As we narrowed our research questions, we were able to identify the five themes and subsequent focus areas on which we based our scholarly literature review. 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.

Informed by this literature review, variables we identified to test included: determining if the differences between the mental health services offered by Cedar Park and Conroe CBOC are statistically significant, determining if rural veterans are more at-risk in the 8th district than they are in the 31st district, determining if female veterans have a statistically significant higher rate of cervical cancer than the average population,

determining if there are barriers to male veterans in the 8th district that prevent participation in programs for substance abuse and MST, determining if there is a difference between the 8th district veteran suicide rate and the national average, determining if there is a correlation between Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) unemployment and homelessness, and determining if homeless veterans fail to receive services because they are not registered with the VA. After becoming familiar with the body of literature regarding the veteran population in the 8th district, we further identified variables and refined our research questions to produce original research for the Fall 2018 semester.

#### RESEARCH QUESTIONS PROMPTED BY LITERATURE REVIEW

The following are the refined research questions separated by assigned themes:

#### **THEME I**

##### **Focus Area: Demographics - Fewer Veterans Trending at State and Local Levels**

1. What is the VA currently doing to prepare for changes in the veteran demographics?
2. How will pitfalls in the current system be improved before a demand shift?
3. How will changing demographics influence the locations and amount of CBOCs available?

##### **Focus Area: Comparative Analysis - Congressional Districts 8 and 31 and VA System in Each District**

4. How are health care expenditures documented by congressional district?
5. How does the Central TX VHCS improve services to veterans within the 31st district?
6. What kind of mental health services are the most prevalent?
7. Why are Katy and Beaumont seeing more mental health patients? Is this service or location related?
8. Has the Conroe CBOC implemented recommendations made by the 2010 report?
9. Is the Cedar Park CBOC actually performing better than the Conroe CBOC?

##### **Focus Areas: Access and Quality of Care Performance**

10. Why are veterans utilizing more VA benefits? Is the aging population of veterans qualifying more people for benefits? Is there a connection between an aging veteran population and increased use of VA benefits?
11. Have more CBOCs hired women's health liaisons? Why didn't all 44 CBOCs evaluated have one?
12. Does the Cedar Park or Conroe CBOC have a family education program?
13. Are rural veterans more at-risk in the 8th district than they are in the 31st district? More services available?
14. What kind of support groups exist for families within the DeBakey and Central Texas networks?
15. Has something like the SAFE program been implemented into the DeBakey and Central Texas VA facilities?
16. What can be done to encourage veterans to seek help more quickly? Is the system broken or is this an attitudinal barrier of veterans?
17. How much coordination is going on between the federal departments within Texas? What is the state's role in managing services provided by these entities?
18. How have the DOD, DHHS and VA worked together in past programs?

#### **Focus Area: Veterans Choice Act and Dual Use Implications**

19. How many veterans has the Veterans Choice Act helped?
20. How will the new legislation VA MISSION Act improve upon downfalls of the VCA?
21. How can dual use be a more efficient model for veterans

#### **THEME II: OVERALL VETERAN HEALTHCARE**

22. What is the current VA healthcare situation?
23. What are the top three channels for veterans seeking care through VA system?
24. What are the governmental budget and expenditures for VA healthcare, and what is the impact?



25. How does the waiting time compared with other non-veteran medical services?
26. Reasons veterans to choose other medical services more than VHA's CBOC?
27. What are the top three opportunities to improve healthcare services in Conroe CBOC?

### **THEME III: WOMEN VETERAN'S HEALTHCARE**

28. How are younger generations targeted for successful service when leaving the military?
29. What educational and/or targeted training are available for the clinicians and nurses (both within and outside of the VHA)? Are these trainings required or mandatory?
30. What nonprofit options are available for women veterans within the 8th district?  
What  
can be done to increase aide to these organizations to assist these veterans?

### **THEME IV: MILITARY SEXUAL TRAUMA AMONG VETERANS IN THE 8TH CONGRESSIONAL DISTRICT**

31. What is driving the lower rate of reporting of MSA among male veterans?
32. Is there anything that can be done to encourage more veterans to report and seek treatment?
33. What are the barriers to 8th district male veterans in completing outpatient treatment programs for both substance abuse and MST?
34. Is there a lower rate of MST among male veterans at the Conroe CBOC?
35. Is there a statistically significant difference between male veterans with a history of MST committing suicide compared with the Texas and/or national average?

### **THEME V: SUBSTANCE ABUSE AMONG VETERANS IN THE 8TH CONGRESSIONAL DISTRICT**

36. What can be done to encourage veterans to complete substance abuse treatment programs?

37. How can the Conroe CBOC share information between VHA and Medicare and/or private healthcare providers to allow continuity of treatment?
38. Is there a difference between the 8th District veteran suicide rate and the national average?

#### **THEME VI: HOMELESSNESS AMONG POST-9/11 VETERANS IN THE 8TH CONGRESSIONAL DISTRICT**

39. What resources are available in TX-08 addressing veteran employment issues?
40. What percentage of veterans in TX-08 are unemployed? Of those, what percentage is post-9/11 veterans? How long have these veterans been unemployed?
41. What percentage of OEF/OIF combat veterans, and women experience challenges obtaining employment? Are they able to maintain employment?
42. How does deployment interfere with employability for post-9/11 veterans?
43. What percentage of veterans who are literally homeless and those at imminent risk, request assistance from VA and/or community services?
44. How many veterans a year are homeless and/or at imminent risk of homelessness but do not receive services because they are not registered with the VA?
45. How is the VA working to remove barriers for female veterans seeking assistance for housing security?
46. How is the VA working to make specialized services for female veterans seeking assistance?

#### **LITERATURE REVIEW FINDINGS**

From our literature review we compiled a number of findings. These are listed by theme below:

#### **THEME I: COMPARATIVE ANALYSIS: CONGRESSIONAL DISTRICTS 8 AND 31 AND VA SYSTEM IN EACH DISTRICT**

- Combined both districts are home to a total of 138,829 veterans which is about 9% of the total Texas veteran population. At this time, the 31st district has more veterans,

and specifically more female veterans, than the 8th district. The 31st district also has a slightly larger general population than the 8th district.

- Total expenditures for veteran services was greater in the 31st district than in the 8th district, which might be attributed to the increased veteran population visiting hospitals and clinics in the Central Texas area. These two congressional districts are crucial in terms of growth and sustainability for veteran services, which is why they deserve more attention in terms of formal research.
- One of the most interesting findings at the Conroe CBOC relates to their performance of mammogram imagery. While the Conroe CBOC is still within range of the target standard, they fall short because of lack of attention to detail in their record-keeping practices.

### **Focus Area I: Demographics and Fewer Veterans Trending at State and Local Levels**

- Compared to 2014 numbers, the Houston veteran population has declined by 9,717 (Veterans in Texas, 2016, 40). This is a relevant finding because the veteran population as a whole has been declining throughout the past few decades.
- The 2014 veteran population is listed as 21.6 million, but the projected 2024 veteran population is expected to decrease by 19% (Amaral et al. 2018, 2).
- More than “70% of urban veterans live within 40 miles of a Veterans Affairs Medical Center (VAMC),” but “less than 20% of rural veterans do” (Amaral et al. 2018, 50).

### **Focus Area II: Access and Quality of Care Performance**

- When evaluating the performance of CBOCs, limited women’s health and family education services are both areas needing improvement.
- It is crucial that women’s health services are improved to meet the increased growth of the female veteran population. Projections indicate that female veteran population “will increase three percentage points from 8% to 11%” by 2024” (Amaral et al. 2018, 28).

### **Focus Area III: Veterans Choice Act and Dual Use Implications**

- A 2016 Inspector General report criticized the VA for continued issues with access, which were “attributed to limited appointment availability and weaknesses in the scheduling practices of VA facilities” (Wilensky 2016, 453).
- While the Choice Act encourages utilization of both VA and non-VA services, many veterans face challenges with communication between their providers regarding patient records and treatment. Many veterans believe it is their responsibility to serve as the liaison between the VA and non-VA providers.

## THEME II: OVERALL VETERANS HEALTHCARE AND WELLNESS

- The professionalism of healthcare providers (84%) and having insurance coverage for the health service needed (82%) were ranked as the most important factors for selecting a healthcare provider to veterans.
- With increasingly greater options for healthcare available, VHA patients experiencing long wait times are likely to seek non-VHA alternatives, which potentially increase duplication of services and fragmentation of care.
- Conroe CBOC does not have emergency service.
- During 2011-2015, 58% of rural veterans are enrolled in the VA healthcare system, compare to 37% enrollment rate of urban veterans.
- In GAO report 2018, VA recognizes the need to provide accessible care to rural veterans, and allocates 32% of its healthcare budget to rural veteran care.
- The average expenditure per patient in Congressional District 8 is about \$9,500 in 2017, it is about \$1,300 lower than Texas’ average, and about \$2,000 lower than the nation’s average.

## THEME III: WOMEN VETERANS’ HEALTHCARE

- District 8 is considered rural in comparison to larger, more heavily populated districts.
- Challenges faced by female veterans and efforts needed to retain those within the VHA include lack of financial resources, uninformed about where to access care, as

well as general lack of access to care, and fears associated with obtaining medical care.

- Researchers have concluded the VA may have one visit to ‘make or break’ women’s decisions to continue using the care at VHA (Yano and Hamilton 2017, 375).
- New research found that unaddressed, mental health and aging issues can affect women’s reproductive health, though access to new medical avenues such as Telemental may prove advantageous.

#### THEME IV: MILITARY SEXUAL TRAUMA IN THE 8TH CONGRESSIONAL DISTRICT

- There is very little data available regarding male survivors of MST.
- Researchers found that while women report MST at a higher rate than men, incidence of suicidal ideation are much higher among male victims (Monteith et al. 2016, 257-265). Studies also show that men are at higher risk than women for homelessness as related to MST (Brignone et al. 2016, 582-589).
- “Veterans with positive MST screens had higher odds than those with negative screens of individual and co-occurring PTSD, Depressive Disorder, and Substance Use Disorder. The association between positive MST screens and diagnostic outcomes, including PTSD, was stronger for women than for men, and the association between positive MST screens and some diagnostic outcomes, including DD, was stronger for men than for women” (Gilmore et al. 2016, 546-554).

#### THEME V: SUBSTANCE ABUSE AMONG VETERANS IN THE TEXAS 8TH CONGRESSIONAL DISTRICT

- Researchers have found a link between cannabis use disorder and suicide among veterans of the Iraq/Afghanistan era.
- Research shows that veterans are less likely to seek help for substance abuse problems than members of the general population.

## THEME VI: HOMELESSNESS AMONG POST-9/11 VETERANS IN TEXAS' 8TH CONGRESSIONAL DISTRICT

- Approximately 34% of our target population have no more than a high school degree which certainly plays into income levels and poverty statistics (American Community Survey 2016).
- Employment issues upon exiting the military contribute to veteran homelessness therefore the 8th district should provide assistance with filing a disability claim and/or registering for VHA benefits; using veteran education benefits; finding on-the-job training opportunities and/or finding employment.
- Socioeconomic and behavioral health factors, especially posttraumatic stress disorder from combat exposure, among veterans deployed in OEF/OIF service eras, are strong indicators of risk for homelessness.
- Veterans who served during the OEF/OIF eras are more likely to be at risk for becoming homeless compared to veterans serving in any other era.
- While the VA appears to provide specialized services for female veterans experiencing homelessness, female veterans continue to experience major barriers to accessing said services due to lack of information being shared regarding available services.

## TEAM AUGMENTED METHODOLOGY

### PRIORITIES

Through our literature review, information collection, and data analysis, our team established the priority areas to conduct research within the 8th district. The team has examined available information and identified cross-cutting issues specifically applicable to the 8th Congressional District including:

1. VHA overall health care services within the 8th district
2. Veterans Choice Act and dual use implications
3. VHA services provided for veteran survivors of MST within the 8th district
4. VHA Services provided for veterans with substance abuse issue
5. Comparative analysis of Conroe and Cedar Park CBOCs

6. Gender-specific healthcare and female veteran healthcare implications
7. Female veteran healthcare services provided by the Conroe CBOC
8. Homelessness among post 9/11 service era veteran

## **METHODOLOGY**

The capstone team has collected information, examined data, and analyzed results for individual subtopic areas within the main focus. Research consisted of a combination of elite interviews, content analysis of additional peer-reviewed literature, and thorough reviews of applicable archival, and publicly available datasets. Elite interviews were conducted with state, federal, and nonprofit organizations. Overall, the capstone team used a mixed methods approach, collecting both quantitative and qualitative data needed to conduct a hybrid literature review of data developed through online sources. Through weekly meetings and individual discussions, the team collaborated to discuss research topics and methodology, and to reach consensus on issues, as we worked through the process.

## **DATA LIMITATIONS**

Several limitations of this study should be considered. First, there is virtually no historical data specific to veteran services with respect to Conroe CBOC services provided, numbers serviced, and demographics of beneficiaries of services within the 8th Congressional District. A true CBOC performance comparative analysis was unable to be done due to lack of available metrics and in all topics, researchers were unable to test statistical significance of findings due to lack of data with the 8th district.

Second, information from Veterans Health Administration (VHA) has not been forthcoming and the accessible data was often contradictory. The FOIA process was overly complicated and unclear. When researchers posed questions to CBOC personnel we were told to request in FOIA process. When a FOIA request was sent we were told that this type of information was not available via FOIA request. The lack of communication and transparency has created barriers to obtaining the relevant data needed to provide accurate answers to Congressman Brady's Conroe CBOC inquiries.

The capstone team was unable 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.

Lastly, the VHA does not track data on veterans who are not enrolled to receive VA healthcare. As a result, the understanding of the facilitators and barriers to access of needed health care and social services among veterans within the 8th district remains incomplete. Researchers were additionally unable to determine if nonprofit organizations within the district were inquiring as to whether veterans were enrolling for VA Healthcare or not. This is problematic, as linking veterans with services for which they are eligible—particularly VA health care, disability compensation payments, and homelessness assistance, is crucial to the health and wellbeing of our veterans.

## REFINED RESEARCH QUESTIONS AND RELATED DATA

Following the literature reviews, the capstone team began collecting and analyzing data relevant to each team members' assigned theme. As progress was made, research focus began to change, and questions were again refined. Below, separated by theme, are the agreed upon research questions, methods and procedures for collecting and analyzing data, limitations, and findings.

### THEME I: COMPARATIVE ANALYSIS: CONGRESSIONAL DISTRICTS 8 AND 31 AND VA SYSTEM IN EACH DISTRICT AND THE VETERANS CHOICE ACT

#### **1. How are health care expenditures documented in each congressional district?**



**Sub question 1:** Do district VA hospitals report this information to the VA, to the state, or to both?

**Finding:** We were unable to verify how congressional districts document expenditures, as well as how hospitals report this information.

**2. How does the Central TX VHCS improve services to veterans within the 31st district?**

**Sub question 1:** Does the Central TX VHCS offer mental health education services for families?

**Sub question 2:** Are there more services available through this facility than in DeBakey? If so, how are these services different?

**Finding:** We were unable to verify how the Central TX VHCS improves services to veterans within the 31st district, if the Central TX VHCS offers mental health education services for families, or if there were more services available in Temple versus Houston.

**3. What kind of health services are the most prevalent in Conroe and Cedar Park?**

**Sub question 1:** Are mental health illnesses being treated more frequently compared to other ailments?

**Sub question 2:** How are health service categorized by CBOCs and VA hospitals?

**Sub question 3:** Do CBOCs and VA hospitals use the same type of documentation process for mental health patients?

**Finding:** We were unable to verify which services were more prevalent in Conroe and Cedar Park CBOCs. We were also unable to verify frequency of mental health treatment, how health services are categorized, and how CBOCs document the process for mental health patients.

**4. Are Katy and Beaumont seeing statistically more mental health patients? Is this service or location related?**

**METHOD** - We analyzed the report titled Department of Veterans Affairs Office of Inspector General. 2017. "Clinical Assessment Program Review of the Michael E. DeBakey VA Medical Center Houston, Texas," which included information about mental health patients in the DeBakey system.

**DATA** - A 2017 report by the Office of the Inspector General accounted for primary care workload and mental health workload for CBOCs in the DeBakey system. There was not

enough data to test significance, but the Beaumont CBOC accounted for the highest percent of total primary care workload at 24% and the most mental health workload at 18% for CBOCs within the DeBakey network (CAP Review of DeBakey 2017). Katy accounted for 11% of total primary care workload and 17% of total mental health workload. In contrast, the Conroe CBOC accounted for 13% of total primary care workload and 17% of total mental health workload. Based on these findings, Beaumont accounted more primary care and mental health patients than Katy and Conroe in 2017.

**LIMITATIONS** - There was not enough data to test significance. There was also no historical data to compare against the 2017 Inspector General Report to determine if these percentages have increased or decreased over time.

#### **5. Has the Conroe CBOC implemented recommendations made by the 2011 report?**

**Sub question 1:** Are recommendations similar between the 2011 and 2017 reports?

**Finding:** We were unable to verify if the Conroe CBOC implemented recommendations from the 2010 Inspector General report. The FOIA request submitted to answer this question did not provide additional information related to implementation. Additionally, the 2011 and 2017 reports were not consistent in terms of recommendations reported. Therefore, the similarity of recommendations could not be verified.

#### **6. Is the Cedar Park CBOC actually performing better than the Conroe CBOC?**

**METHOD** - We analyzed secondary data using the Department of Veterans Affairs. 2018. “What Veterans Say About Access to Care” database, and the Centers for Medicare and Medicaid Services. 2016. “Veterans Health Administration Hospital Performance Data” database.

**DATA** - The VA surveys veterans to gauge access to appointments using the Experience of Care Measures (VA Survey of Healthcare Experiences of Patients (SHEP)) method. Results are then posted to an online database (access.gov). An access report ranging from September 2017 to February 2018, compared all Texas VA clinics and VA hospitals across the state. Based on these results, the Cedar Park CBOC received a SHEP score of 67%, meaning that veterans reported they were always or usually able to get an appointment for primary care needs 67% of the time (What Veterans Say 2018). Conroe CBOC received a SHEP score of 77%, which is more desired than a lower score on the percentage scale. This means that

veterans were better able to schedule an appointment in a timely manner with the Conroe CBOC, more so than with the Cedar Park CBOC.

**LIMITATIONS** - There were no other metrics available to gauge actual performance between Conroe and Cedar Park CBOCs.

**Sub question 1:** Do patients who visit Cedar Park CBOC suffer from recidivism in terms of treatment?

**Finding:** We were unable to verify if and how the Cedar Park CBOC tracks recidivism.

**7. What are statistically significant demographic differences between the 8th district and TX/national averages?**

**METHODS**

- We analyzed the United States Census Bureau. “Veteran Status 2012-2016 American Community Survey 5-Year Estimates” data.
- We reviewed the secondary database names National Center for Veterans Analysis and Statistics. 2016. “VetPop 2016 Living Veterans By 115th Congressional District, state, age group, gender, 2015-2045.”
- We analyzed the United States Census Bureau. “Age By Veteran Status By Poverty Status In The Past 12 Months By Disability Status For The Civilian Population 18 Years And Over” data.

**DATA** - Many demographic aspects were analyzed for this question. Veteran characteristics relating to population, poverty, male to female ratio and population projections in districts 8 and 31 were considered in this result.

**Populations in 2016:** The total population of the 8th district in 2016 was 813,519. Out of that number, 51,121 or 7% were veterans (VetPop 2016). The total population of the 31st district in 2016 was 830,908. Out of that number 87,708 or 11% were veterans. There are 1.6 million veterans in Texas and 20 million in the United States. Texas accounts for 8% of the total United States veteran population. The 8th district makes up 3% of the total Texas veteran population, while the 31st district makes up 5% of the total Texas veteran population.

**Poverty rates:** Using Census data from 2017, poverty rates for the 8th district indicated that 4% of the total veteran population (45,814) was below the poverty line. Poverty rates for the

31st district indicated that 6% of the total veteran population (78,045) was below the poverty line (Age by Veteran Status 2016). Overall the veteran age range of 18-34 in the 8th district has the highest percentage (8.9%) of poverty, followed by the 55-64 age range (7%). The 18-34 age range in the 31st district also has the highest percentage (12%) of poverty out of all other age ranges. The 18-34 range was followed by the 55-64 age range at 6%.

**Male to female ratio:** Male veterans make up 91% of the total veteran population and female veterans make up 9% of the veteran population in the 8th district. Male veterans make up 84% of the veteran population and female veterans make up 16% of the veteran population in the 31st district (VetPop 2016). Numerically, the 31st district has more female veterans than the 8th district, but since the total veteran population is larger in the 31st district, the percentage is only one digit larger than in the 8th district.

**Population projections:** The 8th district has a larger total population based on data between 2012-2016, but the 31st district has more veterans overall. District 31 also has more male veterans at 11% of the total population versus 8% of total population for the 8th district. In terms of female veterans, the 31st district has more, but female veterans only make 2% of the total population.

- The male veteran population for ages 17-64 in the 8th district is expected to decrease -3% by 2027 (VetPop 2016). The female veteran population of that same age range is expected to increase +39%. For the 65+ age range, male veterans are expected to decrease -8%. Female veterans of the same age are expected to increase by +83%.
- The male veteran population for the age range 17-64 in the 31st district is expected to increase +9% over 10 years (VetPop 2016). The female veteran population is expected to increase +18%. For the age range of 65+, male veterans are expected to increase +25% and female veterans are expected to grow by +3%.

**8. What areas does Cedar Park CBOC perform in better as measured by having women's liaisons and having family education programs for veterans and their families?**

**Sub question 1:** Do you have women's liaisons?

**Sub question 2:** What constitutes family education programs at the Cedar Park CBOC

**Finding:** We were unable to verify if Cedar Park performs better than Conroe in terms of women's health services. We conducted an elite interview and submitted a FOIA request but did not retain information to answer these questions.

**9. Do Conroe and Cedar Park see statistically more MH patients than the TX/national averages?**

**Finding:** We were unable to verify if the Conroe CBOC saw more mental health patients than the Cedar Park CBOC because each facility reported MH patients differently

**10. Do rural veterans receive statistically significant less care (as defined as services offered for mental health) than the TX/national averages?**

**Finding:** We were unable to verify if rural veterans receive statistically significantly less care than the Texas and national averages. Obama, Barack. 2012. Executive Order -- Improving Access to Mental Health Services.

**11. What is the projected growth rate of the 8th district veterans as compared to the TX/national averages per sex. Age, etc.? Statistical significance?**

**METHOD** - We reviewed the National Center for Veterans Analysis and Statistics. 2016. "VetPop 2016 Living Veterans By 115th Congressional District, state, age group, gender, 2015-2045" datasheet and the United States Department of Veterans Affairs. 2016. "Texas Summary," which is based on national projection figures.

**DATA** - Depending on the age range, the male and female veteran population varied on projections. The male veteran population for ages 17-64 in the 8th district is expected to decrease -3%, while the female veteran population is expected to increase +39% (VetPop 2016). Male veterans who are 65+ will also have a projected decrease of -8% in population. The most surprising percentage is the female veterans who are 65+. This age range is expected to increase +83% in the 8th district over a 10-year period. From a state perspective, Texas is expected to surpass California with more veterans by 2027. However, the total veteran population in Texas is expected to decrease overall to 1.3 million in 2045 compared to 1.6 million in 2015. The United States' veteran population is expected to "decline from 20 million in 2017 to 13.6 million in 2037" (VA 2017). The percent change of male veterans in the United States is expected to decrease -2.3% and the percent change of female veterans in the United States is +0.7%.

**LIMITATIONS** - There was not enough data to test statistical significance.

**12. What are average wait times for services in Conroe and Cedar Park and are they statistically significantly different?**

**METHOD** - We analyzed secondary data collected by the United States Department of Veterans Affairs - Data.gov. 2018. “Patient Access Data Pending Appointments - Report 2018 July 15.”

**DATA** - The Conroe CBOC recorded 8,633 total appointments scheduled in July 2018. Out of that total, 8,364 (97%) were scheduled in 30 days or less (Patient Access Data 2018). Only 3% of the appointments scheduled in July were scheduled over 30 days. The Cedar Park CBOC listed 13,551 total appointments scheduled in July 2018. Out of that total, 12,973 (96%) were scheduled in 30 days or less. Additionally, only 4% of the Cedar Park CBOC’s appointments were scheduled over 30 days.

**LIMITATIONS** - There is not much data to analyze in terms of performance. There is a concentration of wait time analytics over a short period of time.

**13. Is Bell County Comparable to Montgomery County in terms of poverty rates?**

**Finding:** We were unable to verify poverty rates by county.

**Focus Area: Veterans Choice Act and Veterans Choice Program**

**14. How many veterans has the Veterans Choice Act helped?**

**METHOD** - We analyzed secondary data in the Congressional Research Service. 2018. “The Veterans Choice Program (VCP): Program Implementation” report.

**DATA** - According to a report produced by the Congressional Research Service, 5.2 million unique veterans utilized the Veterans Choice Program (VCP) between November 2014 and August 2018 (CRS 2018). Veterans can become eligible for the VCP in several ways, which include wait times, choice first, mileage, limitations of VA access in the state of residence, and unusual/excessive travel burden. The highest category of utilization eligibility for VCP,

was the choice first category with 1.2 million veterans followed by the wait time eligibility with 908,884. The choice first category was created in 2015 to allow VA medical facilities to refer veterans to other non-VA facilities in a more efficient way.

**LIMITATIONS** - Data is not tracked by state. This is problematic because more states represented by the third-party administrator Tri-West are becoming eligible for the VCP.

#### **15. How will the new legislation VA MISSION Act improve upon downfalls of the Choice Act?**

**METHOD** - We reviewed a recent publication titled United States Department of Veterans Affairs. 2018. “VA MISSION Act and New Veterans Community Care Program.”

**DATA** - The VA MISSION Act of 2018 is like the initial VCP, but it “consolidates VA’s community care programs into a new Veterans Community Care Program” and \$5.2 billion were appropriated to ensure the VCP continues to provide services to veterans (VA MISSION 2018).

**LIMITATIONS** - The data VA MISSION Act was just passed in 2018, so there is no way to track its effectiveness yet.

#### **16. How can dual use be a more efficient model for veterans?**

**Finding:** We were unable to verify how dual use can be more efficient for veterans.

#### **ADDITIONAL FINDINGS**

Even though we were unable to find exact answers to some of our refined research questions for the comparative analysis theme, we did find relevant information that is important to share.

#### **17. How are health care expenditures documented in each congressional district?**

**METHOD** - We analyzed data from the National Center for Veterans Analysis and Statistics expenditure data for fiscal years 2011, 2013, 2015, and 2017.

**DATA** - Based on expenditure data tracked in FY17, total medical care expenditures for the 8th district in 2017 equaled \$129 million, while the 31st district expenditures totaled \$321,359 million (NCVAS 2017). In addition to medical care, other district expenditures of the VA include compensation and pension, construction, education/rehabilitation, loans, operating expenses, and insurance. When totaling all categories by district, the 8th district spent \$364 million on veterans and the 31st district spend \$1.2 billion on veterans overall in 2017. It should also be noted that the 31st district has a larger population of veterans with 87,708 while the 8th district has 51,121.

**18. How does the Central TX VHCS improve services to veterans within the 31st district?**

**Sub question 1:** Are there more services available through this facility than in Debakey? If so, how are services different?

**METHOD** - We reviewed a Central Texas Veterans Health Care System. “Mental Health Services” publication.

**DATA** - A report published by the Central Texas Veterans Health Care System (CTVHS) titled Mental Health Services, lists all programs for mental health needs that are available through the VA facility. Half of the services listed are offered at VA facilities in Austin, Temple and Waco (CTVHS 2018). It is not clear if the services listed are actually being provided in CBOCs, as well as VA hospitals. CTVHS offers the following services for mental health:

- Primary care behavioral health
- Mental health clinics
- Suicide prevention hotline
- Post-traumatic stress disorder programs and specialty clinics
- Outpatient and residential substance abuse treatment programs
- Special inpatient, outpatient or residential treatment programs for male and female veterans suffering from military sexual trauma (MST)
- Psychosocial Rehabilitation and Recovery Center (PRRC) for mental health recovery
- Therapists and medication for depression and anxiety
- Mental Health Intensive Case Management (MHICM) for serious mental illness
- Polytrauma Wellness Program (PWP)



**19. Does the Central TX VHCS offer mental health education services for families?**

**METHOD** - We reviewed the Central Texas Veterans Health Care System. “Mental Health Services” publication.

**DATA** - The CTVHS offers several mental health programs for veterans. There is only one program in the list we found that specifies treating veterans in their homes and community, but there is not a specialized family education program mentioned.

**20. Are there more services available through this facility than in DeBakey? If so, how are services different?**

**METHOD** - We compared the Michael E. DeBakey. “Fast Facts for Returning Veterans brochure to the Central Texas VHCS publication.

**DATA** - A brochure created by the Michael E. DeBakey VA Medical Center, highlights programs for returning veterans. By count, DeBakey does have more programs/resources listed in their brochure than the Central Texas VHCS, but many services offered are less specialized than the programs offered by the VA in Temple (Michael E. DeBakey 2018). DeBakey also has a targeted audience of returning veterans for the brochure they created, which could influence the programs listed in the handout. DeBakey offers the following services for mental health:

- On site mental health care and PTSD treatment
- Specialized inpatient mental health services for “mental health problems, PTSD, anger management, substance abuse, and depression” (DeBakey).
- Healthcare for Homeless Veterans Program
- Post-Deployment Clinic
- Women’s Health Center
- Houston Vet Centers
- VA Community Based Outpatient Clinics
- Nursing hotline
- Suicide prevention hotline
- Moving forward and reintegration programs
- Substance abuse and homeless shelters

- Supported employment program
- Polytrauma Rehabilitation Center
- Active outreach to combat veterans

## **21. Do Conroe and Cedar Park see statistically more MH patients than the TX/national averages?**

### **METHOD**

- We analyzed the Department of Veterans Affairs Office of Inspector General. 2013. “Community Based Outpatient Clinic Reviews at Central Texas Veterans Health Care System Temple, TX and VA Texas Valley Coastal Bend Health Care System Harlingen, TX” report.
- We reviewed the Department of Veterans Affairs Office of Inspector General. 2017. “Clinical Assessment Program Review of the Michael E. DeBakey VA Medical Center Houston, Texas” report.

**DATA** - A CBOC review report published by the Office of the Inspector General, accounted for two types of mental health patients: mental health unique and mental health visits. Unfortunately, the accounting for the Conroe CBOC is categorized differently than the Cedar Park CBOC. Because the mental health terminology varies between the two CBOCs, data cannot be compared directly to each other.

**LIMITATION** - Cedar Park CBOC categorizes mental health related treatments as mental health visits rather than mental health workload, like Conroe does. The two different definitions made it impossible to compare data side by side.

## **22. Is Bell County Comparable to Montgomery County in terms of poverty rates?**

**METHOD** - We analyzed the United States Census Bureau. “Age By Veteran Status By Poverty Status In The Past 12 Months By Disability Status For The Civilian Population 18 Years And Over” datasheet.

**DATA** - Poverty rates were evaluated by congressional district rather than county because it was more representative. In the 8th district, there were 1,719 veterans, or about 7% of the

total veteran population in the district, who were below the poverty line over the past 12 months (Age by Veteran Status 2016). In the 31st district, there were 4,577, or about 6% of the total veteran population in the district, who were below the poverty line over the past 12 months. The poverty rate percentages for veterans are similar in both congressional districts.

**LIMITATIONS** -The data used by the Census Bureau does not match population numbers by the VA. This proves to be problematic because it is not clear if the VA or the United States Census Bureau is more accurate in accounting for veteran populations.

## THEME II: OVERALL VETERAN HEALTHCARE IN TEXAS' 8TH CONGRESSIONAL DISTRICT

### **1. What is the current VA healthcare situation in the 8th District?**

**METHOD** – Research was conducted by searching the TAMU library with the key word of “Overall health care of veteran” and “primary care of veteran in US, Texas, and Conroe.” And Department of Veterans Affairs (VA)

**DATA** - According to VA, the Veterans Health Administration (VHA) is the largest integrated health care system in the United States, providing care at 1,243 health care facilities, including 172 VA Medical Centers and 1,062 outpatient sites of care of varying complexity (VHA outpatient clinics) to over 9 million veterans enrolled in the VA health care program nationwide. VHA Medical Centers provide a wide range of services including traditional hospital-based services such as surgery, critical care, mental health, orthopedics, pharmacy, radiology and physical therapy. In addition, most of the medical centers offer additional medical and surgical specialty services including audiology & speech pathology, dermatology, dental, geriatrics, neurology, oncology, podiatry, prosthetics, urology, and vision care. Some medical centers also offer advanced services such as organ transplants and plastic surgery. Patient advocates at every medical center are highly trained professionals who can help resolve veterans concerns about any aspect of healthcare experience, particularly those concerns that cannot be resolved at the point of care. Patient advocates listen to any questions, problems, or special needs veterans have and refer veterans' concerns to the appropriate medical center staff for resolution. There are 12 offices and 10 administrative & financial programs support VHA from all aspects.

In 2018, a study published in *Family Practice* indicates that healthcare providers outside of the Veterans Affairs (VA) Department are uncertain how to address veterans' needs. The study says that this is due to limited knowledge of resources and coordination problems (Bonnie M Vest). Moreover, another survey also find the similar findings that the VA system performed similarly or better than the non-VA system on most of the nationally recognized measures of inpatient and outpatient care quality, but high variation across VA facilities indicates a need for targeted quality improvement.

From the directory of VA website, There are 7 VA healthcare systems in Texas, 5 medical centers, 18 outpatient clinics, 38 Community Based Outpatient Clinics(CBOCs), including one COBC in Conroe, the 8th Congressional District.

## **2. How does the overall VHA healthcare service quality in CD 8 compare to Texas and the country?**

**METHOD** - We analyzed the Department of Veteran Affairs' Quality of Care

**DATA** - In the veterans' world, "quality care" has many definitions in VA: The right type of care for veterans health condition; Care that results in the best possible outcome for veteran and deliver care with attention to veterans' concerns, needs, and life goals; VA keeps veterans safe from hazards and harm. VA has been acting on new approaches improve the quality of care by centering care around veterans, providing more support and improving access.

**Comparison of Patient Experience – Data from Houston VA medical center to regional and national**

<i>Survey Items</i>	<i>Houston VA Medical Center-Primary care</i>	<i>Houston VA Medical Center-Specialty care</i>	<i>CAHPS Clinician &amp; Group –Regional</i>	<i>CAHPS Clinician &amp; Group - National</i>
<b>Access</b>	44%	45%	N/A	67%
<b>Comprehensiveness</b>	56%	N/A	41%	46%
<b>Patients’ rating of the Provider</b>	62%	62%	N/A	82%

From the above table, it shows that the access to Houston VA medical center is 44% comparing 67% national. Comprehensive in Houston is 56% comparing to regional 41% and national 46%. The patient rating to the provider catalog, the Houston is 62% while the national is 82%. There is a room to improve the services.

**LIMITATIONS** - There are no much information and data found in CD 8.

**3. What services and programs provided by CBOC in CD 8, what do not they have, how do they deal with the patient if they do not have the healthcare service to offer?**

**METHOD** - VA Healthcare about DeBakey VA Medical Center-Houston, Central Texas Veterans Health Care System.

**DATA** - Information published by VA healthcare administration, the Michael E. DeBakey VA Medical Center in Houston (MEDVAMC) serves as the primary health care provider for almost 130,000 veterans in southeast Texas, it is the parent facility of Conroe CBOC. MEDVAMC outpatient clinics have more than a million outpatient visits annually. Conroe CBOC has the following services available:

- Primary care services for veterans
- Behavioral Health services including individual, and group counseling
- Specialty Mental Health Groups including PTSD, SUD, Anger Management

- Women's Health
- MST Services
- Tele-Health Services
- Handicapped Accessible
- Prescriptions: Routine prescriptions processed through the mail or My HealtheVet
- Audiology Services
- General Diagnostic Radiology/Fluoroscopy
- Retinal Imaging
- Laboratory: Blood drawing services available
- Specialty PA's: Orthopedic, Podiatry, ENT
- OEF/OIF PCSW CASE MGMNT
- MOVE! Program
- Diagnostic ultrasound - no transvaginal
- CT Radiology, with/without contrast
- Occupational and Physical Therapy
- Optometry
- Optical shop (contract)
- Home Based Primary Care
- Limited prosthetic services
- Home Telehealth care coordinator (referred by PCP)
- Blood thinner/Diabetes surveillance
- Claims and benefits counselling (Texas Veterans Commission)
- Sleep Clinic, take home system
- Dental – In construction – Requires special eligibility

Conroe CBOC does not have many critical medical services and also there is no emergency care service. As it is close to and within the Debakey system, it is easy to refer and connect patients to the proper medical section to Debakey. Conroe CBOC suggests patients to call 911, or VA Suicide Prevention Hotline, and call Network Telecare and Appointment Center to help answer some non-emergency healthcare questions.

**LIMITATIONS** - We cannot find more information we need about Conroe CBOC so far, we need Rebecca from Congressman Kevin Brady's office to set an appointment or interview to get the information we need soon.

#### **4. What is the challenges to veterans living in rural area? Do they have special healthcare service for rural veterans?**

**METHOD** - VA Health Services Research and Development, the Department of Veteran Affairs.

**DATA** - Study shows that distance most important barrier for rural-residing veterans seeking healthcare. The average one-way distance that veterans traveled to a VA primary care clinic was 44.5 miles.

VA provides healthcare for approximately 7.8 million of the 25 million Veterans, with 36% of these enrollees residing in rural areas; which means about 3 million veterans living in rural areas. Therefore, VA has made rural outreach and support a top priority. For example, establishing the Office of Rural Health to address rural Veteran needs. Compared to urban veterans, rural veterans have lower health-related quality of life, in particular for physical as compared to mental symptoms. Though the causes for this are likely multifactorial, access to health services may be hindered by travel distance. To improve access to primary care and help address the distance issue, VA developed 788 Community Based Outpatient Clinics (CBOCs). This mixed-methods study of rural veterans, providers, and staff examined the impact of travel distance on the use of VA healthcare services, satisfaction, and impact on care delivery.

**LIMITATION** - limited information to find about the special healthcare services for rural veterans in CD 8.

#### **5. How do the rural veterans and aging veterans in CD 8 using the VA system compare to the Texas and the country?**

**METHOD** - Driven by this question, we used a mixed research method of qualitative and quantitative analysis. Searched for the related articles and reports.

**DATA** - Qualitative data collection and analysis used to study about rural veteran healthcare. There were about 5 million veterans lived in areas designated as rural by the United States Census Bureau during the 2011–2015 period. 58% of rural veterans are enrolled in the VA health care system – significantly higher than the 37% enrollment rate

of urban veterans. Rural veterans were older than veterans who lived in urban area. The median age of rural veterans was 65 years, compared with 63 years for urban veterans. Rural veterans were 2 years older than urban veterans and their age increased as the level of rurality increased. Rural veterans used VA healthcare at comparable rates to urban veterans and few used it as their only source of health insurance. Usage of VA healthcare by rural veterans increased by level of rurality, with almost 40% of veterans in completely rural counties enrolled in or using the VA system. Rural veterans had the highest rates of disability overall and at all ages. Rural veterans from every period of service also had higher rates of disability than similar urban veterans. Rural veterans who served during World War II (the oldest cohort) had the highest rate of disability and urban veterans who served in Gulf War II (the youngest cohort) had the lowest. Rural Gulf War II veterans, however, had the highest rate of service-connected disability. Healthcare services required for these two groups may differ dramatically and access to those services may be more difficult in rural areas.

Compared to urban areas, rural communities tend to:

- Have higher poverty rates
- Have more elderly residents
- Have residents with poorer health
- Have fewer physician practices, hospitals and other health delivery resources

Just like any rural resident, it may be difficult for rural Veterans and their caregivers to access health care and other services due to rural delivery challenges, including:

- Hospital closings due to financial instability
- Fewer housing, education, employment and transportation options
- Greater geographic and distance barriers
- Limited broadband internet
- Higher uninsured rates
- Difficulty of safely aging in place in rural America

VA recognizes the need to provide accessible care to rural Veterans and allocates 32% of its health care budget to rural veteran care.



Understanding who rural veterans are and what sets them apart from other veterans, as well as from their rural neighbors, provides the necessary perspective for rural communities, government agencies, veterans' advocates, and other policymakers interested in directing programs and services to this population.

**LIMITATIONS** - Most of the data available to the VA come only from rural veterans enrolled in their healthcare system, and not all veterans are enrolled. However, to anticipate demand for care, as well as to understand what types of services may be requested or utilized, requires data on all rural veterans.

## **6. What are the challenges for veterans seeking care through VA system?**

**METHOD** - Department of Veteran Affairs, VA benefits and healthcare

**DATA** - Through our research that we found, many soldiers have challenges of readjustment to civilian life. When moving to a new base or post, the military helps military personnel and families adjust. This structure is often not automatically in place when someone separates from the military. The Veteran and his or her family may have to find new ways to join or create a social community, and may have to learn how to get a doctor, dentist, life insurance, etc. These services were previously provided by the military. A Veteran may also need to navigate the paperwork and process of obtaining benefits and services from the Department of Veteran Affairs. Long waiting time is another challenge to veterans to seek healthcare through VA system, the average waiting time is about 30 days.

## **7. What are the budgets and expenditures government spends on VA healthcare to CD 8 veterans and Texas and the country? What is the impact?**

**METHOD** - the Department of Veterans Affairs' (VA's) Office of Enterprise Integration (OEI) publishes the Geographic Distribution of VA Expenditures (GDX) report. The National Center for Veterans Analysis and Statistics, June 2018.

**DATA** - The information published that Each Fiscal Year (FY), the Department of Veterans Affairs' (VA's) Office of Enterprise Integration (OEI) publishes the Geographic Distribution of VA Expenditures (GDX) report. This report provides the estimated dollar expenditures for major VA programs at the state, county, and Congressional District levels. Expenditure

data included medical healthcare, veteran population estimates at the state, county and Congressional District level and the number of unique patients who used VA healthcare services are also included in the report.

<b>FY17 Summary of Healthcare Expenditures by Nation, State, Congressional District 8 (Expenditure in \$000s)</b>			
	<i>Veteran Population</i>	<i>Unique Patients</i>	<i>Healthcare</i>
<b>Nation</b>	19,902,577	6,056,199	\$69,709,570
<b>Texas</b>	1,584,844	489,510	\$5,291,232
<b>CD8</b>	51,121	13,522	\$129,480

We collected the datas and analyzed that there is about 3.2% of total Texas veterans live in Congressional District 8 (CD 8) in 2017, about 2.8% unique patients in CD 8 across the state. The healthcare expenditure of CD 8 is about 2.4% of the total expenditure of Texas. The average expenditure for each patient in CD 8 is about \$9,500. While comparing with Texas, the average expenditure per patient is about \$10,800, and it is about \$11,500 for the nationwide. The average expenditure per patient in CD 8 is about \$1,300 lower than Texas state, and \$2,000 lower than the nation's average.

Notes for the tables:

1. Veteran population estimates, as of September 30, 2017, are produced by the VA Predictive Analytics and Actuary Service (VetPop 2016).
2. Unique patients are patients who received treatment at a VA health care facility. Data are provided by the Allocation Resource Center (ARC).
3. Medical expenditures data come from both the Allocation Resource Center (ARC) and FMS. Medical Care expenditures do not include dollars for construction or other non-

medical support. Medical Care expenditures are allocated to the patient's home location, not the site of care.

### **9. What about the Non-VA purchased care Program?**

**METHOD** - Non-VA Purchased Care Program Guidebook for Veterans from the Department of Veteran Affairs.

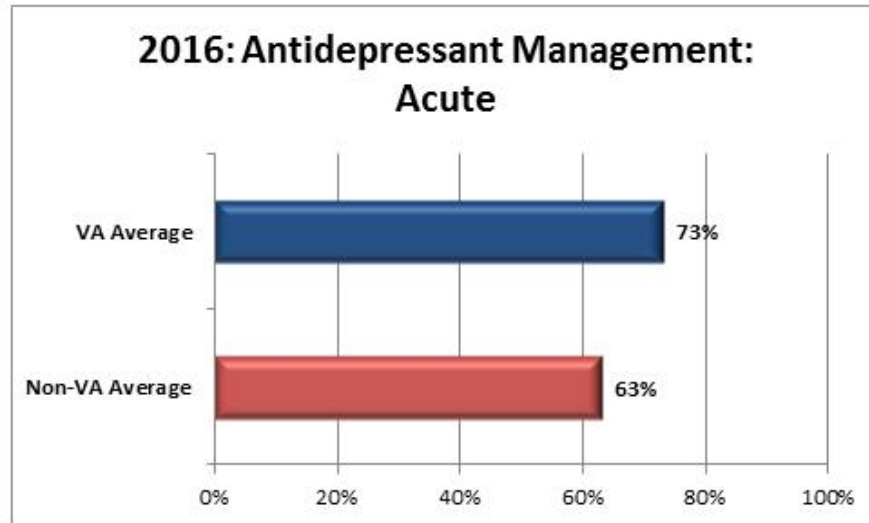
**DATA** - According to the guidebook, Non-VA Purchased Care Program is medical care provided to eligible Veterans outside of the VA. It was formerly known as ‘Fee Basis’, ‘Purchased Care’, or ‘Non-VA Care’. NVCC care is used when VA medical facilities are not ‘feasible available’. This includes lack of available specialists, medically unacceptable wait times for a particular condition, or long distances from the Veterans home when the Veteran is medically unable to travel.

### **10. What are the reasons veterans to choose VA healthcare services more than Private Healthcare providers?**

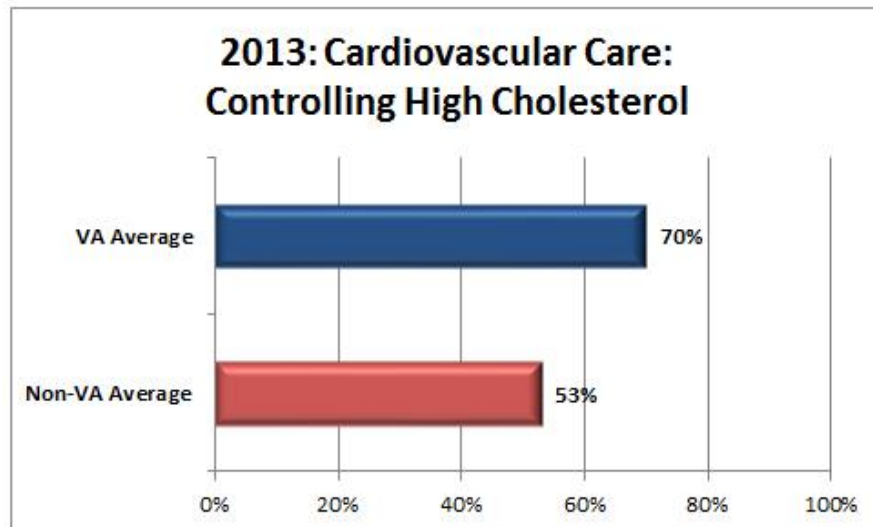
**METHOD** - VA Quality of Care, Department of Veteran Affairs.

**DATA** - First of all, as we state before, VA is home to the United States’ largest integrated health care system with 151 medical centers and nearly 1,400 community-based outpatient clinics. Together these health care facilities and the more than 53,000 independent licensed health care practitioners who work within them provide care to more than 8.3 million Veterans each year. Secondly, VA often outperforms private health care providers in a number of important areas. Health care performance can be measured using the Healthcare Effectiveness Data and Information Set (HEDIS) scores. HEDIS scores allow consumers to compare health plan performance based on standard measurements. The following three example graphs show the comparison of average VA medical center performance to non-VA hospital performance in three areas.

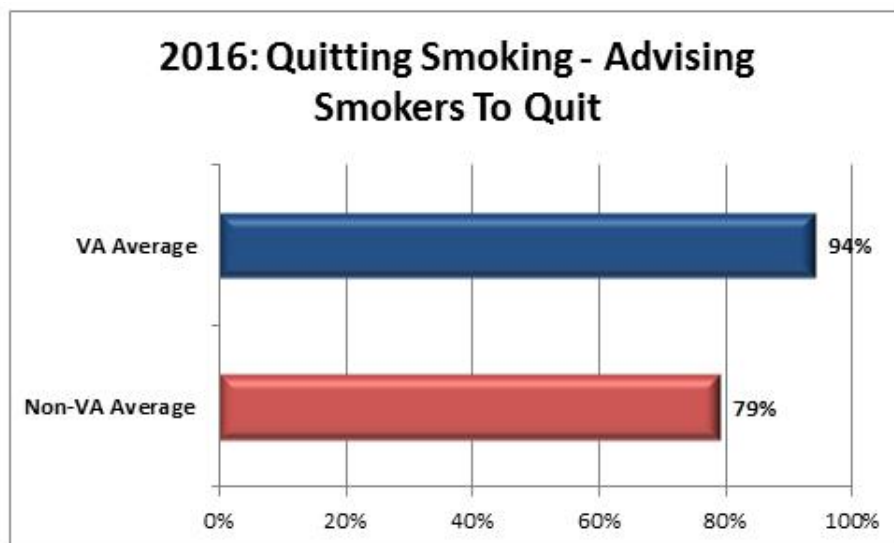
- Antidepressant Management - Acute



- Cardiovascular Care – Controlling High Cholesterol



- Quitting Smoking - Advising Smokers to Quit



The graphs above show VA medical center scores compared with non-VA hospital scores for acute antidepressant management, Cardiovascular Care and Quitting Smoking. For this measure, a higher percentage indicates a higher quality of care, with 100 percent being the target.

## **12. What are the top three opportunities to improve the healthcare services in Conroe CBOC?**

**METHOD** - Driven by this question, we did qualitative analysis by studying GAO's report to Congressional Requesters about VA Healthcare: Actions Needed to Improve Oversight of Community-Based Outpatient Clinics, April, 2018.

**DATA** - In fiscal year 2016, VHA's 733 CBOCs provided care to more than 3 million veterans at a cost of \$5.3 billion. Although most of these clinics are VHA-owned and -operated, 101 are operated through contracts with nonVHA organizations. Community-based outpatient clinics (CBOC) are an important part of the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) health care delivery system. These clinics are geographically separate from VA medical centers (VAMC) and provide outpatient services, including primary care and mental health care. VHA policy states that CBOCs, whether VHA-operated or contracted, must provide one standard of care that is of high quality. According to GAO's findings, VA CBOCs including Concore CBOC can improve its healthcare services in the following top three ways: To complete policy implementation,

create an accurate and complete CBOC report, and have guidance or training on the COBC report.

**LIMITATIONS** - We were unable to verify if Concore COBC has more needs or it has the same issues to be improved for the requirement of a high quality services to the veterans.

### THEME III: FEMALE VETERANS' HEALTHCARE

#### **3.1 How are the younger generations targeted for successful service when leaving the military?**

**METHOD** - We looked at doctoral dissertations that have been published online. We looked within the Congress' website at bills that have been presented to the House of Representatives or the Senate.

**DATA** - According to scholarly research, over half (52%) of the enlisted members in the United States Armed Forces are 25 or under (Zagos 4). The training given in military is often seen as abundantly adequate. However, after leaving service these soldiers lack the training reversal needed to return them to society. The VA hospitals are not looked to the same way as a civilian hospital is, but more as an "extension of military" (Zagos 14). A House Bill 91 has passed the House of Representatives that, once approved, would become a law that forces the VA to appoint peer support counselors for women veterans. These supporters would assist with women that have experienced MST, PTSD, any additional mental health, homelessness, and suicide risk. The bill requires the VA perform outreach, coordinate with community, business, educational, and state/local government to provide peer support and support counselor training (House Bill H.R.4635 2017). Along with these bills, another has been introduced that requires the Veterans Affairs to enforce a pilot program that provides reintegration and readjustment services (in a group treatment setting) for women veterans who were recently separated from service after deployment (House Bill H.R.91 2017).

**LIMITATIONS** - We were unable to verify if or how the younger generations (those ages 25 and under) are targeted at the Conroe CBOC or within Congressional District 8.

**2. What educational and/or targeted training are available for the clinicians and nurses (both within and outside of the VHA)? Are these trainings required or mandatory?**

**METHOD** - We found information within the United States Department of Veteran Affairs website on articles regarding the topic. We looked within the Congress' online website at bills that have been presented to the House of Representatives or the Senate.

**DATA** - A new training program to increase providers and nurses with knowledge of women's health topics was developed; a mini-residency program delivered to rural medical care teams. The initiative is a multi-year training that launched nationally in June 2018 (Women Veterans Healthcare 2016). The trainings include women's health courses for abnormal uterine bleeding, contraception, breast issues, and intimate partner violence (IPV). The on-site trainings that were offered in one day were focused on facilitated case discussions, use of simulation equipment, videos of gynecological procedures and exams, and live models for breast and pelvic exams. The Patient-Aligned Care Team (PACT) train providers and nurses' side-by-side. With a total of 18 hours of training, the partnership with ORH and WHS is delivered in over 40 rural clinics. According to this data, these trainings are not mandatory.

**LIMITATIONS** - We were unable to verify the delivery of this training (or any other trainings) to have taken place at Conroe CBOC or within Congressional District 8.

**3. What nonprofit options are available for women veterans within the 8th district?**

**METHOD** - We found information within the Texas Veterans Commission website

**DATA** - The Texas Veterans Commission offers resources for the veteran population through social media, federal, state, groups, and nonprofit organizations. Women veterans have access to the Women Veterans Professional Network on social media. Those closest to Congressional District 8 can utilize the Facebook groups "Women Veterans of West Texas" and Veteran Females United." Nonprofit organizations that are local or near the Congressional District 8 are the Easter Seals, Family Endeavors, Grace After Fire (US Women Veteran Assistance), YMCA, The Pink Berets, and The Samaritan Center.

**LIMITATIONS** - We were unable to verify how this information is advertised within Congressional District 8 nor that the Conroe CBOC assists veteran women with finding nonprofit options.

**4. Do female veterans have a statistically higher rate of cervical cancer than the average female population?**

**METHOD** - We found information through scholarly articles found online.

**DATA** - Of the 5-million veterans receiving care in the United States, 3% of those are registered among the Veterans Affairs Central Cancer Registry (Zullig et. al. 2012).

**Finding:** We were unable to verify specific information for cervical cancer within the female veteran category (between the specified dates of 2011 to present).

- **Sub question 1:** How are female veterans impacted by military service when compared to the average female population?
- **METHOD** - We found information on The National Center for Biotechnology Information website and United States Department of Veteran Affairs articles online. We looked within the Congress' website at bills that have been presented to the House of Representatives or the Senate.
- **DATA** - Studies have shown that infertility and negative pregnancy outcomes are associated with deployment (NCBI 201). Studies show that veterans that have been deployed show an increased demand for medical intervention for infertility. The VA has specified that fertility and infertility needs should be met for all veterans. Another House Bill has been introduced in early 2017 that, once passed, would require the Department of Defense to furnish treatment and counseling for fertility issues experience by veterans (House Bill H.R.1681 2017). This bill also would allow for spouses, domestic partners, and gestational surrogates for that veteran to receive treatments. The data from an article titled "Women Veterans Health Care," indicates that expenses obtained for adoptions have been identified for reimbursement when the adoption is finalized after September 29, 2016 (2016). The data from US Department of Veterans Affairs indicates that infertility treatments are available through the VA.



- **LIMITATION** - We were unable to verify specific information to validate that the Conroe CBOC offers infertility services, adoption services, or any other fertility needs.

**5. What percent of District 8 female veterans are disabled?**

**Finding:** We were unable to verify the demographics of the district 8 females disability status.

**6. Do the female veterans in District 8 utilize the VHA at the same level as female veterans in urban districts?**

**Finding:** We were unable to verify the level of VHA usage of females within Congressional District 8 or the number of female veteran VHA usage within other urban districts.

- **Sub question 1:** What percentage of District 8 females utilize more than one medical source (dual usage)?
- **Finding:** We were unable to verify the level of VHA use within specific districts or Congressional District 8

**7. Are the women veterans of District 8 with PTSD or depression experiencing worse or more physical/medical health conditions in comparison to women veterans without PTSD or depression?**

**Finding:** We were unable to verify the health conditions for female veterans within Congressional District 8.

**8. Of the female veterans in District 8 that have served in the Gulf War eras or after the events of September 11, 2001, are there more mental health cases than those female veterans in other eras of military service?**

**Finding:** We were unable to verify the number of veteran women that have been deployed and now currently live in Congressional District 8.

**9. What is the average age of the 8th congressional district females?**

**Finding:** We were unable to verify the average age of the females within Congressional District 8.

**10. What is the differences in ages of women and men in the 8th congressional district?**

**Finding:** We were unable to verify the demographics of the Congressional District 8 population.

**11. Do services of Conroe CBOC meet the needs of the female veterans?**

**METHOD** - We explored the Conroe CBOC website and utilized the information supplied within the response from the November 2017 FOIA request.

**DATA** - The Conroe CBOC website only indicates Women's Health services in an overarching generality. The 2017 FOIA response indicates that well women exams and pap smears are the only gender-specific services offered to female veterans at the Conroe CBOC. Infertility services are not offered at the Conroe CBOC.

**LIMITATIONS** - We were unable to verify any additional services offered at the Conroe CBOC.

**ADDITIONAL INFORMATION**

**METHOD** - We located information within the VA's public health information website. We looked within the Congress' online website at bills that have been presented to the House of Representatives or the Senate. We found data online at the 2016 Veteran Integrated Service Networks.

**DATA** - The House of Representatives Bill 4334 has passed through to Senate for voting. The "Improving Oversight of Women Veteran's Care Act of 2018" was introduced in November of 2017. This bill requires that the Department of Veterans Affairs is to annually report on the access that women veterans have to gender-specific care (H.R.4334 2017). These are required to be contracted through non-VA medical providers. This bill, also, requires that each VA medical facility would quarterly report to the VA with issues of compliance that involve privacy, safety, and dignity of women veterans when receiving care. The VA will be forced to report to Congress with plans to add strength to this initiative. The

Conroe CBOC does not have definitive information that indicates if all of the health services are offered to women veterans as required. The Senate introduced a bill that would ensure that VA facilities and medical centers share information between other VA and non-VA facilities within a state-wide electronic format. This would be to ensure that VA medical centers are meeting the healthcare needs of female veterans (Senate Bill S.804 2017). The 2016 Veteran Integrated Service Networks indicate that the most used healthcare system for women in Texas is the VA Heart of Texas Healthcare Network.

**LIMITATIONS** - We were unable to verify what form or format of health coverage that the female veterans in the Congressional 8 currently or formerly utilize. We were unable to verify specific information regarding the Congressional District 8 and the veterans that utilize the Conroe CBOC.

#### THEME IV: MILITARY SEXUAL TRAUMA (MST) AMONG VETERANS OF THE 8TH CONGRESSIONAL DISTRICT

##### **1. What is driving the lower rate of reporting of MSA among male veterans?**

**METHOD** - We performed a review of scholarly literature including information from the Texas A&M University library, JSTORs, and other electronic sources.

**DATA** - Research shows that the current military culture is one of denial and suppression when it comes to reporting of MST. Approximately 50% of sexual assaults in the United States military are of male victims, but only 13% of these assaults are reported. The myth that strong males cannot be victims of sexual assault is pervasive in the military today. This, along with the belief that one must be strong to be successful in the United States military result in feelings of guilt and shame from male victims of MST.

##### **2. Is there anything that can be done to encourage more veterans to report and then seek treatment?**

**METHOD** - We performed a review of scholarly literature including information from the Texas A&M University library, JSTORs, and other electronic sources.

**DATA** - Changing the culture in the United States military to one where sexual assault and sexual harassment is unacceptable is needed. Attitudes at the Department of Defense and top military leaders are slowly changing towards encouraging the reporting of instances of MST.

**3. What are the barriers to 8th district male veterans in completing outpatient treatment programs for both substance abuse and MST?**

**METHOD** - We performed a review of scholarly literature including information from the Texas A&M University library, JSTORs, and other electronic sources. We requested information from the VA regarding the type of counselling available at the Conroe CBOC via direct request and via Freedom of Information Act request.

**Finding:** We were unable to verify the type of counselling available at the Conroe CBOC due to lack of response to our requests.

**4. Is there a lower rate of MST among male veterans at the Conroe CBOC?**

**METHOD** - We performed a review of scholarly literature including information from the Texas A&M University library, JSTORs, and other electronic sources.

**Finding:** We were unable to verify any information regarding the rate of MST occurrence among veterans of the Conroe CBOC.

**5 Is there a statistically significant difference between male veterans who are victims of MST committing suicide and the TX/national average?**

**METHOD** - performed a review of scholarly literature including information from the Texas A&M University library, JSTORs, and other electronic sources.

**Finding:** Were unable to verify any information regarding the suicide rates of veterans of the 8th district.

**1. What can be done to encourage veterans to complete substance abuse treatment programs?**

**METHOD** - We performed a review of scholarly literature including information from the Texas A&M University library, JSTORs, and other electronic sources.

**DATA** - While inpatient treatment is more effective for long term sobriety, the fact is that funding and space is not available for all veterans. One study showed that by issuing vouchers and gift cards to veterans who continue attending outpatient treatment numbers of those who complete the programs increased.

**2. How can the Conroe CBOC share information between VHA and Medicare/private healthcare providers to allow continuity of treatment?**

**METHOD** - We performed a review of scholarly literature including information from the Texas A&M University library, JSTORs, and other electronic sources. We requested information from the VA via direct contact and through the Freedom of Information Act (FOIA) process.

**Finding:** We were unable to verify any information regarding information sharing between the VA and any other agency. Our research has led us to believe that the VA will not share information with any other group or agency without legislative intervention.

**3. Is there a difference between the 8th district veteran suicide rate and the national average?**

**METHOD** - We performed a review of scholarly literature including information from the Texas A&M University library, JSTORs, and other electronic sources. We requested information from the VA via direct contact and through the Freedom of Information Act process.

**Finding:** We were unable to verify any information regarding the suicide rate of veterans of the 8th congressional district.

## THEME VI: POST-9/11 VETERANS IN TEXAS' 8TH CONGRESSIONAL DISTRICT

### **1. What does the post-9/11 veteran population of Texas' 8th Congressional District look like?**

**METHOD** - Compiled and calculated veteran status data from the American Community Survey years 2012-2017. Reviewed the FY2017 VA Disability Compensation and Pension Recipients by County of Residence TX-08 and the Department of Veterans Affairs, Office of Data Governance and Analytics, United States Veterans Eligibility Trends & Statistics (USVETS) 2017

**DATA** - Between 2012 and 2017 approximately 48,673 veterans lived in the 11 counties making up the TX-08 district. Of those, approximately 9,600 or 20% served during the Post 9-11 era.

- Approximately 20,600 male and 3,100 female veterans fell between 35 and 64.
- Approximately 3,177 Post-9/11 era veterans between the ages of 18-34 were residing in TX-08; of those, 284 lived below the poverty level for at least 12 months; 14% of those veterans have a service connected disability.
- Approximately 15,133 were between the ages of 35-54; of those, only 41 lived below the poverty level for at least 12 months; 41% of those veterans have a service connected disability.
- Approximately 6,682 were between the ages of 55-64; of those, approximately 438 lived below the poverty level for at least 12 months; 21% of those veterans have a service connected disability.

**LIMITATIONS** - Secondary data can be general and vague the information and data may not be accurate. The sources of the data appear to be reliable but may be biased. The data includes only those veterans who have enrolled with the VA for eligible veterans and therefore leaves out a significant number of veterans.

## **2. Based Texas state data, what are the common characteristics among Post-9/11 veterans experiencing homelessness that TX-08 service providers should be aware of?**

**METHOD** - Reviewed and analyzed secondary data from the Texas Department of Housing and Community Affairs (TDHCA) 2016 Report on Homelessness among Veterans.

**DATA** - From a data analysis of the 2014, 2015, and 2016 PIT counts of persons experiencing homelessness, a list of common demographics found that Texas veterans:

- Were white males in their mid-50s; were older when first experience homelessness;
- Were more likely to have served in one of the Gulf area conflicts than in Vietnam;
- Became homeless in their mid-40s;
- Had been homeless for a year; but have repeated episodes of homelessness;
- Had been unemployed for a year;
- Be single without household members with them;
- Have higher education levels;
- Have one or more of the following: substance abuse, mental illness, and physical disability;
- Have Post-Traumatic Stress Disorders (“PTSD”)
- Were more likely to be sleeping outdoors than in a shelter; and
- Were more likely to be in a major metropolitan city than in Texas rural and mid-sized cities

**METHOD** - Reviewed and analyzed secondary data from the United States Veterans Eligibility Trends & Statistics (USVETS) 2016 database and VetPop2016.

**DATA** - Through ongoing efforts working with Texas veterans, Texas Department of Assistive and Rehabilitative Services (“DARS”) counselors have identified several reasons contributing to Veteran homelessness, including:

- A direct correlation between lack of income due to limited education and lack of
- ability to demonstrate transferable skills from military to civilian life (especially true of
- younger veterans returning from Iraq and Afghanistan);
- Combat-related physical health issues and disabilities;
- Combat-related mental health issues and disabilities;
- Substance abuse problems that negatively impact job retention; and
- Weak social networks due to problems adjusting to civilian life.

**LIMITATIONS** - Secondary data can be general and vague the information and data may not be accurate. The sources of the data appear to be reliable but may be biased. The data includes only those veterans who have enrolled with the VA for eligible veterans and therefore leaves out a significant number of veterans.

### **Focus Area: Prevention of Homelessness Among Post-9/11 Veterans in the 8th Congressional District**

### **3. Based on 8<sup>th</sup> Congressional District Post-9/11 Demographic Data what are the major areas of concern service providers should focus on for intervention and/or prevention of homelessness among Post-9/11 veterans?**

**METHOD** - Reviewed the following scholarly literature and government reports:

- Veterans of the Post-9/11 Era from the Joint Economic Committee
- Profile of Post-9/11 Veterans: 2016 Prepared by the National Center for Veterans Analysis and Statistics: March 2018. United States Department of Veterans Affairs
- The Veteran Working-Poor: The Relationship between Labor Force Activity and Poverty Status. National Center for Veterans Analysis and Statistics, Department of Veterans Affairs, Washington, DC. November 2017
- Employment Policies for Post 9/11 Veterans: Lessons Learned and a Vision for the Future Simeon John-Armando Switzer Grand Valley State University



- Women Veterans Report: The Past, Present, and Future of Women Veterans. National Center for Veterans Analysis and Statistics, Department of Veterans Affairs, Washington, DC. February 2017
- Fargo and Jamison. 2017. "Homelessness Following Disability-Related Discharges from Active Duty Military Service in Afghanistan and Iraq." *Disability and Health Journal* 10 (4):592-529.
- Reviewed and analyzed secondary data from both the 2015 Veterans and Homelessness Congressional Research Service Report and 2015 Review of the Literature Related to Homeless Veteran Reintegration.

## **DATA – DEPLOYMENT**

- In FY2013, the VA reported that 14% of the more-than 260,000 veterans served in VA  
  
homeless programs were those from OIF/OEF/OND.
- The literature suggests that the Iraq/Afghanistan-era veterans are at a higher risk for homelessness than previous generations of veterans. Because of deployment conditions and recruitment strategies of the recent conflicts, the returning veterans are at higher risk for sustaining the mental health problems correlated with homelessness compared to prior war generations.
- Between 15% - 17% of veterans returning from Iraq and Afghanistan are screening positive for mental health-related trauma, including PTSD, and veterans returning from Iraq are seeking mental health services at higher rates than veterans returning from prior conflicts.
- Veterans returning from Iraq are seeking mental health services at higher rates than veterans returning from prior conflicts (Tanielian and Jaycox 2008). Research also found that the length and number of deployments of troops in Iraq result in greater risk of mental health problems (Tanielian and Jaycox 2008).

## **DATA - EMPLOYMENT**

- In 2015, the unemployment rate for post-9/11 veterans averaged 6%, a somewhat higher unemployment rate than nonveterans and the overall unemployment rate for veterans across all service periods.

- Post-9/11 veterans who served in Afghanistan and/or Iraq have a lower labor force participation rate (78.2%) than post-9/11 veterans who served elsewhere (83.1%). Four in five post-9/11 veterans are working or actively searching for work.
- Veterans who served in Afghanistan have a higher unemployment rate (10.5%) than veterans who served in Iraq (7.1%) and veterans who served elsewhere (7.8%).
- Secondary to the missions in Iraq and Afghanistan, combat military operation specialties (MOS) make up a large percentage of the service members that are attempting to enter the labor force. Due to the negative stereotypes potential employers may hold about combat deployment, veterans who served in Iraq and Afghanistan face the negative stigma of Post-Traumatic Stress Disorder (PTSD), which can create a significant employment barrier.

## **DATA – POVERTY/WORKING POOR**

- Veterans who served during the Post-9/11 Gulf War Era have the highest working-poor rate (5.5%) compared to those who served during either Pre-9/11 Gulf War era (4.1%), Vietnam Era (3.7%) or peacetime only (4.7%).
- More than one in ten (11.3%) veteran's ages 18 to 34 years lives in poverty. Poverty is even higher among disabled young veterans.
- A higher percentage of post-9/11 veterans lived in a household that received food stamps, had no health insurance coverage, lived in poverty and had no income compared to their counterparts.

## **DATA – SERVICE CONNECTED DISABILITY**

- OEF/OIF female veterans represent the largest cohort of women in history who were involved extensively and actively in combat operations.
- For the post-9/11 veteran population, a higher percentage female than male veterans were age 34 or younger. About 48% of the total post-9/11 population was age 34 or younger.
- A higher percentage Post-9/11 female veterans lived in poverty, lived in a household that received food stamps and had no income compared to their male colleagues.
- The average unemployment rate in 2015 for female post-9/11 veterans (6.7%) was higher than for male post-9/11 veterans (5.9%). It was also higher than the average unemployment rate for women who are not veterans (5.1%).

## **DATA – FEMALE POST-9/11 VETERANS**

- OEF/OIF female veterans represent the largest cohort of women in history who were involved extensively and actively in combat operations.
- For the post-9/11 veteran population, a higher percentage female than male veterans were age 34 or younger. About 48% of the total post-9/11 population was age 34 or younger.
- A higher percentage post-9/11 female veterans lived in poverty, lived in a household that received food stamps and had no income compared to their male colleagues.
- The average unemployment rate in 2015 for female post-9/11 veterans (6.7%) was higher than for male post-9/11 veterans (5.9%). It was also higher than the average unemployment rate for women who are not veterans (5.1%).

**LIMITATIONS** - Secondary data can be general and vague the information and data may not be accurate. The sources of the data appear to be reliable but may be biased. The data includes only those veterans who have enrolled with the VA for eligible veterans and therefore leaves out significant number of veterans.

### **Focus area: Service Providers Assisting Homeless Veterans in Texas' 8th Congressional District**

#### **4. Are there enough service providers to meet the needs of the veterans experiencing homelessness in the 8th Congressional District, Texas?**

**METHOD** - Reviewed and analyzed service provider list on TexVet; ([www.texvet.org](http://www.texvet.org)). TexVet is an initiative of the Texas A&M University Health Science Center and Texas Health and Human Services, TexVet is a state program for Texas' Service Members, Veterans, Families, and those that serve them, providing the best and most reliable information and referral resources. For each of the organizations listed in the TexVet database (as of October 2017), I looked through the organization's website for in-depth information. Specifically, I wanted to categorize the type of service(s) provided, and the location(s) of the service. I compiled a list of all the TX-08 counties with the veteran population of each area. I was then able to compute the number of veterans relative to the

population in each county. After completing the dataset, I was able to remove all duplicate organizations.

**DATA** - On the home page of the TexVet website a veteran can click on their county of residence and will be directed to a list of all organizations within the selected county providing law, housing, transportation, medical, mental health, peer network, women specific, employment and counseling services;

TexVet provides lists of nonprofit and government run organizations within each county within the 8th district offering homeless assistance. This list can lead one to believe there are an appropriate number of service organizations per county however this can be misleading because many of the organizations either only serve one specific county or are spread thinly between several counties. Of the 40 organizations categorized as providing homeless assistance services only 17 provide the assistance for which they are categorized. Some were just in one city or county, some were in multiple cities or counties, some statewide, and others were nationwide.

Very few of those provide any type of report or data on the number of veterans served; a fact to me which prompts the question, do organizations in the 8th district receive the necessary funding needed to sufficiently support our veterans experiencing homelessness and how can organizations better collect data needed to substantiate these needs.

**LIMITATIONS** - Secondary data can be general and vague the information and data may not be accurate. The sources of the data appear to be reliable but may be biased. The data includes only those veterans who have enrolled with the VA for eligible veterans and therefore leaves out a significant number of veterans.

#### **Focus area: Veteran Health Care Administration Enrollment**

#### **5. Are eligible veterans residing in the 8th Congressional District enrolling to utilize VA healthcare and if not, why?**

**METHOD** - I searched the internet, Government Accountability Office (GAO) reports, Office of Inspector General (OIG) reports, and the VA website for any information collected on the reasons why veterans choose not to enroll for VA benefits and what those numbers

looked like but was unable to find any significant quantitative data. However, and most unfortunately, that data is not made available as the nonprofit organizations within the Balance of State Continuum of Care who submit data to the THN using the HMIS serving veterans in the 8th Congressional district do not collect any data on the subject.

**DATA** - The Texas Homeless Network (THN) and the Texas Department of Housing and Community Affairs (TDHCA) collaborate to help communities strategically plan to prevent and end homelessness. THN acts as the data integrity arm of the partnership collaborating with all communities, large and small, across the state to build systems to achieve this goal. THN coordinates local and national advocacy efforts, data collection and research, and serves as the host agency for the Texas Balance of State Continuum of Care (CoC), which includes the 8th Congressional District, assisting in the coordination of programs and funding.

Sophia Checa serves as the THN Continuum of Care (CoC) Director responsible for implementing Coordinated Entry in the Texas Balance of State Continuum of Care (BoS CoC). Per Sophia, the BoS CoC does not require any of the nonprofit organizations to inquire as to whether the veterans they serve are enrolled with the Veterans Healthcare Administration (VHA) and subsequently would not accumulate any data on reason why veterans choose not to use VHA.

**Finding:** Based on the information and data provided we were unable to verify if nonprofit organizations within the Texas' 8th Congressional District are capturing information regarding veteran participant VHA enrollment and subsequently reasons why they would choose not to enroll if that was the case.

**LIMITATIONS** - Secondary data can be general and vague the information and data may not be accurate. The sources of the data appear to be reliable but may be biased. The data includes only those veterans who have enrolled with the VA for eligible veterans and therefore leaves out a significant number of veterans.

## FINDINGS

As previously stated, our team found some new information to report to Congressman Brady. However, many data gaps still exist when trying to find information specific to the 8th

district veterans and services available to them. Limitations with transparency and access to information within the VA system was a common occurrence for all team members during this project. We are presenting the evidence-based research and data that was available, as well as reporting on information we were unable to verify in hopes of shedding more light on the needs of veterans living in the 8th district.

## THEME I: COMPARATIVE ANALYSIS AND THE VETERANS CHOICE ACT

### *Congressional Districts 8 and 31:*

- CD8 has a smaller (51,121) total population of veterans than CD 31 (87,708).
- CD8 has a declining male veteran and an increasing female veteran population projection, while CD31 has an increasing male and female veteran population projection.
- CD8 spends less on total expenditures (\$364M) and medical care (\$129M) for veterans than CD31 which spends (\$1.2B) on total expenditures and (\$321M) on medical care for veterans.
- CD8 and CD31 have a higher percentage of poverty for veterans in the 18-34 age range compared to other age ranges.

### *Conroe CBOC and Cedar Park CBOC*

- Conroe CBOC accounts for 13% of primary care workload and 17% of the DeBakey mental health workload. Beaumont CBOC accounts for the 24% (the highest percentage overall) of primary care workload and 18% of the DeBakey mental health workload.
- Conroe CBOC performs better than the Cedar Park CBOC in terms of scheduling primary care appointments; 77% of veterans were able to always or usually schedule a primary care appointment at the Conroe CBOC versus only 67% at the Cedar Park CBOC.
- Conroe CBOC schedules 97% of their appointments in 30 days or less while the Cedar Park CBOC schedules 96% of their appointments in 30 days or less.

### Veterans Choice Act

- The Veterans Choice Program has served 5.2 million veterans between November 2014 and August 2018.
- The highest eligibility category is the first choice category.
- The third party administrator for Texas and much of the Southwest (TriWest) authorized 3.5 million eligibilities between November 2014 and August 2018, while the other major third party administrator (HealthNet) only issued 1.7 million eligibilities.
- The VA MISSION Act was signed in 2018, is intended to consolidate programs and add new veterans programs, as well as appropriate \$5.2 billion for future Veterans Choice Program services.

### **THEME II: VETERAN OVERALL HEALTHCARE**

- According to GAO report 2018, the VA allocates 32% of its healthcare budget to rural veteran care.
- The average expenditure per patient in CD8 is about \$9,500. Compared to Texas, the average expenditure per patient is about \$10,800, and it is about \$11,500 for the nation.
- The average expenditure per patient in CD8 is about \$1,300 lower than the Texas average, and about \$2,000 lower than the nation's average.
- Between 2011-2015, 58% of rural veterans were enrolled in the VA healthcare system, compared to only 37% of urban veterans.
- Conroe CBOC does not have emergency service, but it is about an hour drive to the Debakey VA hospital.
- Veteran patient experience in Houston compared to the nation shows that access in Houston is 44% versus 67% nationwide, while the patients' rating of the provider in Houston is 62% versus 82% nationwide.

### **THEME III: FEMALE VETERANS HEALTHCARE**

- Researchers have found that infertility and negative pregnancy outcomes have been associated with deployment. These studies indicate there is, also, an increased demand for medical intervention to infertility in these veterans.

- Gender-specific healthcare trainings are not a mandatory requirement, though they increase the knowledge for clinicians and nurses on women's health topics specifically tailored to rural medical care teams.

#### **THEME IV: MILITARY SEXUAL TRAUMA (MST) AND SUBSTANCE ABUSE AMONG VETERANS OF CD8**

- More than 50% of the victims of rape in the United States military are male.
- Only 13-15% of male victims of sexual assault or sexual harassment in the United States military report the crime.
- The Department of Defense, as early as 2006, recognized an unofficial culture present in the United States military, which perpetuates rape.
- One of the most difficult parts of substance abuse treatment for veterans is encouraging them to continue and complete treatment programs.
- There is a critical need for sharing of patient information across the multiple platforms of treatment available to veterans. There is currently no method of sharing information between the VA, Medicare and other healthcare programs to promote continuity of care for veterans.

#### **THEME V: POST-9/11 VETERANS IN CD8 AND POST-9/11 VETERAN DEMOGRAPHICS**

- 20% of CD8 veterans served during the post-9/11 era.
- Approximately 20,600 male and 3,100 female veterans fell between 35 and 64.

##### *Verified Factors Contributing to Veteran Homelessness in Texas*

- A direct correlation between lack of income due to limited education and lack of ability to demonstrate transferable skills from military to civilian life (especially true of younger veterans returning from Iraq and Afghanistan);
- Combat-related physical health issues and disabilities;
- Combat-related mental health issues and disabilities;
- Substance abuse problems that negatively impact job retention; and
- Weak social networks due to problems adjusting to civilian life.



### Post-9/11 Veteran Homelessness

- In FY2013, the VA reported 14% of +260,000 veterans served in VA homeless programs were those from OIF/OEF/OND.
- Iraq/Afghanistan-era veterans are at a higher risk for homelessness than previous generations of veterans. Due to deployment conditions and recruitment strategies of recent conflicts, returning veterans are at higher risk for sustaining mental health problems correlated with homelessness.
- In 2015, the unemployment rate for post-9/11 veterans averaged 6%, a higher unemployment rate than nonveterans and the overall unemployment rate for veterans across all service periods.
- Secondary to the missions in Iraq and Afghanistan, combat military operation specialties make up a large percentage of service members attempting to enter the labor force. Due to negative stereotypes employers may hold about combat deployment, veterans who served in Iraq/Afghanistan face the negative stigma of PTSD.
- Veterans who served during the post-9/11 have the highest working-poor rate (5.5%) compared to those who served during either Pre-9/11 Gulf War era (4.1%), Vietnam Era (3.7%), or peacetime only (4.7%).
- A higher percentage of post-9/11 veterans lived in a household that received food stamps, had no health insurance coverage, lived in poverty and had no income compared to their counterparts.
- OEF/OIF female veterans represent the largest cohort of women in history who were involved extensively in combat operations.
- The average unemployment rate in 2015 for female post-9/11 veterans (6.7%) was higher than for male post-9/11 veterans (5.9%). It was also higher than the average unemployment rate for women who are not veterans (5.1%).
- A higher percentage post-9/11 female veterans lived in poverty, lived in a household that received food stamps and had no income compared to their male colleagues.

### **CROSS CUTTING THEMES**

Our research consisted of a combination of elite interviews, content analysis of additional peer-reviewed literature, and thorough reviews of applicable archival and publicly available

datasets. Throughout our research, five themes reflecting the most prevalent topics that affect veterans' lives consistently reemerged. Given the themes are interconnected, there may be a risk that considering them in isolation will lead to failure to spot repeated issues that could affect all. From our literature review, information collection, and data analysis, our team identified several cross-cutting themes specifically applicable and unique to the 8th district including:

Cross-cutting themes are as follows:

### **Post 9-11 Veterans**

A significant number of post-9/11 veterans living in the 8th district. Between 2012 and 2017, approximately 48,673 veterans lived in the 11 counties making up the 8th district. Of those, approximately 9,600 or 20% served during the post-9-11 era. Post-9/11 veterans are the youngest cohort being served by the VA. Post-9/11 veterans are those who have served after September 2001. As of 2016, there are 4.2 million post-9/11 veterans of which 2.8 million served only during post-9/11. As an end date to the post-9/11 era has not been established, the post-9/11 cohort will continue to grow. VA projects a post-9/11 veteran population of just under 5.1 million by 2021.

About 74% of post-9/11 veterans are under age 45. A higher percentage of post-9/11 veterans had a service-connected disability, used VA healthcare only, lived in a household that received food stamps, had no health insurance coverage, lived in poverty and had no income compared to their counterparts.

A lower percentage of post-9/11 veterans enrolled in VA healthcare than all other veterans. Of those enrolled in VA healthcare, post-9/11 veterans used VA healthcare at a lower rate than all other veterans. Among the service-connected disabled population, the post-9/11 veterans used VA healthcare at a lower rate than all other veterans (NCVAS 2018).

### **Age**

According to scholarly research, over half (52%) of the enlisted members in the United States Armed Forces are 25 or under (Zagos, pg. 4). This places over half of our veteran population serving during post-9/11 service eras. For the post-9/11 veteran population, a

higher percentage of female than male veterans were age 34 or younger. About 48% of the total post-9/11 population is age 34 or younger (NCVAS 2018).

Male veterans make up 91% of the total veteran population and female veterans make up 9% of the veteran population in the 8th district. However, the male veteran population for ages 17-64 in the 8th district is expected to decrease -3%, while the female veteran population is expected to increase +39% (VetPop 2016). Male veterans who are 65+ will also have a projected decrease of -8% in population. The most surprising percentage is the female veterans who are 65+. This age range is expected to increase +83% in the 8th district over a 10-year period.

### **Female Veterans**

Nationally the OEF/OIF female veterans represent the largest cohort of women in history who were involved extensively and actively in combat operations. Consequently, in 2016 a higher percentage of post-9/11 female veterans lived in poverty, lived in a household that received food stamps and had no income compared to their male colleagues. The VA is making female veteran service availability a top priority. “Improving Oversight of Women Veteran’s Care Act of 2018” was introduced in November of 2017. This bill requires that the VA is to annually report on the access that women veterans have to gender-specific care (H.R.4334 2017). The Conroe CBOC does not have definitive information that indicates if all of the health services listed are offered to women veterans as required. In fact, the Conroe CBOC website only indicates women’s health services in an overarching generality. The 2017 FOIA response indicates that well-women exams and pap smears are the only gender-specific services offered to female veterans at the Conroe CBOC. Infertility services are not offered at the Conroe CBOC.

### **Deployment Attributed Issues**

According to the Institute of Medicine 2013 report “Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans...” problems of unemployment and underemployment, appear to be more acute for veterans of the post-9/11 era, particularly young veterans. In 2011, the unemployment rate among all post-9/11 veterans 18 years old and older was more than one-third higher than that among equivalent nonveterans—12.1%

compared with 8.7%. Among veterans 18–24 years old, the rate was almost twice as high—30.2% compared with 16.1% (Institute of Medicine, p.375, 2013).

Additionally, the literature suggests that the Iraq/Afghanistan-era veterans are at a higher risk for homelessness than previous generations of veterans. Because of deployment conditions and recruitment strategies of the recent conflicts, the returning veterans are at higher risk for obtaining the mental health problems correlated with homelessness compared to prior war generations. Researchers also found that the length and number of deployments of troops in Iraq results in greater risk of mental health problems (Tanielian and Jaycox 2008). Veterans returning from Iraq are seeking mental health services at higher rates than veterans returning from prior conflicts (Tanielian and Jaycox 2008).

### **Barriers to Care**

Britt et al. (2008) and Hoge et al. (2008) highlight issues such as veterans not knowing where to go for treatment, not having enough leave time, long distances to travel to a facility, lengthy wait times, workforce shortages, and stigma. Furthermore, among military personnel who screened positive for a mental disorder, 55% stated it would be difficult to obtain time off from work, and 45% stated it would be difficult to schedule an appointment (Hoge et al., 2008). Similarly, a recent GAO report (2011) notes logistical challenges for veterans in accessing mental-healthcare, including difficulty in scheduling and coordinating appointments, long distances to facilities and other transportation challenges, cost of services, challenges in arranging child care or spousal support, and other time constraints (IoM, p. 340, 2013).

### **Poverty**

Using United States Census data from 2017, poverty rates for the 8th district indicated that 4% of the total veteran population (45,814) was below the poverty line. Overall the veteran age range of 18-34 in the 8th district has the highest percentage (8.9%) of poverty.

Nationally, veterans who served during the post-9/11 Gulf War era have the highest working-poor rate (5.5%) compared to those who served during either pre-9/11 Gulf War era (4.1%), Vietnam era (3.7%), or peacetime only (4.7%). More than one in ten (11.3%) veterans ages 18 to 34 years lives in poverty. Poverty is even higher among disabled young veterans.

A higher percentage of post-9/11 veterans lived in a household that received food stamps, had no health insurance coverage, lived in poverty and had no income compared to their counterparts. In 2015, the unemployment rate for post-9/11 veterans averaged 6%, a somewhat higher unemployment rate than non-veterans and the overall unemployment rate for veterans across all service periods.

Post-9/11 veterans who served in Afghanistan and/or Iraq have a lower labor force participation rate (78.2%) than post-9/11 veterans who served elsewhere (83.1%). Four-in-five post-9/11 veterans are working or actively searching for work. Veterans who served in Afghanistan have a higher unemployment rate (10%) than veterans who served in Iraq (7.1%) and veterans who served elsewhere (7.8%).

## DISCUSSION AND IMPLICATIONS

In an effort to focus on the veterans of the 8th district, our capstone group has analyzed the Conroe CBOC and the district's veteran population. The 8th district is home to over 3% of the total veteran population in Texas. Relative in size and population, Congressional District 31 (the 31st district) houses over 5% of the total veteran population in Texas. Our capstone group looked closely at these two districts to analyze how well the 8th district is performing for its veterans in comparison to relatively similar districts. Both districts have similarities in poverty levels (4% in the 8th district and 6% in the 31st district) with the majority of those in poverty being 18-34-year-old veterans. Post-9/11 veterans are among the highest working-poor veterans, receiving food stamps, lacking health insurance, and lacking income.

Poverty levels are important, as they are related to the level of physical and mental healthcare needed for veterans. Conroe CBOC held a rate of 17% of the Michael E. DeBakey system's mental health workload and 13% of the DeBakey system's primary care workload in 2017. As it was compared, the Conroe CBOC was better at setting appointments within 30 days (at 97%) than Cedar Park CBOC (at 96%). The Veterans Choice Act was established to ensure that veterans are able to have their needs met. Over 5-million veterans utilized the Veterans Choice Program in the past 4 years. Choice first was the highest level of eligibility for veterans within this program.

Access to care has been rated at over 60% nationwide. The DeBakey Medical Center in Houston offers more advertised programs and resources than the Central Texas Veterans Health Care System. The DeBakey Center serves over 130,000 veterans in southeast Texas and is the parent facility for Conroe CBOC. The Conroe CBOC offers many services but is lacking in emergency care service, suggesting patients call 9-1-1, VA Suicide Prevention Hotline, or Network Telecare and Appointment Center for unavailable emergency services. Additionally, it was found that only one mental health program can be identified to treat veterans in their homes/communities within the Central Texas VHCS.

Mental health and substance abuse are associated with many issues among veterans. Substance abuse lacks sufficient space and funding for all veterans. Military Sexual Trauma (MST) is an underreported area of Veteran Affairs, especially with male veterans. Only 13% of males within the 50% of males who experience MSTs are actually reported. Male veterans are the majority in both congressional districts, with the 8th district having 91% and the 31st district having 84% male veterans of the total veteran population in the districts. Though the number of male veterans is far more than female veterans, the projection of male veteran numbers for ages 18-34 in the 8th district is set to decrease (-3%) versus female veterans of the same age that will increase (+39%). This same projection in female veterans is set to increase more than +83% for elderly veteran females.

Female veterans comprise over half of those under age 25 enlisted in the United States Armed Forces. Post-9/11 female veterans are higher in percentage than post-9/11 male veterans. With higher unemployment rates, higher poverty rates, and higher levels of combat-related experience, a greater need exists for female veteran peer support. This peer support is lacking within the VA for those that transition from active to veteran status and outreach is essential. The female veterans in the 8th district are able to utilize the Texas Veterans Commission to find nonprofit, social media, federal and state groups. Similarly, catering to veteran women's health requires a certain level of gender-specific training. Though trainings exist to assist clinicians and nurses with education in this field, the on-site trainings are short and never mandatory. As infertility rates increase with deployed veterans, the need for infertility and adoption services has also increased. The United States Department of Veterans Affairs shows that infertility treatments are available through the VA. Women services offered at the Conroe CBOC are limited to well-women exams and pap smears with no infertility services offered.

As the post-9/11 veterans emerge and populate the 8th district, homelessness is a factor that needs to be addressed. As 20% of veterans in the 8th district served in the post-9/11 era, the primary ages of veterans living in poverty that have served in post-9/11 era are ages 18-34 and closely following are ages 55-64. Texas veterans that enter into homelessness are primarily white males in their mid-50s, having served in one of the Gulf War conflicts, with repeated episodes of homelessness, are unemployed, single, have PTSD, are more likely living within major metropolitan areas. The primary causes of homelessness among veterans is limited education, inability to transfer military skills to civilian, physical and/or mental health disabilities, substance abuse issues, and weak social networks when adjusting to civilian life. Researchers have found data that shows 15% -17% of veterans returning from Iraq/Afghanistan have positive screening for mental health, of those 6% of veterans (post-9/11) have higher unemployment rates, and these veterans face negative stereotypes when returning to the workforce.

Additionally, disabilities among veterans is highest among the World War II veterans living in rural areas. With over 36% of Texas veterans living in rural areas, the distance a veteran must travel for care is vital. The average age of a rural veteran is 65-years-old and the average distance traveled for primary care is over 44 miles. These rural veterans have a lower health-related quality of life. The Conroe CBOC was established to assist with access to primary care for these rural veterans. Of these rural veterans, 58% are enrolled in the VA Health Care System, however, few rural veterans utilize the VA as their primary source of health insurance. Rural veterans are found to have higher poverty rates, more elderly residents, poorer health, and fewer physician practices, hospitals, and other health resources to rely on. The VA has allocated 32% of its healthcare budget to accessible care for rural veterans.

The expenditures within a district are necessary to explore when considering the effectiveness of the 8th district. Even higher in comparison is the difference of spending between the two comparable districts. Data establishes that the 8th district spends less on medical care per veteran in comparison to the 31st district. The difference in the total medical expenditures per district is high, as well. CD8 spent less (\$364M) than CD31 (\$1.2B) on total expenditures for veterans in FY2017. CD8 also spent less on medical care (\$129M) than CD 31 (\$321M). With over 30,000 more veterans in the 31st district, the difference in spending can be evaluated as such. The TexVet website leads a veteran to believe there are many

resources within reach, however, the resources are found to often spread across several counties. With lacking data available to validate the usefulness of these resources, the ability to verify the 8th district's veterans needs are being met is lacking.

## RECOMMENDATIONS

Our team findings provide some insightful information about the 8th district. However, a greater level of transparency and data accessibility are needed for future research. The following recommendations propose methods that could increase efficiency to provide better healthcare services to veterans.

### 1. Comparative Analysis and the Veterans Choice Act

- Create a third party accountability division of the VA (like the United States Government Accountability Office but only for veterans) to cross-check data provided by the United States Census Bureau.
- Develop a female liaison accountability program for all CBOCs to ensure that all clinics are equipped to handle an increased female veteran population.
- Develop a better accounting system for geographic expenditures within congressional districts.
- Develop a universal reporting system for VA clinics and hospitals to ensure that all facilities report mental health patients using the same terminology.

### Veterans Choice Act

- Limit the work of the third-party administrator TriWest to increase state involvement.
- Develop a method to account for veterans using VCP usage by state.
- Create a database of veterans who have used private hospitals in place of VA facilities because of one of the five eligibilities for the VCP.
- Provide more funding to VA hospitals and clinics versus the VCP.

### 2. Overall Veterans Healthcare

- Apply for more healthcare funding from the VA specifically allocated to rural veteran care to better serve rural veterans in CD8.
- In order to improve the quality of care to reach the national level, apply for more funding for veterans from the VA, as the average expenditure per patient in this area is much lower than the state's average and the nation's average.
- Launch a transparent and effective management and service system at Conroe CBOC.



- Establish a ER for veterans in Conroe CBOC.

### 3. Female Veterans Healthcare

- Increase fertility treatment options at the Conroe CBOC.
- Increase adoption sources and assistance at the Conroe CBOC.
- Ensure that gender-specific healthcare training be required for all clinicians and all staff.

### 4. Military Sexual Trauma (MST) Among Male Veterans and Substance Abuse of CD8 Veterans

- Ensure the DOD acknowledges an “unofficial” culture that perpetuates rape.
- Change the current culture.
- Destroy current myths.
- Unable to determine specific specialized treatment available to veterans of the 8th district due to lack of response from the VA.

### Substance Abuse

- VA refuses to share information.
- Legislation needed:
  - Database of patient information across all care platforms
  - Increased levels of care
  - Increased safety for patients

### 5. Post-9/11 Veterans in CD8 and Post – 9/11 Veteran Demographics

- Identify and be accountable to all veterans experiencing homelessness.
- Continue working with the Texas Homeless Network and the Texas Veterans Commission to establish and conduct district wide coordinated outreach and engagement efforts to reach all sheltered and unsheltered veterans within the community.
- Create an interagency group that meets regularly, as often as once a week, to discuss and create action plans for the Veterans on the list, review the options for housing that are currently available for homeless households, and follow up with those households who have been housed.

## APPENDIX A.1: EXTERNAL COMMUNICATION

**Team Request:** November 1, 2017\* a Freedom of Information Act (FOIA) request was filed with the Michael E. DeBakey VA Medical Center, Houston, TX requesting the following information:

1. "Total dollars spent for the Conroe CBOC VA Outpatient Clinic per year for the years 2012-2016.
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 ([https://www.houston.va.gov/locations/Conroe\\_VA\\_Outpatient\\_Clinic.asp](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 year for the years 2012-2016.
5. List of "Women's Health" services offered at the Conroe CBOC per year for the years 2012-2016.
6. Total dollars spent on "Primary Care" services at the Conroe CBOC per year for years 2012-2016.
7. Total number of veterans served per year with "Primary Care" services at the Conroe CBOC for years 2012-2016 and what percent of those were women.
8. Total dollars spent per year on "Audiology" services at the Conroe CBOC for years 2012-2016.
9. Total number of veterans served per year with "Audiology" services at the Conroe CBOC for years 2012-2016 and what percent of those were women
10. Total dollars spent per year on "Behavior Health" services at the Conroe CBOC for years 2012-2016.
11. Total veterans served per year with "Behavioral Health" services at the Conroe CBOC for years 2012-2016.

12. Total veterans served per year with "Retinal Imaging" and general optometry services at the Conroe CBOC 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 for years 2012-2016."

**External Response:** December 12, 2017 a "no records" response was issued by the VA regarding several of the requested items of information.

**Team Request:** January 8, 2018\* an appeal was filed on the "no records" response.

**In Person Meeting:** June 6, 2018 we had a client meeting with Thomas Mardik, of Congressman Brady's Conroe office, who was to be our contact at the Congressman's office. We asked him if he could acquire some of the information that we were needing through the Congressional Research Service (CRS).

**Team Request:** June 8, 2018 William Huffman sent the following list of requested information to Thomas Mardik.

1. Total dollars spent for the Conroe CBOC and Cedar Park CBOC VA Outpatient Clinic per year for the years 2012- 2017.
2. Total dollars spent for "Women's Health" at Conroe and Cedar Park CBOCs for years 2012-2016.
3. Total dollars spent on "Primary Care" services at the Conroe and Cedar Park CBOCs per year for years 2012-2017
4. Total dollars spent on "Audiology" services at the Conroe and Cedar Park CBOCs
5. Total dollars spent per year on "Behavioral Health" services at the Conroe and Cedar Park CBOCs for years 2012-2017.
6. Total dollars spent on optometry services at the Conroe and Cedar Park CBOCs for 2012-2017.

**Team Request:** The following are additional questions which were submitted in a FOIA provided by a different team member.

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 2012-2017.
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 - 2017.
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 the nation broken down by state.
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).
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).
7. Total dollars spent, total hours of training provided, and total medical providers trained (for the Conroe CBOC and Cedar Park 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.
8. Total number of female veterans from the zip code list that used the Conroe and Cedar Park CBOCs per year for years 2012-2017.
9. Total number of veterans categorized as "rural" who have received care from the Conroe and Cedar Park CBOCs per year for years 2012-2017. 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 Cedar Park CBOC releasing (and sending) medical information requested by Conroe and Cedar Park CBOC patients to a non-VA provider for the years 2012-2017.

11. The number of veteran suicides disaggregated by gender per year for the years 2012-2017 in Texas broken down by zip code.

- 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?
- e. How many had been screened or treated for substance abuse?

**External Response:** July 2, 2018 a response was issued by the VA stating that Freedom of Information Act standards had been met and that no further information would be forthcoming.

**Team Request:** July 7, 2018 William Huffman emailed Thomas Mardik of Congressman Brady's office in a second request regarding the information we were hoping to obtain through the CRS.

**External Response:** September 14, 2018 Adeline Fox spoke with Deborah Meyer at the Central Texas Veterans Healthcare System who advised that for answers to questions such as we were requesting that a FOIA request would have to be filed.

**Team Request:** September 29, 2018, a Freedom of Information Act request was filed with the South Texas Veterans Healthcare system, FOIA officer Nigel Burns. The following information was requested.

1. What does the head of behavioral services at the Cedar Park CBOC see as the key successes the Cedar Park CBOC regarding mental/behavioral health services?
2. What does the head of behavioral services at the Cedar Park CBOC see are the greatest challenges the Cedar Park CBOC has in its efforts to help veterans heal/improve behavioral health conditions they and their families face?

3. Are Cedar Park CBOC mental health practitioners specifically trained for the care of veterans' behavioral health issues? If yes, is the training a requirement for work at the Cedar Park CBOC? If yes, what does this training involved?
4. Does the Cedar Park CBOC offer veteran specific training for community partners and external practitioners in the 8th District region?
5. Is the Cedar Park CBOC participating in any VA initiative to providing training and educational opportunities at the CBOC or by partnering with educational institutions (i.e. internship, residencies, staff lectures at regional academic programs such as Sam Houston State University graduate counseling program)?
6. Does the Cedar Park CBOC have a referral network of mental health practitioners and services?
7. Does the Cedar Park CBOC have unfilled vacancies of mental health professional staff at present time? If so, why?
8. How many mental health professionals does the Cedar Park CBOC have on staff full time and part time?
9. What variety of mental health professionals (i.e. psychiatrists, psychologist, counselors, nurse practitioners, social workers) does the Cedar Park CBOC have on staff full time and part time?
10. How many veterans seek mental health services at the Cedar Park CBOC – weekly/monthly/yearly?
11. How many veterans' spouses seek mental health services at the Cedar Park CBOC - weekly/monthly/yearly?
12. How many veterans' children seek mental health services at the Cedar Park CBOC - weekly/monthly/yearly?
13. How many evaluation and diagnostics does the Cedar Park CBOC conduct - weekly/monthly/yearly?
14. What are of most prevalent mental health diagnoses.

15. How many medication check appointments does the Cedar Park CBOC conduct - weekly/monthly/yearly? Are these in person or telemedics?
16. Is there information on how many remain being treated at the Cedar Park CBOC and how many are referred to external services? If so, what are the numbers?
17. Does the Cedar Park CBOC keep statistics on treatment completion/ levels of improvement/reduced disability? If yes, what are the numbers?
18. What is the productivity level of the Cedar Park CBOC? And more specifically, what is the productivity level of the Cedar Park CBOC behavioral health services?
19. Has a correlation between productivity and veterans' behavioral health improvement / disability reduction been studied at the Cedar Park CBOC? If yes, has the information been published?
20. Do practitioners/case managers notice specific reluctance to treatment for fear of reduced disability rating and loss of benefits? Is this noted in any form or tracked in any way?
21. Who is involved in the creation of treatment plans? Case worker/mental health practitioner/ regular healthcare provider/veteran/family member/other.
22. Is there an interdisciplinary mental health medication management approach at the Cedar Park CBOC?
23. Are medications provided in-house or externally?
24. Does the Cedar Park CBOC offer individual psychotherapy?
25. Does the Cedar Park CBOC offer group psychotherapy?
26. Does the Cedar Park CBOC offer tele-mental health alternatives?
27. Does the Cedar Park CBOC offer eye movement desensitization therapy?
28. Does the Cedar Park CBOC offer reprocessing therapy?
29. Does the Cedar Park CBOC offer cognitive processing therapy?
30. Does the Cedar Park CBOC offer dialectical behavior therapy?
31. Does the Cedar Park CBOC offer prolonged exposure therapies?

32. Does the Cedar Park CBOC offer alternative therapies such as equine or art (creative art/drama/ music/dance & movement) therapies?
33. Does the Cedar Park CBOC offer peer support groups?
34. Does the Cedar Park CBOC offer counseling services? For individual veterans? For spouses? For children? For couples?
35. Does the Cedar Park CBOC offer motivational interviewing therapy?
36. Does the Cedar Park CBOC offer anger management therapy?
37. Does the Cedar Park CBOC offer social skills therapies/workshops?
38. Does the Cedar Park CBOC offer substance use disorders therapies?
39. Does the Cedar Park CBOC offer or allow others to offer at their facility other recovery services such as AAA, Al-Anon, etc. meetings?
40. Does the Cedar Park CBOC follow any particular collaborative care model such as Patient-Aligned Care Team model?
41. Does the Cedar Park CBOC participate in outreach and disseminating activities that relate to veteran mental health in general and the Cedar Park CBOC in particular?
42. Does the Cedar Park CBOC receive any grant money for training, research and/or education related to veteran mental health issues?

**External Response:** October 1, 2018, received a response from the South Texas Veterans Healthcare System stating that the FOIA request did not meet the standards for a FOIA request and that no response would be forthcoming.

- October 4, 2018, received an email from Rebecca Stanley stating that she was our new contact with Congressman Brady's office and that she would attempt to acquire some of the information that we needed.
- October 15, 2018, Rebecca Stanley filed an information request on our behalf with the CRS.

\*Request filed by previous capstone group.



### Abstract

This literature review completed phase one of two required Capstone classes in the Bush School of Government and Public Service's Executive Master of Public Service and Administration (EMPSA) graduate program. The authors conducted a systematic, critical review of literature to assess and summarize existing publications, in addition to those found in the 2017 Capstone, related to veteran health services in the United States 8th Congressional District (8th district). Additional reasons we conducted the review included familiarizing ourselves with the body of literature related to the 8th district, identifying variables to test for next semester, and formulating research questions.

This Capstone effort is a continuation of the 2017 Capstone report titled *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* (Castro, Hare, & Willis, 2017). Research findings from last year, provided important information about the 8th district and its veteran health services, but findings also indicated a need for further research. Our team continued research from last year and added to the scope of subject matter. Previous research focused on financial implications of VA health expenditures, policy implications of the Veterans Choice Act, and veteran homelessness and suicide. Additional subject matter included 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.

During our review, we examined a total of 155 scholarly and non-scholarly publications. The body of literature regarding the 8th district can be described as limited. Outstanding areas to note include a lack of data regarding the Conroe CBOC and an observation that much of the research found was either funded by the VA or by an affiliate of the VA. Informed by this literature review, variables we identified to test included: determining if the increase of mental health professionals at the Conroe CBOC is a correlated to shorter wait times, determining if the differences between the mental health services offered by Cedar Park and Conroe CBOC are statistically significant, determining if rural veterans are more at-risk in the 8th district than they are in the 31st district, determining if female veterans have a statistically significant higher rate of cervical cancer than the average population, determining if there are barriers to male veterans in the 8th district that prevent participation in programs for substance abuse and MST, determining if there is a difference between the 8th district veteran suicide rate and the national average, determining if there is a correlation between Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) unemployment and homelessness, and determining if homeless veterans fail to receive services because they are not registered with the VA.

A. The original research question agreed upon by the group is:

- What literature exists regarding the following veteran issues: similar CBOCs, overall health, women's health, mental health, substance abuse, and homelessness in addition to what the previous Capstone found?

B. After completion of our hybrid literature review, the group expanded the original question into the following 71 questions broken out by theme. Research questions we identified to investigate next semester include:

**Theme: Comparative Analysis: Congressional Districts 8 and 31 and VA System in Each District**

1. How are health care expenditures documented by congressional district?
  - Sub question 1: Do district VA hospitals report this information to the VA or state? Both?
2. How does the Central TX VHCS improve services to veterans within the 31st district?
  - Sub question 1: Does the Central TX VHCS offer mental health education services for families?
  - Sub question 2: Are there more services available through this facility than in Debakey? If so, how are services different?
3. What kind of health services are the most prevalent in Conroe and Cedar Park?
  - Sub question 1: Are mental health illnesses being treated more frequently compared to other ailments?
  - Sub question 2: How are health services categorized by CBOCs and VA hospitals?
  - Sub question 3: Do CBOCs and VA hospitals use the same type of documentation process for mental health patients?
4. Are Katy and Beaumont seeing statistically more health patients? Is this service or location related?
5. Has the Conroe CBOC implemented recommendations made by the 2010 report?
  - Sub question 1: Has Conroe hired more staff to address limitations in women's health services?

- Sub question 2: Has Conroe gotten worse in any of the evaluated categories?
6. Is the Cedar Park CBOC actually performing better than the Conroe CBOC?
    - Sub question 1: Do patients who visit Cedar Park CBOC suffer from recidivism in terms of treatment?
  7. What are statistically significant demographic differences between the 8th district and TX/national averages?
  8. What areas does Cedar Park CBOC perform in better as measured by having women's liaisons and having family education programs for veterans and their families?
  9. What are the differences between Conroe and Cedar Park in terms of services? Are they statistically significant?
  10. Do Conroe and Cedar Park see statistically more MH patients than the TX/national averages?
  11. Do rural veterans receive statistically significant less care (as defined as services offered for mental health) than the TX/national averages?
  12. What is the projected growth rate of the 8th district veterans as compared to the TX/national averages per sex. Age, etc.? Statistical significance?
  13. What are average wait times for services in Conroe and Cedar Park and are they statistically significantly different?
  14. Is Bell County Comparable to Montgomery County in terms of poverty rates?

**Focus Area One: Demographics and Fewer Veterans Trending at State and Local Levels**

15. What is the VA currently doing to prepare for shifts in veteran demographics?
16. How will pitfalls in the current system be improved before a demand shift?
17. How will changing demographics influence the locations and number of CBOCs available?
18. Why are some areas of Texas seeing more veteran growth than others?

## **Focus Area 2: Access and Quality of Care Performance**

19. Why are veterans utilizing more VA benefits?
  - Sub question 1: Is the aging population of veterans qualifying more people for benefits?
20. Have more CBOCs hired women's health liaisons?
  - Sub Question 1: Why didn't all 44 CBOCs evaluated in the CBOC review have one?
21. Does the Cedar Park or Conroe CBOC have a family education program?
22. Are rural veterans more at-risk in the 8th district than they are in the 31st district?
  - Sub Question 1: Are there more services offered in Cedar Park than in Conroe?
  - Sub Question 2: Are rural veterans missing out on helpful mental health services because of where they live?
23. What kind of support groups exist for families within the DeBakey and Central Texas networks?
24. Has something like the SAFE program been implemented into the DeBakey and Central Texas VA Facilities?
25. What can be done to encourage veterans to seek help more quickly?

- Sub questions 1: Is the system broken or is this an attitudinal barrier of veterans?

26. How much coordination is going on between the federal departments within Texas?

- Sub Question 1: What is the state's role in managing services provided by these entities?

27. How have the DOD, DHHS and VA worked together in past programs?

### **Focus Area 3: Veterans Choice Act and Dual Use Implications**

28. How many veterans has the Veterans Choice Act helped?

29. How will the new legislation VA MISSION Act improve upon downfalls of the Choice Act?

30. How can dual use be a more efficient model for veterans?

### **Theme: Veterans Healthcare and Wellness**

31. What is the current VA healthcare situation?

32. What are the budget and expenditures government spend on VA healthcare, and what is the impact?

33. What is the waiting time for the appointments compare with other non-veteran medical services?

34. What is the reason and impact for veterans to choose other medical services more than VHA's CBOX?

35. The possibility to improve the overall healthcare services to veterans in district 8?

### **Theme: Women Veterans' Healthcare**

36. How are the younger generations targeted for successful service when leaving the military?
37. What educational and/or targeted training are available for the clinicians and nurses (both within and outside of the VHA)? Are these trainings required or mandatory?
38. What nonprofit options are available for women veterans within the 8th district?
39. What can be done to increase aide to these organizations to assist these veterans?
40. Do female veterans have a statistically higher rate of cervical cancer than the average female population?
41. What percent of District 8 female veterans are disabled?
42. Do the female veterans in District 8 utilize the VHA at the same level as female veterans in urban districts? What percentage of the District 8 female veterans use more than one medical source (dual-usage)?
43. Are the women veterans of District 8 with PTSD or depression experiencing worse or more physical/medical health conditions in comparison to women veterans without PTSD or depression?
44. Of the female veterans in District 8 that have served in the Gulf War eras or after the events of September 11, 2001, are there more mental health cases than of those female veterans in other eras of military service?

### **Theme: Mental Health Services Provision to Veterans**

45. Is there a shortage of mental health providers at the Conroe CBOC as measured by wait times?
46. If so, how is the Conroe CBOC planning on overcoming the shortage of mental health service providers?
47. Do primary care providers at the Conroe CBOC also provide mental health services?
48. Are mental health professionals at the Conroe CBOC specifically trained in military mental health issues and military culture?
49. Has the Conroe CBOC established a program, or does it offer educational opportunities to regional external mental health providers on issues that relate to mental health of veterans and military culture?

**Theme: Military Sexual Trauma among Veterans in the 8th Congressional District**

50. What is driving the lower rate of reporting of MSA among male veterans?
51. Is there anything that can be done to encourage more veterans to report and then seek treatment?
52. What are the barriers to 8th district male veterans in completing outpatient treatment programs for both substance abuse and MST?
53. Is there a lower rate of MST among male veterans at the Conroe CBOC?
54. Is there a statistically significant difference between male veterans with hx of MST committing suicide and the TX/national average?

**Theme: Substance Abuse Among Veterans in the Texas 8th Congressional District**



55. Is there a lower rate of reporting of MST among male veterans at the Conroe CBOC? Is there anything that can be done to encourage more veterans to report and seek treatment?
56. What are the barriers to TX08 male vets in completing outpatient treatment for both substance abuse and MST?
57. How can the Conroe CBOC share information between VHA and Medicare/private healthcare providers to allow continuity of treatment? (Note – could be measured by reduced medication errors???)
58. Is there a SS difference between male vets with hx of MST committing suicide and the TX/national average?
59. Is there a difference between the TX08 vet suicide rate and the national average?

**Theme: Homelessness among OEF/OIF and Female Veterans**

60. What resources are currently available in the 8th District addressing veteran employment issues?
61. What percentage of total veterans in the 8th District are unemployed?
62. What is the employment rate of OEF/OIF (male and female), and female veterans in the 8th District?
63. What is the average length of time OEF/OIF (male and female), experience unemployment or time between jobs?
64. Do combat veterans, in the 8th District experience greater challenges obtaining employment?

65. What percentage of veterans who are experiencing housing insecurity, request assistance from VA and/or community services in the 8th District?
66. How many veterans a year are homeless and/or at imminent risk of homelessness but do not receive services because they choose not to register with the VA?
67. How is the VA working to remove barriers for female veterans seeking assistance for housing security?
68. How is the VA working to make specialized services for female veterans seeking housing assistance?
69. What percentage of female veterans experiencing housing insecurity have children with them?
70. What if any, are the best practices/solutions to veteran homelessness in the 8th district?
71. Programs specifically addressing veteran homelessness among OEF/OIF female in in the 8th district?

After becoming familiar with the body of literature regarding the veteran population in the 8th district, we identified variables and research questions to produce original research for the Fall 2018 semester.

## **Purpose**

Our mission is to provide the Honorable Kevin Brady with evidence-based information to help inform his decisions regarding services for veterans of the 8th district. Keeping the overarching team mission in mind, we hope to report important findings regarding veterans' healthcare to the Honorable Kevin Brady that will serve as evidence to inform decision making regarding veteran healthcare within the 8th district.

## **Research Question**

Our research question was “What literature exists regarding the following veteran issues: similar CBOCs, overall health, women’s health, mental health, substance abuse, and homelessness in addition to what the previous Capstone found?”

## **Method and Research Strategy**

Because our research question was broad, we began our research by achieving consensus on six narrowed themes. These included:

1. a comparative analysis between the Conroe CBOC and the Cedar Park CBOC,
2. overall health,
3. women’s health,
4. mental health
5. substance abuse, and
6. homelessness

While we started with only six main themes, several other themes emerged as we conducted our research. Our main themes are highlighted in blue, while the secondary focus areas are highlighted in orange.

Our literature review is a hybrid review because we used scholarly and non-scholarly articles in our research. Each team member researched one of the six identified themes mentioned previously. We searched keywords including “Texas,” “veterans,” “rural,” and

“healthcare.” We also searched keywords specifically relating to our assigned themes. We utilized the Texas A&M University Library system and Google Scholar to identify scholarly, peer-reviewed articles. We used Google to locate additional reports from the VA and the Inspector General’s office, as well as the United States Government Accountability Office (GAO). We also created a time frame limitation of 2011- 2018 to help narrow the research focus. Our group used RefWorks to store and organize our citations and articles.

## **Inclusion and Exclusion Criteria**

The inclusion/ exclusion criteria for the present study are as follows.

1. Non-scholarly publications were used only for scoping and demographics data.
2. Only scholarly, peer-reviewed articles were reviewed for the other themes.
3. Reviewed publications were limited to English only.
4. Research was limited to that which referenced veterans in the United States Armed Forces.
5. The geographic area of research was limited to the confines of the United States of America.
6. The research inclusion and exclusion dating criteria refers exclusively to the scholarly research published from 2011 onward to 2018.

## **Definitions and Key Terms Presented:**

Community Based Outpatient Clinics: A Community Based Outpatient Clinic (CBOC) is a VA-operated clinic or a VA-funded or reimbursed health care facility or 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: The Department of Veterans Affairs (VA), 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). VA'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.).

Food Inefficiency: When a person and/or family is lacking food to have adequate supply for health and nutrition in all areas of life.

Functional Zero: Used in this context, is reached when the number of veterans who are homeless, whether sheltered or unsheltered, is no greater than the monthly housing placement rate for veterans (HUD 2016).

Medicare: Medicare is a federal health insurance program for individuals age 65 and older and those under age 65 with certain disabilities (National Center for Veterans Analysis and Statistics n.d.).

Medicaid: Medicaid is a state-administered health plan for individuals and families with low incomes and limited resources. Veterans who qualify for Medicaid do not pay copayments for VA health care (National Center for Veterans Analysis and Statistics n.d.).

National Center for Veterans Statistics and Analysis (NCVAS): The National Center for Veterans Analysis and Statistics (NCVAS) leads the effort to implement corporate data governance and corporate data management in VA (National Center for Veterans Analysis and Statistics n.d.).

Post-Traumatic Stress Disorder (PTSD): PTSD is a 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.).

Private insurance: Private insurance is available when provided through a veteran's employer, spouse, or other non-federal source (National Center for Veterans Analysis and Statistics n.d.).

TRICARE: Tricare is the Department of Defense's (DoD) health care program that serves active duty military and active members of the reserves and National Guard. Veterans are eligible for TRICARE if they are military retirees who have served for at least 20 years (National Center for Veterans Analysis and Statistics n.d.).

VA Benefits: Eligible services and programs offered by VA such as pensions, education assistance, housing, burial aid, life insurance, employment preferences and other services (National Center for Veterans Analysis and Statistics n.d.).

VA Medical Center (VAMC): VA hospital facilities that provide a diverse range of health care services to Veterans (National Center for Veterans Analysis and Statistics n.d.).

Veterans' Health Administration (VHA): A VA organizational component that is responsible for coordinating and providing health care for all enrolled Veterans based upon need and service (National Center for Veterans Analysis and Statistics n.d.).

## **Scholarly Literature Review**

As we began researching our designated themes, we realized that more specific keywords were inevitable. We included more specific keywords in the introduction sections of our individual theme presentations. We individually used the Texas A&M University Library

system and Google Scholar to search our unique keywords. Team member Fox also used search engines, like Google, to help scope initial information for her section. To ensure accountability, the team developed a consensus regarding a timeline for deliverables. This included individual team member deadlines for finding 10 articles by June 22 and 20 articles by July 6. All articles were then uploaded to RefWorks for organization, sharing, and review. Theme presentations were written by the individual team member assigned.

- Comparative Analysis: Congressional Districts 8 and 31 and VA - Adeline Fox
- Veterans' Healthcare and Wellness – Jenny Huang
- Women Veterans' Healthcare – Jennifer White
- Mental Health Services Provision to Veterans – Josefa Gonzalez Mariscal
  - Substance Abuse Among Veterans in the Texas 8th Congressional District – William Huffman
- Homelessness Among OEF/OIF and Female Veterans – Leslie Krueger

### **Theme Presentation I: Comparative Analysis: Congressional Districts 8 and 31 and VA System in Each District and the Veterans Choice Act**

My portion of the research relates to comparing congressional district demographics and CBOCs, identifying current veteran demographics, and outlining a general overview of VA system performance compared to the private sector. I also researched the Veterans Choice Act and dual use to a lesser degree. Most of my research came from the Texas A&M University library system using limitations like scholarly and peer-reviewed articles. However, many of my sources are from the United States Department of Veterans Affairs Office of the Inspector General (IG) because there is a lack of scholarly data related to the Conroe CBOC and the 8th Congressional District. I searched the following keywords:

“CBOCs,” “demographics,” “Texas veterans,” “veteran policy,” and “Veterans Choice Act.” Each keyword provided a different set of results. I initially found about 2,000 related publications. This was narrowed to 650 by the inclusion/exclusion guidelines. Ultimately, 26 publications were included, 15 scholarly and 11 non-scholarly.

Because of the demographic characteristics of the 8th district, we chose to compare it to the 31st Congressional District. Both districts border a highly urban area, and both have similar demographics. Additionally, both congressional districts have (CBOCs) within their jurisdictions. The goal is to evaluate veteran services available between the two districts and to identify a general performance comparison to help generate research questions that will form a direction for next semester.

## **CHARACTERISTICS: CONGRESSIONAL DISTRICTS**

TEXAS 8th CONGRESSIONAL DISTRICT OVERVIEW. Representative Kevin Brady represents the 8th Congressional District. The 8th district covers all of Montgomery, Walker, Houston, San Jacinto, Trinity, Grimes, Madison, and parts of Leon and Harris counties (Brady 2018). The 8th district’s total population is 813,519, and the veteran population is 51,121 as of 2016. Of the total population, 4,447 are women ranging in age from 17 to over 65 (VetPop 115<sup>th</sup> 2018). The Woodlands is the largest city in the 8th district with a population of 93,847 followed by Conroe with a population of 56,207 (Suburban Stats 2018). Despite a relatively small population, “over 40% of the state’s veteran population [reside]” in a collection of 10 counties, which includes Montgomery County (Veterans in Texas 2016, 14). For this reason, the Conroe CBOC was opened in 2015 (Jordan 2015). The goal of the Conroe CBOC is to provide veterans in the 8th district with greater access to healthcare



services. The Conroe CBOC is supervised by the Michael E. DeBakey VA Medical Center in Houston (Michael E. DeBakey 2016).

The Department of Veterans Affairs produced a recent report relating to expenditures by county and congressional districts. In 2017, the VA spent a total of \$364,673 on veterans' expenses in the 8th district. Of this total number, \$129,480 was spent on medical care alone (Geographic Distribution 2017).

This snapshot of the 8th district validates a need for veteran services based on populations, as well as expenditures spent on medical care.

Nationally, the veteran population is expected to decrease from 21.6 million in 2014 to 17.5 million in 2024 (Amaral et al. 2018, 28). However, some scholarly reports indicate that there will be growth in certain areas of the United States. More research needs to be conducted to determine how these trends impact the Conroe area.

TEXAS 31<sup>ST</sup> CONGRESSIONAL DISTRICT OVERVIEW. Representative John Carter serves the 31<sup>st</sup> congressional district (31<sup>st</sup> district). The 31<sup>st</sup> district encompasses Williamson and Bell counties (Carter 2018). The 31<sup>st</sup> district's population is 830,908, and the veteran population is 87,708. Of the total population, 14,394 are female veterans between the ages of 17 to over 65 (VetPop 115<sup>th</sup> 2018). Temple is the largest city in Bell County with a population of 66,102. Fort Hood is also a notable city/military base in Bell County with a population of 29,589. Round Rock is the largest city in the 31<sup>st</sup> district with a population of 99,887 (Suburban State 2018). Like Montgomery County, Bell County is in the top 10 counties with the highest veteran populations in the state. The Cedar Park CBOC is part of the Central Texas Veteran Health Care System, which is based in Temple.

In 2017, total expenditures for veteran services equaled \$1.1 million (Geographic Distribution 2017). Medical care expenses totaled \$321,359, which is almost 28% of total expenses paid to the 31st district by the VA.

As mentioned previously, both districts have a CBOC. The next section of this comparative analysis theme will focus on the services and performance of the Cedar Park and Conroe CBOCs.

### **CHARACTERISTICS: COMPARING CONROE CBOC AND CEDAR PARK CBOC**

Many inspector general reports mention the Michael E. DeBakey Veteran Affairs Medical Center (DeBakey VAMC) and the Central Texas Veterans Health Care System (VHCS), as well as the Cedar Park CBOC and the Conroe CBOC (Community Based Outpatient Clinic Reviews Branson, MO, Harrison, AR, Conroe and Lufkin, TX, and Hammond and Houma, LA, Healthcare Inspection: Evaluation of Community Based Outpatient clinics fiscal year 2011, Community Based Outpatient Clinic Reviews at Central Texas Veterans Health Care System Temple, TX and Texas Valley Coastal Bend Health Care System, Combined Assessment Program Review of the Central TX Veterans Health Care System, Temple, TX, and Clinical Assessment Program Review of the Michael E. DeBakey VA Medical Center Houston, Texas), but none of the reports compare Cedar Park with Conroe directly. For this reason, I have included publications that mention either entity. Findings based on these reports indicate a need for improvements for both VAMC systems and CBOCs.

MICHAEL E. DEBAKEY VAMC AND CONROE CBOC. The DeBakey VAMC, which is located outside of the 8th district, encompasses a network of nine outpatient clinics. A 2017 Clinical Assessment Program (CAP) Review of the DeBakey VAMC provides a positive

review of the facility in general. However, there are recommendations for the management of disruptive/violent behavior in addition to five other areas relating to quality of care. Most recommendations from the Inspector General relate to proper training of staff and increased oversight of certain services provided by the DeBakey VAMC (CAP DeBakey 2017, i). This report includes information relating to mental health services offered by the Conroe CBOC. According to the 2017 DeBakey CAP report conducted by the Department of Veterans Affairs Office of Inspector General, the Conroe location encountered a mental health workload of 12,085 and encountered a primary care workload of 17,254 for fiscal year 2016. Compared to other facilities in the DeBakey network, Conroe encountered the third most patients behind Beaumont and Katy respectfully. This is relevant because it reflects the magnitude of patients, as well as mental health needs of the Conroe area.

In 2011, a separate report titled Community Based Outpatient Clinic Reviews (CBOCR) compares performance of a select group of CBOCs in Missouri, Arkansas, Texas, and Louisiana. The Conroe and Lufkin CBOCs, which are both located in the DeBakey VAMC network, were analyzed based on their overall performance.

For the purposes of this research, I have reviewed the Conroe CBOC findings exclusively. The Inspector General evaluated the following administrative subjects for the Conroe CBOC: short-term fee basis care in the patient's medical record, written notification is provided to the patient when this type of transaction is approved, mammogram radiology orders are entered for all fee basis, and all volunteers with access to personally identifiable information (PII) receive and maintain annual training (CBOC Reviews 2011, 25).

During fiscal year 2010, the Conroe CBOC recorded 39,173 visits to their facility. Additionally, Conroe CBOC is classified as a large yet rural facility. One important

characteristic of these visits is how many of them relate to mental health subject matter. In 2010, Conroe recorded 5,075 mental health visits out of the total 39,173 (CBOC Reviews 2011, 3). Results from this report indicate that Conroe was noncompliant in four key areas reviewed. Two areas relating to fee basis status included justifying documentation “in lieu of providing staff treatment” and failing to notify patients of “consult approvals in writing” (CBOC Reviews 2011, 7). In terms of women’s health issues, the Conroe CBOC scored a 73, which falls below the 77 targets of the VA. Seven out of 10 mammogram radiology orders were not entered consistently, which also affected other record keeping of imaging results. One of the more common offenses of the Conroe CBOC relates to clinical privileges. Essentially, the professional standards board (PSB) granted clinical privileges to certain emergency procedures, “which were not performed at [Conroe or Lufkin]” in normal circumstances (CBOC Reviews 2011, 11). Another shortfall of the Conroe CBOC relates to utilizing help from a community volunteer who had access to patients’ personal information without proper privacy training. The Inspector General offered the following recommendations for improvement of the Conroe CBOC:

- Document short-term fee basis care
- Notify patients of the short-term fee basis
- Refine the process for mammogram record keeping
- Ensure that the PSB grants appropriate privileges to providers
- Ensure that all volunteers are being adequately trained

CENTRAL TEXAS VETERANS HEALTH CARE SYSTEM (CENTRAL TEXAS VHCS)  
AND CEDAR PARK CBOC. Similar to the DeBakey Clinical Assessment Program (CAP),

the Inspector General audited the Central Texas Veterans Health Care System (VHCS) with a Combined Assessment Program (CAP) report in 2015.

Eight activities were audited at the Central Texas VHCS, which is located in Temple, by the Inspector General during the 2015 CAP. Recommendations were made in five of the activity areas, which include: quality management, environment of care, advance directives, surgical complexity, and emergency airway management (CAP 2015, 1). Many of the recommendations are administrative in nature and do not result in severe patient negligence. Similar to the Conroe CBOC, the Cedar Park CBOC is large. In 2012, the Cedar Park CBOC recorded 38,817 visits to their facility (CBOC Reviews at Central TX 2013, 8). Data from the same report shows that Cedar Park CBOC sees the second most patients in the Central Texas VHCS network behind the Austin Satellite facility in Austin, which recorded a total of 268,109 visits. Cedar Park CBOC recorded 4,398 mental health visits out of 38,817 (CBOC Reviews at Central TX 2013, 8). The 2012 review by the Inspector General only recommends improvements for the privileges and scopes of practice portion of the evaluation. The Inspector General offered the following recommendation for improvement of the Cedar Park CBOC:

- Document re-privileging decisions for providers

## **SIGNIFICANCE**

When comparing similarities and differences between congressional districts 8 and 31, it is easy to see that both represent many veterans. If both congressional district veteran populations were combined, it would total 138,829, which is about 9% of the total population of all Texas veterans. At this time, the 31<sup>st</sup> district has more veterans, and specifically more female veterans, than the 8th district. The 31<sup>st</sup> district also has a slightly larger general

population than the 8th district. Both districts are also important when it comes to total VA expenditures. Total expenditures for veteran services was greater in the 31<sup>st</sup> district than in the 8th district, which might be attributed to the increased veteran population visiting hospitals and clinics in the Central Texas area. These two congressional districts are crucial in terms of growth and sustainability for veteran services, which is why they deserve more attention in terms of formal research.

Unlike the 8th district, the 31<sup>st</sup> district has a VA hospital and a CBOC within its boundaries. Even though the 31<sup>st</sup> district VA hospital is located in Temple, it is still within an hour of the Cedar Park CBOC potentially increasing access for veterans. In general, both the Michael E. DeBakey VAMC in Houston and the Central Texas VHCS in Temple received a positive report from the Inspector General, which is a relative reflection of the CBOCs within these two networks. Recommended improvements at the DeBakey VAMC relate to documentation and administrative record-keeping. One of the most interesting findings at the Conroe CBOC relates to their performance of mammogram imagery. While the Conroe CBOC is still within range of the target standard, they fall short because of lack of attention to detail in their record-keeping practices. On the other hand, the Cedar Park CBOC received a very clean report requiring only one recommendation from the Inspector General. In terms of mental health, the Conroe CBOC recorded more visits than the Cedar Park CBOC.

## **IMPLICATIONS**

If records are poorly kept, then patients will eventually be affected. Even though there are accountability measures in place, like the inspector general's office, it would be good to evaluate the organizational structure for both CBOCs. It would also be worth taking a closer look into the mental health services of the Conroe CBOC. A large portion of the patients who

visited did so because of mental health needs. On the other hand, more research is needed for the Cedar Park CBOC location. There is not enough evidence available to determine if the differences between the Conroe and Cedar Park CBOC are substantive. However, one report indicates that the Cedar Park CBOC only received one recommendation for improvement, while the Conroe CBOC was given five recommendations for improvement by the Inspector General. Performance information is difficult to find outside of the Inspector General reports, but I recommend attempting to approach this particular research topic from a different avenue to try and find even more information.

### **Focus Area One: Demographics and Fewer Veterans Trending at State and Local Levels**

#### **CHARACTERISTICS**

CURRENT AND FUTURE DEMOGRAPHICS. The 2015 United States veteran population provided by the United States Census Bureau is 21,369,602. Texas has the second-highest veteran population in the nation with a total of about 1.5 million veterans (Veterans in Texas 2016, 14). Most Texas veterans are in the 65 or older age range (U.S. Census Bureau 2015). White veterans make up 66.9% of the Texas veteran population. Female veterans make up 8.7% of the total state veteran population. Additionally, veterans from the Vietnam War era make up most of the population. The Houston area is one of the most densely populated areas of veterans. In 2017, Harris County, which includes the City of Houston, recorded 177, 518 veterans living in the area (VA 2017). Compared to 2014 numbers, the Houston veteran population has declined by 9,717 (Veterans in Texas, 2016, 40). This is a relevant finding because the veteran population as a whole has been declining throughout the past few decades.

Population projections indicate a declining future trend, as well. A 2018 report analyzed veteran population data and created a trend spanning from 2014-2024 to determine how much the veteran population might decline over time. The 2014 veteran population is listed as 21.6 million, but the projected 2024 veteran population is expected to decrease by 19% (Amaral et al. 2018, 2). Aging veteran populations coupled with fewer enlistees replacing deceased veterans is mostly responsible for this population shift.

URBAN/RURAL AND GEOGRAPHIC IMPLICATIONS. The actual population of veterans is not the only variable expected to change in the future. Much of the current veteran population is “concentrated in a small number of heavily urbanized regions” (Amaral et al. 2018, 45). In fact, when combining urbanized areas like Houston, Chicago, and Los Angeles, these populations represent 20% of veterans nationwide. While many veterans live in or near urban areas, many veterans still live in rural areas. Between 2011-2015, “24.1% of the veteran population 18 years and older lived in areas designated as rural” (U.S. Census 2017). Unfortunately, rural veterans are at risk of losing out on particular services because of where they live. More than “70% of urban veterans live within 40 miles of a Veterans Affairs Medical Center (VAMC),” but “less than 20% of rural veterans do” (Amaral et al. 2018, 50).

Veterans are less likely to migrate or change location than members of the general public, but there is a minor risk of migration and changes to the geographic locations of veterans over time (Amaral, et al. 2018, p. 39). Amaral, et al. write that some regions will see population gains, while others will see declines. Places like Washington, D.C., Charlotte, North Carolina; Columbia, South Carolina; Tallahassee/Panama City, Florida; San Antonio and Austin, Texas; and Montgomery, Alabama are all expected to see growth of veteran populations. More research is needed to determine why specific areas of Texas are seeing



more growth than other areas.

## **SIGNIFICANCE**

Understanding the current and future veteran populations is extremely important to projecting services needed. The most important finding in this portion of the research is the decline of the veteran population as a whole. Additionally, the age range of veterans is getting older rather than younger. My second finding is that the Houston area is one of the most densely populated with veterans in the country. Because our focus of study is in the 8th congressional district, attention to the needs of this population is most critical. My third finding is the proposed rate of growth for central and southwest portions of Texas, which can seriously affect services and facilities available to an increased demand of veterans.

## **IMPLICATIONS**

A diminishing veteran population coupled with “a concentration of older veterans” continuing to populate the southwestern region of Texas means there is a need to focus on services available for the projected demand (Amaral et al. 2018, 47). One potential threat of more veterans moving to areas in Texas, is a limitation of current facilities and services available. “Above average rates of population change and wider spacing of VA facilities,” creates a potential high risk scenario for veterans needing specialty and primary care (Amaral et al. 2018, 51). It is critical that the VA evaluate population projections now in order to understand where the greatest future demand exists.

## **Focus Area Two: Access and Quality of Care Performance**

The VA system has been criticized throughout the years for their issues with wait times and organizational challenges (Lee and Begley 2017, 160). This theme reviews literature of the VA system compared to the private sector, as well as discusses continued challenges veterans face.

## **CHARACTERISTICS**

GENERAL PERFORMANCE WITHIN THE VA SYSTEM. Many veterans choose to utilize VA benefits over other private healthcare options. A VA Utilization Report published in 2017, reports that 48% of all veterans used at least one VA benefit or service in 2016 (VA Utilization 2017, 3). Out of the benefits provided, more veterans utilized health care benefits over any other benefit (VA Utilization 2017, 4). Additionally, the percentage of female veterans utilizing veteran benefits has increased from 38.1% in 2011 to 46.9% in 2016. Even though many veterans utilize VA services, it is hard to know how they compare to the private sector because there is not much research available.

A recent study tested the idea that VA facilities are more effective at serving veterans than private sector entities (Watkins, 2016, 391). Findings indicate that this theory is correct when it comes to mental health. “Compared to individuals in private plans, veterans with schizophrenia or major depression were more than twice as likely to receive appropriate initial medication treatment,” which also led to veterans receiving better long-term care (Watkins 2016, 393). While there is always room for improvement, the VA scored the highest in each of the tested measures for this study, which included lab tests, screening tests, and medication indicators, such as “antipsychotics, 12-week supply, maintenance antipsychotics, maintenance mood stabilizers, antidepressants, 12-week supply, and maintenance antidepressants” (Watkins 2016, 394). The VA is credited as a successful

provider to veterans because of its organizational structure and better-understanding of mental health problems for veterans than the private sector. However, following the adoption of the Veterans Choice Act (VCA) in 2014, more veterans have the ability to utilize private sector services. A later section will discuss implications of the Veterans Choice Act (VCA) and the role it plays in access to VA services.

PERFORMANCE OF CBOCS. (CBOCs) are intended to provide services to veterans living in more rural settings. An Inspector General report from 2012 reports that “CBOCs appear to be providing a quality of care that is not substantially different from parent VAMCs” (Healthcare Inspection 2012, i). However, the Healthcare Inspection Evaluation of CBOCs report by the Inspector General for fiscal year 2011 contradicts this notion (Healthcare Inspection 2012, ii). For instance, five of the 44 CBOCs evaluated did not have a Women’s Health Liaison (Healthcare Inspection 2012, ii). This is certainly problematic for female veterans within the service area of the five facilities without a liaison. Another performance issue relates to protocol for mental health treatment. Seven out of 44 CBOCs evaluated “did not have a plan identified in their local policy addressing how mental health emergencies would be addressed during hours of operation” (Healthcare Inspection 2012, ii). Based on patient visit data, mental health is arguably the most important service offered by VA facilities, including CBOCs making protocol efficiency critical.

Because CBOCs are within the VA Medical Center (VAMC) network, they are required to offer mental health support services to families and spouses of veterans. “Many CBOCs are primary-care oriented and many do not have doctorly trained mental health providers on site,” which is problematic when many veterans seek services for mental health problems (Sherman and Fischer 2012, 90). CBOCs also vary in size, which causes

differentiation of services dependent on location. In one sense, it is logical for CBOCs to offer different programs and services depending on location because veterans' needs vary. On the other hand, mental health services for the veteran and his/her family are important at every facility.

In a 2012 study, veterans and their families participated in a focus group evaluation to gauge the need of mental health support groups for families through a VA facility, as well as how difficult implementation might be for the providers (Sherman and Fischer 2012, 89). The study was conducted in Oklahoma City, Oklahoma, but the sample in the study would be similar to the Conroe CBOC's demographics. About "86% of the veterans participating in the VAMC focus group lived in areas designated as rural while 14% lived in areas designated as highly rural" (Sherman and Fischer 2012, 92). Findings from the study indicate that veterans and their family members support the idea of having family education services, but these types of services are not readily available in current facilities they visit. Both veterans and family members expressed interest in working through mental health issues like Post Traumatic Stress Disorder (PTSD) with a VA-provided support group.

Currently, the VA has a family education program called Support and Family Education (SAFE). This program "is the only family education program developed specifically for the VA system," and it has been implemented in "50 VAMCs nationally" (Sherman and Fischer 2012, 91). The problem with this program is that it is not available everywhere and the initial prototype was developed in a more urban setting making direct application to CBOCs challenging.

Despite a positive interest level from veterans and their families, as well as medical providers within the VA system, many physicians "noted their lack of training in working with families dealing with PTSD/mental illness in general" (Sherman and Fischer 2012, 95). The study

goes on to list potential barriers to participation like distance to mental health facilities and lack of child care options once arriving at the facility.

CHALLENGES IN SEEKING CARE. Compared to the general public, “29% of veterans [are] more likely to” report a delay in seeking care based on a 2017 study (Lee and Begley 2017, 163). One issue of delayed care is attributed to extended wait times in the VA system. Other reasons for delay of seeking care involves a variety of factors like “government policies, social and physical environment issues, personal (socioeconomic) characteristics, and enabling factors” (Lee and Begley 2017, 161). Regardless of the reason for prolonging treatment, delayed care has been “blamed for a longer hospital stay,” which ends up costing more time and money in the long run (Lee and Begley 2017, 160).

In addition to delay of seeking care, many veterans still face geographic barriers to services. In 2014, “70% of the urban veteran population [lived] within 40 miles of the nearest VAMC and 90% [lived] within 80 miles” (Amaral et al. 2018, 50). While this projection is not expected to change much in the future, rural veterans should not be penalized because of where they live.

The VA system is the most prevalent health care provider for veterans, but the Department of Defense (DOD) and the Department of Health and Human Services (DHHS) also have forms of veteran assistance. Interestingly, “20% of [United States] counties contain both a Health Resources and Services Administration (HRSA) and Military Health System (MHS) facility” (Calvo 2012, 129). This is interesting because many of the same services are available from multiple facilities, but there is not much coordination between the departments or facilities. This creates issues for veterans who might live closer to a DOD

facility then they do to a VA facility. Many of the services and programs are local and cannot be transferred between facilities.

## **SIGNIFICANCE**

Researchers including Watkins, et al. have concluded the VA system is performing better than the private sector. Superior performance from the VA system is especially important now that veterans are generally utilizing more veteran benefits, with healthcare being the highest use (VA Utilization 2017, 4).

When evaluating the performance of CBOCs, limited women's health and family education services are both areas needing improvement. Implementing a family education program like the SAFE program into CBOCs with a more rural tone could help bridge unmet services for mental health.

Barriers to seeking care are problematic for veterans. According to Amaral, if veterans live too far away from their providers, they lack the treatment they need. Additionally, if federal entities fail to collaborate on a greater scale, then the veteran is the one who suffers because they miss out on receiving care from alternative facilities that may be geographically closer.

## **IMPLICATIONS**

Mental health care services must be available for rural veterans and their families. According to Sherman and Fischer, the VA needs to implement more mental health services for veterans and their families in CBOCs. At this time, "family education programs regarding mental illness and posttraumatic stress disorder are mandated for all VA medical centers and some CBOCs but are mostly available in urban areas" (Sherman and Fischer 2012, 89). Without

proper integration of treating both the veteran and his/her family, rural veterans are not receiving the best quality of care.

More collaboration between federal entities would help provide a greater range of treatment that is consistent and readily available regardless of where veterans live.

Additionally, it is crucial that women's health services are improved to meet the increased growth of the female veteran population. Projections indicate that female veteran population "will increase three percentage points from 8% to 11%" by 2024" (Amaral et al. 2018, 28).

Barriers like geographic location, limited collaboration between federal entities and lack of women's health liaisons are unacceptable. I recommend increasing access to veteran health care services through a more organized partnership between federal services.

### **Focus Area Three: Veterans Choice Act and Dual Use Implications**

Four years ago, Congress passed the "Veterans Access, Choice and Accountability Act of 2014, which provided \$15 billion of new funding for VA health care" (Wilensky 2016, 452-453). One element of the Choice Act is called the Veterans Choice Program, which is intended to expedite veteran health care services with non-VA providers if the VA wait time exceeds a certain amount of days. While the idea behind the Choice Act is a good one, portions of the implementation still fall short. A 2016 Inspector General report criticized the VA for continued issues with access, which were "attributed to limited appointment availability and weaknesses in the scheduling practices of VA facilities" (Wilensky 2016, 453).

## **CHARACTERISTICS**

VETERANS CHOICE ACT OVERVIEW AND UPDATE. In 2018, the United States Government Accountability Office (GAO) conducted an additional evaluation on the

performance of the Choice Act. Findings indicate “that veterans who are referred to the Choice Program for routine care because services are not available at the VA in a timely manner could potentially wait up to 70 calendar days for care if VAMCs and third-party administrators (TPAs) take the maximum amount of time” for scheduling (GAO 2018). This is the opposite result that was anticipated following the Choice Act implementation. Unfortunately, the GAO report also identifies a lack of data, as well as below standard organization of scheduling appointments as major inhibitors to veteran services. These issues will continue to linger until a different scheduling protocol is adopted.

In addition to general issues with the Choice Program, veterans are now dealing with dual use problems. The term dual use refers to veterans utilizing VA and non-VA providers when needed. Veterans are mostly choosing to utilize “both VA and non-VA options because of distance to the nearest VA point of care,” but their choice also depends on wait times (Howren, Cozad and Kaboli 2015, 840).

While the Choice Act encourages utilization of both VA and non-VA services, many veterans face challenges with communication between their providers regarding patient records and treatment. Results of one survey highlight the perceived discrepancies of providers’ communication system. About 62.7% of veterans surveyed believe that they are the primary contact between providers “because they [prefer] direct involvement in their care” (Howren, Cozad and Kaboli 2015, 840).

Recently, President Donald Trump signed the VA MISSION Act into law in hopes of combining “a number of existing private-care programs, including the so-called Choice program” (Slack 2018). The new law also forms a commission to share recommendations on



VA facilities that need to be repaired, built, or destroyed.

## **SIGNIFICANCE**

The 2018 GAO report and Wilensky publication highlight issues that have not been resolved by the Veterans Choice Act. Since the Choice Act's implementation, inefficiencies with wait times and scheduling have prevailed. As if the policy itself does not have enough missteps, communication between dual use providers is failing to satisfy the needs of veterans too.

Veterans should have a say in their treatment, but they should not feel responsible for serving as the liaison between VA and non-VA providers. Despite the Choice Act's best intentions, there is still a need to improve access to veterans' services. Perhaps, the VA MISSION Act will fill the voids of the Choice Act.

## **IMPLICATIONS**

Unfortunately, "the VA continues to suffer from data weaknesses, including the lack of a comprehensive scheduling system" (Wilensky 2016, 453). Many veterans also feel like it is their responsibility to serve as the liaison between VA and non-VA providers. Clearly, the VA framework has work to do in terms of organizational protocols and communication methods. Hopefully, the VA MISSION Act is a better piece of legislation than the Choice Act.

## **Theme: Veterans Healthcare and Wellness**

My portion of the research was focused on the literature of veterans' healthcare. Keywords were "health care," "veterans," "primary care," and "Texas veteran." The results were limited to articles published from 2011- 2018, peer-reviewed, scholarly journals. I used TAMU

Library to search and collected articles in my RefWorks, I also used Google to search some official websites to collect related information and data. I read over 30 articles inside and outside of my RefWorks. I removed some of them once I scoped and realized they were not useful for my portion of the topic. Potentially, I will find and add more articles for future use.

## **CHARACTERISTICS**

There are two federal government institutions involved in health care for the military in the United States, the United States Department of Defense (DoD) and the United States Department of Veterans Affairs. The DoD is responsible for the care of service members until they leave active duty at which point the VA provides health care to veterans. In 1999, the VA began to use a priority-based enrollment system, established by the Veterans' Health Care Eligibility Act of 1996 (Public Law 1996, 104-262). Some veterans have an enhanced eligibility status based on the existence of service-connected or other disabilities or exposures, income, and other factors. Each veteran is assigned a priority group, which is numbered from one to eight, with one being the highest priority group (Veterans Survey of Veteran Enrollees' Health and Use of Health Care, 2017). The VA provides primary and specialty care, a comprehensive pharmaceutical benefits package, and ancillary services to its enrollees through a network of 1,243 healthcare facilities, including 170 medical centers, and 1,063 outpatient clinics. According to the survey, there are about 12% of veterans who are not enrolled in VA health care. Through my research I found that many veterans who use VA health care also have access to health care funded through public and private insurance, which impacts the extent of healthcare services provided by the VA.

Veterans' perceived health status in 2017, indicates that 74% of the respondents report they have "good," "very good," or "excellent" health relative to other people at the same age. This is an increase of seven percentage points since 2013. This is quite optimistic.

VETERANS INSURANCE POLICIES AND CHANGES. Many VA enrollees get a significant share (or all) of their healthcare from other health systems. Veterans' access to health insurance coverage is a critical factor determining whether they use the VA. As a result, veterans who rely heavily on the VA for their care tend not to have health insurance coverage, are less well off financially and are less healthy than the general civilian population. Moreover, the health care needs of VA patients with service-connected disabilities are different from those of the civilian population. Recent health care reform and policy changes are likely to create increased choices for uninsured veterans to obtain health care. These include a realignment under the MyVA Initiative, the Veterans Access, Choice and Accountability Act of 2014, and the Affordable Care Act. Most VA-covered veterans are not totally reliant on the VA for their health care. A 2015 amendment to the Choice Act provides veterans access to VA funded health care with alternative health care systems when the nearest VA facility is within 40 miles, but unable to provide the care sought by the veteran. On August 12, 2017, President Donald Trump signed the VA Choice and Quality Employment Act, to extend the Choice Program through January 2018, and authorized \$2.1 billion in additional funding for the Choice Program. The extension also grants the VA additional time to propose amendments to the program in an effort to improve the way VA interacts with the private sector. There are health insurance options for veterans: TRICARE, Medicare, Medicaid, Private insurance. Just recently, the new VA Secretary Robert Wilkie

said that getting veterans "through the door" to see a doctor would be his top priority (Military official website, 2018).

INTERNET ACCESS TO VA INFORMATION AND RESOURCES. It is very important in this day and age to use Internet access for VA information and other medical related websites (GAO 2018). The most popular uses of the Internet for people were non-health related activities such as sending emails (88%), getting travel directions (84%), and weather reports (81%). Fewer veterans used the Internet to perform health related activities, such as looking up health information (77%), accessing personal health records (45%), and making medical appointments (33%). My HealtheVet (MHV) website is an online personal health record interface for veterans and active duty service members, as well as their health care providers and dependents.

VETERANS' EXPERIENCE WITH VA HEALTH CARE PROVIDERS. The professionalism of healthcare providers (84%) and having insurance coverage for the health service needed (82%) were ranked as the most important factors for selecting a health care provider to veterans. Other important factors are convenient location, professionalism of office staff, and travel time or distance. While concerns about cost did not rise to one of the top-ranked factors of consideration, still almost three-quarters of enrollees (74%) indicated that out-of-pocket costs were an important factor for choosing health care services.

DELAYS IN SEEKING HEALTH CARE. Delays in receiving care among United States veterans, has received national attention for some period. Such delays may have an effect on veterans' propensity to seek healthcare as well, which could be detrimental to their health.

One study also finds that with increasingly greater options for health care available, VHA patients experiencing long wait times are likely to seek non-VHA alternatives, which potentially increase duplication of services and fragmentation of care. Nearly three out of 10 veterans report delay in seeking care in the past year.

## **SIGNIFICANCE**

The Veterans Health Administration (VHA) is America's largest integrated health care system, providing care at 1,243 health care facilities, including 172 medical centers and 1,062 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled Veterans each year. () They have some unique characteristics that may differentiate them from other primary care clinics in private sectors. However, they are rarely studied in literature. The VA operates the largest vertically integrated healthcare system in the United States, and the mission of VA healthcare is to serve veteran patients in the best way. Just like other healthcare systems, VA healthcare is also facing the challenges of rising costs, shortage of providers, increasing number of patients, and other resource constraints.

**IMPLICATIONS** The access problems within the VA system may be creating disparities in health care delay for this vulnerable and deserving population that need to be treated. It may be important for policymakers to be aware of health care delay among veterans.

## **Theme: Women Veterans' Healthcare**

My portion of the scholarly research was focused on the literature that exists, outside of the previous capstone's study, regarding women veteran's healthcare. Keywords used included "women," "veterans," "healthcare," "rural," and "access." I held over 20 articles in my

RefWorks folder, reading all completely, and was able to utilize them all; all being cited below.

## **CHARACTERISTICS**

RURAL VETERANS AND OUTREACH. Women veterans have been more likely to report poor health-related quality of life physically, mentally, and functionally compared to non-veteran women (Shen and Sambamoorthi 2012, 136). One article indicates that these women are seeking care at their local VHA increasingly at a rate over 88% in recent years (Friedman et al. 2011, 20). A majority of these are young women that have a high rate of service-connected disabilities (Friedman et al. 2011, 21). Rural female veterans have significantly worse health conditions and illnesses when compared to urban veterans. Except, the access to this care is not different between rural versus urban care, as there is access to women's healthcare services everywhere. Studies have shown that the rural females and urban females all maintain the same level of utilization of the VHA (Cardasco et al. 2016, 403). However, urban women veterans have higher numbers seeking care outside of the VA. This may be due to VA being the best source of care, according to rural women veterans. The concurrent dual-usage is more common, though, among these rural women (Cordasco et al. 2016, 404).

Some women veterans that do not have a service-related disability may need outreach services, as 40% believe the VA is only for those with disabilities related to their time in active duty (Friedman et al. 2011, 111). Unfortunately, those women that do utilize the veteran health clinics are more likely to have poorer physical and mental health than the ones that do not use VHA for their care (Shen and Sambamoorthi 2012, 15). "Those with PTSD or depression reported a greater number of medical conditions and had significantly worse physical health" (Cohen et al. 2012, 645). Research shows that gender-specific preventative

screening rates among veteran women are higher outside of the VA (Lagro 2015, 156).

Twenty one percent of women deployed to IRAQ report having medical problems that were gynecological in nature during deployment. Half of veteran women were not up to date on their screenings for cervical cancer. This may be due to the higher levels of fear and embarrassment that they felt during pelvic exams at the VHA (Cohen et al. 2012, 470).

CHALLENGES AND RETAINMENT. The female veterans after the events of September 11, 200 and Gulf War Eras see more challenges with finances (Thomas et al. 2018, 111).

Some research suggests that there are women veterans that lack enough food, and this is associated with higher levels of illness. Unfortunately, this food inefficiency is related directly to delayed access to healthcare (Narain et al. 2018, 270). Keeping these women returning to the VA for healthcare is somewhat based on the longer drive times (Friedman et al. 2015, 19). New patients that live far away from VHA may not continue using these facilities, as geography can influence their decision (Friedman et al. 2015, 20). Additionally, rural women veterans are more likely to face transportation difficulties as compared to the urban veterans (Cordasco et al. 2016, 403).

Researchers have concluded the VA may have one visit to ‘make or break’ women’s decisions to continue using the care at VHA (Yano and Hamilton 2017, 375). The majority of those women were able to be retained at their VHA in subsequent years (Friedman et al. 2011, 109). Female patients prefer to see nurse practitioners within the VHA instead of medical doctors or physician’s assistants (Bastian et al. 2014, 610). A majority of these veterans prefer women-only settings. In the Conroe CBOC, there is no female-only setting for women veterans. Studies show that better performing VA sites are more likely to adopt recommended models that address women-focused primary care. However, some women veterans will not use this care as the overall ratings are lower than the ratings of women

using primary care in the private sector (Washington et al. 2015, 29). Women veterans are more likely to seek care at their VHA when they have experienced military sexual assault, have comorbid medical and mental illness, or if they do not have private insurance (Mengeling et al. 2011, 123). Larger VA facilities are more likely to have specialty care associated with women's mental health, and this hinges strictly on caseload of women veterans (Oishi et al. 2011, 133).

When surveyed, most women veterans report that they want access to care that is specific to women's needs, to be able to choose their provider based on gender, for their primary care physician to offer gynecological services, and for female chaperones to be available during exams (Mengeling et al. 2011, 128). Some women sexual assault survivors report high levels of anxiety associated with invasive exams by male physicians (Oishi et al. 2011, 135). While 60% of women receive their care at designated women's health providers (Bastien et al. 2014, 610), "lower female caseloads have translated into a workforce with limited exposure to women's gender-specific care needs, resulting in gaps in clinical experience and frequent lack of recognition of women's military service and exposures" (Lagro 2015, 156). Targeted training of physicians and clinicians on these gender-specific exams were tested, however, the implementation of such training nationwide is highly unlikely due to the extensive training timeframes (Yano, Haskell, and Hayes 2014, 706).

MENTAL HEALTH AND AGING. The female veterans after the events of September 11, 2001 or Gulf War eras see more mental health challenges (Thomas et al. 2018, 109). Women veterans with a mental health diagnosis have a higher likelihood of seeing reproductive and physical problems when comparing those without mental health issues (Bastien et al. 2014, 610). One avenue of relief in this area is the development of Telemental: a program to



improve access to care for women veterans with mental health. This may be beneficial as many avoid VHA due to the stigma that exists as a barrier to mental health care. Though not unique to women, this program provides specialized treatment for women that have more barriers to medical care (Moreau et al. 2018, 185).

As these women veterans age, they show increases in good health when associated with outpatient care (Bastien et al. 2014, 611). Unfortunately, though, “veteran status was found to be independently associated with poorer status of health-related quality of life measures, except in general health” (Shen and Sambamoorthi 2012, 12). Cardiovascular disease is not a women-only health problem. Compared to civilian women, though, female veterans are at increased risk for this disease due to risk factors of smoking, depression, PTSD, and low levels of support. In studies, women are more likely than men to be obese and have mental health diagnoses (Goldstein et al. 2017, 704). Smoking cessation and weight management programs based on women veteran preferences have proven difficult (Lagro 2015, 156). Additionally, post 9/11 and Gulf War Era veterans face higher levels of concern with connecting to other female veterans within their community (Thomas et al. 2018, 111). Surveys of rural veteran women found that, though community support for veterans was high, it was not directly aimed at women (Brooks et al. 2016, 979).

## **SIGNIFICANCE**

My first finding was regarding rural veterans and outreach. The veteran population in District 8 are considered rural in comparison to larger, more heavily populated districts. The research shows that urban and rural women veterans are seeking care outside of VHA, however, rural veterans are doing so concurrently. Therefore, dual usage and considerations on this implication should be further discussed. As such, outreach is something the VA needs to

embrace to reach out to those women who may or may not be aware of available services. As studies show, this is important to their health.

My second finding was in the area of challenges faced by the veterans and efforts needed to retain those within the VHA. These include financial, access to care, and fears associated with medical care. These are not uncommon topics within the women's healthcare industry regarding veterans. New information shows that poor finances raise the likelihood of bad health, while access and fears keep women from seeking medical care.

My third finding relates to women veterans' mental health and aging. Mental health among veterans is a widely researched topic. New research found that unaddressed these issues can affect women's reproductive health, though access to new medical avenues such as Telemental may prove advantageous. Certain programs for women-based health care are not working well within the VHA. These include smoking cessation programs, weight loss, and heart health.

## **IMPLICATIONS**

Civilian nurses are the most likely to become advocates for these women veterans when they come into the community health clinics (Conard and Armstrong 2016, 230). The VHA needs to increase its' responsiveness to the younger generation of veterans (Bastian et al. 2014, 611). Increasing education of military sexual trauma for clinicians could increase the satisfaction ratings that are commonly found with these younger veteran women (Kimberling et al. 2011, 150). The VHA must increase its structural capacity in relation to the young veteran women demographic. Their need for post-deployment services increase as they adjust

to civilian life. They, also, maintain a need for healthcare access for conditions that are common after they leave military service (Friedman et al. 2011, 105).

The Women's Health Practice-Based Research Network was created with commitment to speeding the process of women's health research among veterans (Frayne et al. 2013, 509). Women veterans want the VHA to target telemedicine, community-based clinics, and mobile clinics to women veterans (Friedman et al. 2015, 20). These women seek to see a growing number of VA contracts with local services to provide alternative medicines like acupuncture, massage, and traditional health (Brooks et al. 2016, 979).

### **Theme: Mental Health Services Provision to Veterans**

Research was conducted through Texas A&M University Library system using ebscohost.com databases for scholarly, full text journals. The political science, psychology and behavioral science, military and government, nursing and allied health, PubMed, Medline and Psycinfo collections were searched for academic journals and trade publications. The terms used were: "veterans," "mental," "health," and "services."

I initially found over 66,000 publications. "The increase in peer-reviewed publications appears to coincide with the VHA's increased focus and funding of mental health care for veterans" (Bumgarner et al. 2017, 226). Therefore, Google was used to search for articles in the psychology trade journal *Psychology Today* to research themes related to veterans' mental health that were discussed in trade publications in the time frame set for the present research, as a guide to areas of concern within mental health professionals.

Researchers indicated a general concern on problems and challenges veterans face in accessing mental health services (Brennan 2017; Caplan 2011; Goodman [2005] 2016; Goodyear 2018; Kashdan 2014; Young 2016). A second theme centered on types of

treatments/technologies that exist, are proposed or have shown success in treatment and administration of mental/behavioral services for veterans (Abrams 2017; Bergland 2013; Springer 2016).

I narrowed the focus excluding literature that touched on themes addressed by other researches in this literary review: female veterans, homelessness, substance abuse and sexual trauma. I also chose to exclude literature that addressed race and ethnicity topics.

I reviewed 56 publications of which 46 were ultimately used, 28 peer-reviewed articles, one book published by the RAND think tank, twelve trade publications in psychology, philanthropy and nursing, and five government sources (an executive orders, an act, two report and a newsletter).

Literature was searched that could be useful in the study of the Conroe CBOC. During this phase a third thematic group of articles emerged. It relates to measures; studies that address specific measures of length of treatment, success of initiatives, productivity, income, family involvement, in relation to mental health services provided to the veterans. By adding CBOC to search criteria the thousands of articles were reduced significantly. A systematic review on mental health care of rural veterans only found limited research (19 articles) related to CBOCs and community partnerships combined (Bumgarner et al. 2017, 226). It is important to note that a large number, over two thirds, of researched literature was funded by the VA.

## **CHARACTERISTICS**

As a result of the increase in veterans coming back from the extended military operations in the Middle East, the need for mental health services has ballooned. Veteran mental health diagnoses more than doubled from 2012 to 2017 (Currier 2017, 48). In 2012, President

Barack Obama recognizing the need for expansion and improvement of said services wrote the Executive Order - Improving Access to Mental Health Services for Veterans, Service Members, and Military Families (Obama 2012). This Executive Order has become the guideline for the VA actions in its service expansion and provision.

Timely access to quality mental health care has been the main concern of the VA efforts (Obama 2012). The present literature review has led me to identify a multipronged approach, a) Awareness, b) Service Delivery, c) Establishing Networks, and d) Research. This approach attempts to diminish the barriers to access of quality mental healthcare.

*Awareness* - This has meant implementing efforts that address stigma and empowerment of self-seeking help.

*Service Delivery* - This has implied the development and the implementation of service delivery through a variety of different models.

*Establishing Networks* - This has encompassed efforts and activities that bring together stakeholders that can collaborate in awareness, education and professional training, veterans' organizations that can provide peer support initiatives, research institutions that can study theme specific topics for the VA, referral programs that can connect veterans to services available, healthcare organizations, insurance groups for dual user veterans, medical and mental health professional groups that can help establish educational programs and standards of veteran care, and veteran supportive nonprofits.

*Research* - Through the VA's Health Services Research & Development (HSR&D), VA researchers and external researchers funded by the VA, are studying new drug therapies, mental health service provision through primary care models, and access improvement to mental health care (United States Department of Veterans Affairs,

ORD 2018). Emphasis on “collaborative research to address suicide prevention” was given by the Executive Order (Obama 2012).

## **SIGNIFICANCE**

According to researchers the most significant barriers to mental healthcare access are: stigma (Whealin et al. 2014, 488; Teich et al. 2017, 300; Brooks et al. 2014, 149; Koblinsky 2014, 163; Brennan 2017) and distance (Bumgarner et al. 2017, 224) from services providers.

### *Stigma*

Veterans encounter stigma towards mental and behavioral health diagnosis and treatment on two main fronts. First, there is the educational-socio-economic background of the veteran and the community in which the veteran operates. The lower the educational and socioeconomic background, the higher the stigma (Whealin et al. 2014, 488). Rural veterans face higher levels of societal stigmatization they must overcome to seek mental health treatment. Utilization of mental health treatment among veterans is lower in rural areas (Teich et al. 2017, 300). “Rural women were less likely to present for mental health care compared to urban women veterans” (Brooks et al. 2014, 149). As per above described demographic characteristics and distribution of the district, number of veterans in the 8th Congressional District live in communities where the stigma is higher.

Research has noted correlations between mental health and income, as this relates to areas where mental health stigma is also higher (McDaniel 2018, 1-8).

Second, is the military culture per se. The stigma comes from a perception of weakness, and the potential for discharge or diminished career advancement possibilities that a mental

health diagnosis could bring. This factor is aggravated by the lack of confidentiality of military medical records (Koblinsky 2014, 163; Brennan 2017).

Research has shown the importance of belief in mental health care for patients to seek the needed help. For veterans, who have already overcome the first stigma barrier and have enrolled in VA care, stigma stops being a deterrent. Researchers note the opportunity early behavior modification could have in barrier elimination and suggest interventions while military personnel is in training or active duty (DeViva et al. 2016, 315).

Distance. The Veterans Access Choice and Accountability Act of 2014 established policies that allow veterans to receive treatment through non-VA facilities if the veteran resides more than 40 miles away from the VA facility (Bumgarner et al. 2017, 224). The establishment of CBOCs has helped ease the distance barrier, by reducing the distance to obtain services for some veterans. Nevertheless, some veterans in the 8th Congressional District of Texas live in rural areas where the only mental healthcare available might be through non-veteran providers.

As per the Executive Order Improving Access to Mental Health Services for Veterans, Service Members, and Military Families an expanded mental health professional workforce that is trained in veteran behavioral health issues and those of their families, as well as experience with military culture must be expanded.

Awareness. Awareness of mental and behavioral health issues is an important step in enhancing the psychological health of the military family (Executive Office of the President 2011, 2). Veteran families and partners are an integral component in that process (Executive Office of the President 2011, 8). Their association in treatment has been studied to produce more satisfaction in intimate relations and family concerns among veterans treated for PTSD

(Meis 2013, 339). Therefore, raising awareness of mental and behavioral health issues among veterans' families is important.

The Executive Order Improving Access to Mental Health Services for Veterans, Service Members, and Military Families, mandates the VA to increase its outreach to not only veterans but their families too (Obama 2012). Programs incorporate sessions with spouses and include them into the decision-making process for treatment of mental health services (Beehler 2018, 2).

Other stakeholders such as universities and colleges are becoming aware of the need to facilitate special mental health services to the veterans they enroll. "Student veterans often cite mental health...as a barrier to academic success" (McDaniel 2018, 5-6). "A variety of services have been developed to address the needs of the SSM/V population, but the efficacy of these services remains largely unknown" as reported by a literature review on the subject headed by Borsari et al, from the San Francisco Veteran Affairs Medical Center (Borsari 2017, 162). Employers through whom the veterans obtain their healthcare coverage also have a stake in the behavioral health services available to their veteran employees (Koblinsky 2014, 163).

Veteran organizations have become key partners in helping raise awareness to mental health needs of veterans. Veteran organizations have helped by advancing campaigns to better services for the veterans and also by becoming information sources for provider referrals and empowering veteran self-referrals. Research in satisfaction of VA mental health services has reported that 93% of women would recommend or strongly recommend VA to other veteran women and suggests that timely access to mental health care correlates to views on other VA healthcare services (Brunner 2018, 5).



The Obama administration ordered the recruitment of 1,600 new mental health professionals for the VA (Obama 2012). The VA career opportunities awareness campaign was successful in recruiting more professional mental health practitioners than the mandated minimal number. Incentives for recruitment have included repayment of student loan repayment for psychiatry students (Hester 2017, 3).

Service Delivery Models. Within the Executive Order Improving Access to Mental Health Services for Veterans, Service Members, and Military Families, the VA was directed to develop arrangements with community-based providers and in particular to help stem the high suicide rates (Obama 2012; Hester 2017, 3). One of the solutions for expanding and improving the delivery of mental health services has been the collaborative care model.

The Patient-Aligned Care Team (PACT) model helps address some of the barriers to care, as the team is led by the primary health provider (VA Research Quarterly 2014, 2). Almost 70% of veterans who encounter stigma as their barrier to mental health care (Taylor et al. 2016, 124) can overcome this challenge through treatment via their primary care providers (PCPs), particularly in rural areas where stigma is higher and mental health practitioners are lacking (Taylor et al. 2014, 129). However, the research team lead by Taylor et al., in their exploratory study find PCP do not routinely ask mental health questions to their patients and “wait for the veterans to bring up the mental health concerns” (2016, 126). Often rural PCPs are unaware that their patients are veterans and lack knowledge of resources available for their veteran patients (Taylor 2016, 128; Davis 2017, 9). Improved coordination with and referrals to networks are seen, by Taylor et al., as solutions to the aforementioned barriers to mental health care. The lack of information on veteran eligibility and services extends also to the veterans themselves (Bovin et al. 2018, 2).

Telehealth services through phone and Internet resources at CBOCs have been introduced in veteran mental health treatment models. Mohr et al., on their Brief Report on Telephone Administered Cognitive Behavioral Therapy (T-CBT) to Veterans Served by CBOCs in California, reported that though enough positive trials exist for T-CBT to support the treatment, their research showed that interventions among veterans have lower impact, and suggest further study of the issue (Mohr 2011, 261-265). Other innovative technologies, such as the Stress Eraser® for biofeedback, have been put to trial at CBOCs in Texas to address the issue of treatment between appointments for rural veterans (Tan 2013, 1012). Focus groups using video conferencing technology at CBOCs received a positive outcome by the same research team at the Texas CBOCs (Tan 2013, 1014-1016).

Research on Internet-Based Interventions (IBIs) has found to be useful in circumventing barriers to access, stigma, and distance in the provision of mental help treatment for veterans. A challenge noted has been the difficulty in motivating veterans to participate due to the intrinsic nature of the behavioral issues for which they are being treated and “buy-in from veterans given the distal nature of IBIs” (Grubaugh 2014, 624).

Jameson et al., specifically studied the use of telemental health care at regional CBOCs, finding uneven use, barriers to program expansion, limited training, and dedicated space constraints. The utilization of telemental health care has been limited. It has focused on medication management without much expansion into psychological treatment/therapy (Jameson 2011, 429). This study included CBOCs associated with the Michael E. DeBakey Veterans Affairs Medical Center (VAMC) in Houston.

A critical issue the Veterans Access, Choice and Accountability Act of 2014 (the Choice Act) brings is that of veterans getting evidence based or evidence informed

therapeutic interventions, as well as non-medical evidence base or evidence informed support services for the veterans themselves and their families. Evidence-based information is critical for treatment determination, as exemplified in the study on the association between residential treatment length in the reduction of PTSD and the need for outpatient services (Banducci et al. 2017, 2).

Treatment models such as the Trauma-informed care is among the many proposed treatments on which further research is needed prior to adoption. Advocates of innovation, such as the proponents of this model, suggest adoption though direct link to mental health improvement has not been documented, but see benefits in advocating adaptive cultural change to serving veterans (Currier 2017, 60).

As an approach to recovery oriented mental health services for veterans, their involvement and that of their families has been encouraged in a variety of ways and research has found “provisional evidence that family involvement is associated with PTSD symptom reduction” (Laws 2017, 1). One of them has been the creation of Veteran Mental Health Councils within VA medical clinics. Their effectiveness has been studied by a group of researchers within the VA and lead by Beehler and Marsella in Boston. Their study has found councils that focus externally on the community, help connect veterans to community based providers effectively. Their value also rests in their proximity to the veteran users, which allows them to identify deficiencies and advocate change (Beehler et al. 2018, 4).

A mandate of the Executive Order Improving Access to Mental Health Services for Veterans, Service Members, and Military Families (Obama 2012) to improve mental health services for veterans, was to hire and train peer to peer counselors “to empower veterans to support other veterans” (Obama 2012). Job satisfaction studies have revealed to be high amongst this cohort of VA employees. This strategy plays a double effect benefit as it not

only helps the veterans seeking mental health care; it serves to employ and rehabilitate veterans by offering them a fulfilling employment, and the opportunity to continue their own healing and reintegration to society through their work as counselors (Chang 2016, 48). Research reports that veteran recovery groups are complemented with peer lead groups, as clinical facilitators provide a different set of strengths than the peer veteran counselors (Beehler 2014, 43).

Establishing Networks. The dual choice mental health care has accentuated the need for mental health professionals to be trained in veterans' mental health issues as well as military culture (Koblinsky 2014, 163). With veterans and their families accessing mental health services outside the VA many are being treated by private providers not knowledgeable in PTSD, MST, comorbid depression and anxiety, and particularly, on military culture (Matarazzo 2016, 158-164). The rapid recruitment of mental health professionals within the VA has also dealt with this problem. For this reason, professional awareness of deficiencies in training has been addressed by numerous articles. Some have pointed towards the need to partner between the educational institutions that provide professional training and continuous education and those that recruit the mental health professionals (Matarazzo 2016, 163).

Referral networks act as links between the veterans and service providers. These networks can signify the difference between obtaining service or not (Bovin et al. 2018). In some cases, veterans can circumvent privacy concerns, by accessing private mental health care providers (Matarazzo 2016, 162-163). In other cases, these networks can guide veterans to organizations that can facilitate the care (Davis 2017), which the veteran would otherwise not receive due to financial constraints (Matarazzo 2016, 161) or ineligibility. The issue of access to care due to ineligibility is critical to those veterans who were precisely discharged because of mental health issues, and desperately need the treatment.

Research. HSR&D funding initiative Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE) (VA Health Services Research & Development), through which VA researchers collaborate with VA partners are trying to find ways of improving rural veterans' access to mental health services by measuring veterans' own perception of access to mental health, and ways to engage them in mental health services at the local CBOCs (VA Research Quarterly Update 2014). Literature was found with recommendations for studying the new behavioral care models' outcomes (Barry et al. 2016, 149).

## **IMPLICATIONS**

As public awareness for veterans needs declines, due to a reduction in the size or presence of military forces worldwide, support and resources to help the veterans diminishes (Caplan 2015). Foundations and nonprofits refocus their efforts to areas that are perceived as more critical or that align with the current zeitgeist (Tanielian 2017, xiii). Nonprofits, including those that address veteran mental health issues, face a changing donor shrinkage (Wallace 2018, 10). Therefore, it is important that programs addressing the mental health needs of veterans become self-supportive; be this through collaborative network models or third-party payments systems, so that the private mental health care programs that increase capacity can continue to be viable (Tanielian 2017, 51).

Research funding by the VA is crucial when private funding is not available. Partnering in research initiatives is paramount to continuously find better ways of addressing and servicing veterans' mental health needs. Given that the majority of peer reviewed publications found were funded by the VA, there could be biases by the implementing agency.

Funding for research initiatives is paramount for finding better access and quality of mental health treatment. CREATE must increase funding for research on unresolved high-priority mental health issues, such as veteran suicide. Without such research, finding a solution to the high suicide rates of veterans is unlikely.

The Executive Order Improving Access to Mental Health Services for Veterans, Service Members, and Military Families mandates incentives to promote professional development in the field of mental health service by ordering the VA to partner with training programs, give scholarships and repay student loans (Obama 2012), to adequately address the growing number of veterans needing mental health services. In addition, Kearney et al. note the need for mentoring mental health professionals to develop leadership skills beyond their mental health training (Kearney 2018, 30).

The United States Government Accountability Office report of 2017 on VA Health Care points out what researchers on VA mental health services have been noting. Metrics and measurements on productivity and efficiency need improvement. Kearney et al. (2017, 4) show concern over the problem, pointing out that lack of accurate data can prevent the VA from being sufficiently staffed to satisfy the increased demands of mental health services. Studies on the correlation between mental health and income (McDaniel 2018, 4) suggest further consideration. This correlation could be significant to the area serviced by the Conroe CBOC, where low income induced stress could aggravate veterans' mental health. The studies suggesting early intervention on attitude towards mental health could have a positive impact to lower stigma barriers (DeViva et al. 2016). "Challenges remain in forging sustainable, collaborative systems of care that address mental health issues among service members, veterans and their families" (Tanielian 2017, 1).

## **Theme: Military Sexual Trauma Among Veterans in the Texas 8th Congressional District**

I defined the following keywords for searches: “veterans,” “veterans medical care,” “Texas,” “military sexual trauma,” “MST,” “military sexual assault,” and “MSA.” I used the Texas A&M University’s online research library to conduct searches and stored applicable publications in RefWorks for organization and sharing. I reviewed 31 scholarly articles.

### **CHARACTERISTICS**

MILITARY SEXUAL TRAUMA. Identified as a gap in previous Capstone research, Dr. Cole specifically asked that we search for Military Sexual Trauma (MST) data related to male survivors. There is a great deal more data available on MST involving women victims. I was able to locate very little data which related to MST and male survivors. One in particular showed that while women report MST at a higher rate than men, incidence of suicidal ideation are much higher among male victims (Monteith et al. 2016, 257-265). Studies also show that men are at higher risk than women for homelessness as related to MST (Brignone et al. 2016, 582-589).

That is not to say that women are not at risk due to MST. Women who have been subjected to military sexual assault are more likely to suffer symptoms of substance abuse and PTSD. Results further suggest that women exposed to both MSA and other military stressors are at increased risk for developing co-occurring SUD and PTSD (Yalch, Hebenstreit, and Maguen 2018, 28-33). An additional study attempted to determine the interaction between MST gender on co-occurring disorders. “Veterans with positive MST screens had higher odds than those with negative screens of individual and co-occurring PTSD, Depressive Disorder, and Substance Use Disorder. The association between positive MST screens and diagnostic

outcomes, including PTSD, was stronger for women than for men, and the association between positive MST screens and some diagnostic outcomes, including DD, was stronger for men than for women” (Gilmore et al. 2016, 546-554). While perceptions of quality of care at VHA facilities were very good overall, there is some room for improvement regarding the specific treatments involved with patients who have been victims of MST (Kimerling et al. 2011, S151). Other studies show that both men and women who suffered from sexual trauma are more likely to be victimized again later in life (Schry et al. 2016, 406-411).

### **Theme: Substance Abuse Among Veterans in the Texas 8th Congressional District**

I defined the following keywords for searches: “veterans,” “substance abuse,” “veterans medical care,” “Texas.” I used the Texas A&M University’s online research library to conduct searches and stored applicable publications in RefWorks for organization and sharing. I reviewed 31 scholarly articles.

## **CHARACTERISTICS**

SUBSTANCE ABUSE. While Military Sexual Trauma (MST) may be a factor in many instances of substance abuse, it is not the only factor. Substance abuse, also termed substance use disorder, substance misuse, etc. is a significant factor affecting the lives and wellbeing of veterans in the 8th district. Again, it was difficult to find research specifically tied to the 8th district, but there is a great deal of information about substance abuse among veterans. There was also some amount of correlation between substance abuse and other issues facing veterans.



For instance, in one study researchers identified that high inpatient numbers for treatment of substance use disorders was related to the homeless veteran population (Painter et al. 2018, 386-394). Studies show a higher rate of suicide by veterans than the general population. This correlated to a higher rate with patients who had symptoms of substance abuse (Chapman, Carroll, and Wu 2013, 1-10). There is also a higher rate of regular cannabis use among women who are racial or sexual minorities and in those who are younger and unmarried, than the rate of the general population (Browne et al. 2018, 144-150).

Women veterans with substance use disorders are less likely to have prescribed contraception, which could lead to an increase in unintended pregnancy (Callegari et al. 2014, 97-103). Overall, use of cannabis by veterans is approximately the same and even lower in some areas as the national average for the general population. However, non-medical cannabis use was associated with higher rates of heavy episodic alcohol use and alcohol use disorder, it may be important to address problematic alcohol consumption among this high-risk group (Davis et al. 2018, 223-228). For men ages 18-25, heavy episodic drinking, daily cigarette smoking, alcohol use disorder, and substance use disorder were more prevalent among veterans than civilians. For women, the age-specific, overall, and age-adjusted prevalence of daily cigarette smoking was generally greater among veterans than civilians (Hoggatt et al. 2017, 357-365).

One issue is getting patients to complete outpatient treatment programs. One program showed that by issuing vouchers, gift cards, etc. to patients who return for treatment in outpatient substance abuse programs, the number of those who continued treatment increased (Businelle et al. 2009, 122-129). Continued abstinence for a period of four months after treatment was strongly associated with improvement in symptoms of PTSD, violence,

suicidality, and other medical problems (Manhapra, Stefanovics, and Rosenheck 2015, 70-77).

Researchers have concluded suicide rates are higher among female veterans than women in the general population. Substance use may increase the likelihood of suicidal behaviors among female veterans, particularly those with a mental diagnosis. More data is needed to better assess this increasing problem (Chapman, Carroll, and Wu 2013, 1-10).

Studies show a link between cannabis use disorder and suicide among veterans of the Iraq/Afghanistan era. Prospective research aimed at understanding the complex relationship between Cannabis Use Disorder, mental health problems, and suicidal behavior among veterans is clearly needed at the present time (Kimbire et al. 2017, 1-5).

## **SIGNIFICANCE**

Among homeless female veterans, Military Sexual Assault (MSA) is associated with greater mental health symptoms and greater interest in safety-focused treatment. Services targeting the needs of homeless MSA survivors should be encouraged (Decker et al. 2013, e380).

Suggestions for future study include examination of comparison samples of female veterans with and without PTSD and substance abuse across a variety of dimensions, including psychiatric symptoms, substance use, treatment utilization, and impact of treatment (Davis and Wood 1999, 123-127).

Sometimes there are extreme differences between the needs of the general population and those of veterans. Differences in culture and experiences make it difficult for veterans to reach out for help. It is recommended that nurses undergo specialized training in the diagnosis and treatment of substance abuse among veterans (Kiernan, Moran, and Hill 2016, 92-98).

There needs to be a procedure for patient information sharing between VHA and Medicare/private care providers. Studies show that veterans using both VHA and Medicare have a much higher risk of opioid overuse (Gellad et al. 2018, 248-255).

## **IMPLICATIONS**

There is a great deal of recent research on substance abuse in the United States, and much of this data examines impacts to veterans. However, there is clearly a gap in the research when it comes to how substance abuse and military sexual trauma affect veterans once they are out of the service. Research shows that veterans are less likely to seek help for substance abuse problems than members of the general population. There must be further research into what programs can be instituted and added for treatment of United States veterans.

### **Theme: Homelessness among Veterans**

The purpose of this research is to examine scholarly literature addressing homelessness among female veterans, and those who served in the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) eras. The following keywords were used to conduct searches; “veteran homelessness,” “Texas veterans,” “female veterans,” “Texas 08 Congressional District,” “prevention,” “OEF/OIF,” “service connected disability,” and “employment.” Scholarly, peer reviewed literature and governmental entity reports were used to collect qualitative and quantitative data for 2011 – 2018 project scope of research date range. Utilizing this information, my goal is to determine the most effective services to provide to OEF, OIF, and female veterans who are at risk of homelessness, currently experiencing homelessness, or have had multiple experiences of homelessness within the 8th district.

### **Focus Area One: Homelessness Among Texas Veterans**

“In 2010, the President and the United States Department of Veterans Affairs (VA) announced the federal government’s goal to end veteran homelessness” (U.S. Dept. of Veterans Affairs, 2017). Over the next several years, several initiatives were implemented focusing on prevention, crisis intervention and other relevant factors of veteran homelessness; and by 2015 the overall number of homeless veterans in Texas reduced dramatically. “In 2015, Houston announced reaching the federal benchmarks considered as having effectively ended veteran homelessness” or reaching a functional zero (U.S. Dept. of Veterans Affairs, 2015). The VA uses functional zero, in this context, to describe “when the number of veterans who are homeless, whether sheltered or unsheltered, is no greater than the monthly housing placement rate for veterans.”

According to the 2016 Texas Continuum of Care Point-In-Time (“PIT”) count, 1,768 veterans were recorded as experiencing homelessness during one night in January 2016; a 66% decrease since the PIT count in 2010 (U.S. Department of Housing and Urban Development, 2017). While reports between 2010 and 2016 exhibit significant progress in reaching the goal to end veteran homelessness, the 2017 PIT count displays an increase in homeless veterans nationally by nearly 600 people. “This 2016-2017 increase is said to be driven entirely by an 18% increase in the number of veterans experiencing homelessness in unsheltered places (2,299 more veterans) (U.S. Department of Housing and Urban Development, 2017). During the 2017 PIT count conducted by the Texas Continuum of Care, more than 430 veterans reported experiencing homelessness; an increase of 24% compared to the 2016 count.

## **CHARACTERISTICS**

PROFILE OF TEXAS VETERANS EXPERIENCING HOMELESSNESS. The 2017 Point in Time (PIT) count covering the 8th district listed demographic commonalities among veterans experiencing homelessness to white males in their mid-50s who were more likely to have served in one of the Gulf area conflicts than in Vietnam. This group would have had a previous experience of homelessness of at least a year in their mid-40s; likely to have been between jobs for at least one year also, would have chosen to sleep outdoors rather than in a shelter; and were slightly more likely to be located in a major metropolitan city than in Texas' rural and mid-sized cities (HUD 2017).

VETERAN POPULATION CONGRESSIONAL DISTRICT 8, TEXAS. According to American Community Survey results covering 2016, 49,963 veterans, 8.6% of the Texas population, call the 8th district home. Ninety two percent of veterans (45,965) are male, and 8% (3,998) are female. Almost half of the veteran population (47.6%) is over 55 and would have served either in the Vietnam era or earlier. The remaining 35.4% or 17,678 veterans living in the 8th district fall between the ages of 18 and 54 and have served between 2018 and 1990; many of them served during the OEF/OIF eras. Approximately 27% of this veteran population, has a disability rating, while the other 73% do not. According to the survey, the 8th district unemployment rate for veterans in 2016 was 5.3% with 95% of veterans living at or above the poverty line; this is not always positive, however, because government program assistance requires participants to fall within a specific range of income to qualify for services. Approximately 34% of our target population have no more than a high school

degree however, 37.6% have some college and the remaining 28.6% have a bachelors or higher (American Community Survey 2016).

UNDERSTANDING THE NEEDS OF TEXAS' HOMELESS VETERANS. There are several identified housing needs for single adult veterans experiencing homelessness, as well as those within families. Research conducted by the Texas Department of Housing and Community Affairs (TDHCA 2016) identified the following housing needs for veterans; affordable housing, potentially subsidized housing; housing with low barrier to entry, such as landlords or property managers that will accept persons with criminal backgrounds or with poor credit history, on a case-by-case basis; emergency shelters that accept children; housing units compatible with family size; greater access to VA benefits such as housing, including recognition of mental health needs which may have led to an other-than-honorable or dishonorable discharge, and possible reversal of the discharge status.

TEXAS VETERAN HOMELESSNESS: CONTRIBUTING FACTORS. The Texas Department of Assistive and Rehabilitative Services ("DARS") counselors have identified several contributing factors to veterans experiencing homelessness including but not limited to; a direct correlation between lack of income due to limited education and lack of ability to demonstrate transferable skills from military to civilian life (especially true of younger veterans returning from Iraq and Afghanistan); combat-related physical/mental health issues and disabilities; substance abuse problems that negatively impact job retention; and weak social networks due to problems adjusting to civilian life (TDHCA 2016).

Upon exiting the military veterans may seek the following services which can contribute to housing security; assistance with filing a disability claim and/or registering for

VHA benefits; using veteran education benefits; finding on-the-job training opportunities and/or finding employment; getting housing assistance; mental health services; and finding family and child services (TDHCA 2016).

## **SIGNIFICANCE**

For quite some time Texas experienced a reduction in veteran homelessness. However, the results of the 2017 PIT count conducted by the Texas Continuum of Care, show a significant increase of 24% compared to the 2016 count.

Veterans have unique housing needs and are experiencing socioeconomic and health issues that contribute to those needs. Understanding the evolution of the veteran population in the 8th district is critical to the implementation and success of prevention and intervention programs. The most significant finding of this portion of the research was the number of OEF, OIF, and female veterans between 18 and 54 residing in the 8th district as well as the number of female veterans from the OEF OIF service eras. Approximately 34% of our target population have no more than a high school degree which certainly plays into income levels and poverty statistics (American Community Survey 2016). Providers cannot appropriately meet the needs of veterans without an in depth understanding of their needs, concerns, and risk factors contributing to homelessness.

## **IMPLICATIONS**

With a large population of veterans who were more likely to have served in one of the Post-9/11 service eras, there is a need to focus on issues contributing to veteran housing stability within the 8th district. Additionally, almost a third of the 8th district veteran population falls between 18 and 54, with many of them serving in OEF/OIF eras, both male and female, and

approximately 70% have some college or less. Employment issues upon exiting the military contribute to veteran homelessness therefore the 8th district should provide assistance with filing a disability claim and/or registering for VHA benefits; using veteran education benefits; finding on-the-job training opportunities and/or finding employment. Preventive screening of veterans upon exit from the military as well as periodically over the next two years can identify risk and mitigate factors contributing to homelessness among veterans in the 8th district. Access to prevention and crisis intervention homeless services that can provide practical assistance and guidance is necessary.

### **Focus Area Two: Veterans of the Operation Enduring Freedom (EOF) and Operation Iraqi Freedom (OIF) Service Eras (Post-9/11)**

According to the U.S. Department of Veterans Affairs Supportive Service for Veterans and Families (SSVF) Annual Report, in FY 2016, the SSVF program served 96,401 Veterans. Among these Veterans, 16% (15,848 Veterans) served in Iraq or Afghanistan and were veterans of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or Operation New Dawn (OND)—the highest proportion of OEF/OIF/OND veterans served by any VA homeless initiative. Sixty-five (65%) percent of those Veterans received rapid re-housing assistance, 36% used homelessness prevention assistance, and 1% used both assistance types (VA SSVF Annual Report, 2016).

### **CHARACTERISTICS**

**RISK FACTORS FOR HOMELESSNESS.** In a study assessing the baseline risk factors for homelessness among OEF/OIF veterans, Metraux et al., found that service in Iraq or Afghanistan and, more specifically, posttraumatic stress disorder among veterans deployed there, were significant risk factors of modest magnitude for homelessness, and



socioeconomic and behavioral health factors provided stronger indicators of risk. (2013, S255) In fact, Veterans who served during the OEF/OIF eras are 34% more likely to be at risk for becoming homeless compared to veterans serving in any other era.

Reports of combat exposure combined with behavioral health disorders, particularly substance abuse disorders and, mental health disorders, have been linked with increased incidence of homelessness. Post-9/11-era veterans seem to be particularly vulnerable to a range of problems following military separation which substantially raises the risk of housing insecurity such as struggling to reconcile combat experiences with daily civilian routines. “The prevalence of PTSD diagnosis among Post-9/11-era veterans is higher than that of any previous veteran service cohort” (Byrne et al. 2017).

UNEMPLOYMENT. According to data from the 2016 American Community Survey, Post-9/11 veterans are the youngest cohort of veterans with a median age of 35 years old. This group was more likely to have no income and to live in a household receiving food stamps than all other veterans in 2016. Post-9/11 male veterans who worked year-round and full-time earned almost \$10,000 less than other veterans. This may be because the median age of Post-9/11 male veterans was 35 years while the median age of all other male veterans was 68 years in 2016. As for Post-9/11 female veterans, the personal income was about \$5,000 less than all other female veterans. This could be attributed to the aging of the other female veterans and a higher number of females serving in Post-9/11 era.

In the 2016 Urban Institute (UI) Report on The State of Post-9/11 Veteran Families; Post-9/11, veterans are more likely than civilians to be unemployed, and many report struggling to find adequate employment after returning to civilian life. Eight percent (8%) of Post-9/11 veteran families are poor, and 26% are low income. Thirty-two percent (32%) of families are housing cost burdened, and 10% are severely housing cost burdened. A family is

housing cost burdened if costs exceed 30% of their income and severely housing cost burdened if costs exceed 50%.

UI also reported that 24% of veterans with combat exposure and 8% of veterans without combat exposure are disabled (Morin 2011). “These disabilities have consequences, and 28% report that their disability has prevented them from getting or keeping a job” (Morin 2011) (UI 2016). Research regarding OEF/OIF service connected disability-discharged Veterans to be at 60% greater risk for homelessness than their routinely discharged counterparts. Disability rated income has not proven to be able to sustain the cost of living for veterans, and as such supplemental disability rating income does not prove to protect veterans from experiencing homelessness. Findings from one study suggests the value of supplemental income from service connected disability may diminish over time due to complications with long-term disability issues and other factors that can trigger economic instability (Fargo 2017). This is particularly problematic for veterans who must rely on disability income to live. If the OEF/OIF veteran is also experiencing issues which complicate gaining employment, and/or if they are also providing for a family, homelessness is a very real concern.

## **SIGNIFICANCE**

Socioeconomic and behavioral health factors, especially posttraumatic stress disorder from combat exposure, among veterans deployed in OEF/OIF service eras, are strong indicators of risk for homelessness. Veterans who served during the OEF/OIF eras are more likely to be at risk for becoming homeless compared to veterans serving in any other era. Post-9/11 veterans are more likely than civilians to be unemployed, and struggle to find and maintain adequate employment after returning to civilian life. OEF/OIF service connected disability-discharged

veterans report that their disability has prevented them from getting or keeping a job and therefore experience an increased risk for homelessness.

## **IMPLICATIONS**

As previously discussed, 35.4% or 17,678 veterans living in the 8th district are between the ages of 18 and 54 and have served between 2018 and 1990. Many of these veterans would have served the OEF/OIF eras. Approximately 27% of this veteran population, have a disability rating. To appropriately serve veterans in the 8th district, providers addressing veteran homelessness must understand the unique set of needs and risk factors which are attributable to OEF/OIF veterans experiencing housing instability. Preventive screening and consultation for issues such as employment stability, PTSD, mental health issues, and disability can identify concerns and challenges early on and may keep the veteran from experiencing literal homelessness. To improve the transition from the military to civilian life and lessen the risk of housing insecurity, greater coordination is required among VA and community programs dedicated to preventive measures.

### **Focus Area Three: Homelessness Among Female Veterans**

As more women serve in the United States military, the proportion of females among homeless veterans is increasing. In 2015, the estimated number of female veterans was 2 million and it is expected that the number will increase to 2.2 million by 2020. Leading the nation with the largest population of female veterans is the state of Texas. “The growth in the female veteran homeless population may be attributable to factors related to the increased deployment of women in the recent conflicts in Iraq and Afghanistan” (Byrne, Montgomery, and Dichter 2013, 589).

## **CHARACTERISTICS**

PROFILES OF FEMALE VETERANS EXPERIENCING HOMELESSNESS. Byrne, Montgomery, and Dichter found homeless female veterans to be younger than their male counterparts, had higher levels of unemployment, and had lower rates of drug or alcohol dependence or abuse but higher rates of mental health problems (2013, 590). Among female veterans, several factors have been found to be associated with the experience of homelessness, including unemployment, disability and low-income; experiencing military sexual trauma (MST); being in fair or poor health; having diagnosed medical conditions; and screening positive for an anxiety disorder, PTSD, or tobacco use. “Female veterans who have experienced MST have a significantly increased likelihood of mental health conditions including PTSD all of which will increase the likelihood of homelessness by more than a factor of four” (O’Toole 2016).

“Homeless female veterans were also much more likely to have children with them”(Tsai, Rosenheck, and Kane 2014, 5). The VA Female Veterans Health Program provides various avenues for homeless veterans to live more independently. These include: emergency shelters, transitional housing programs, and permanent housing. There are also some services and programs available for homeless females who have dependent children in their care. Some additional characteristics associated with homelessness among female veterans include younger age, being unmarried, and having a 100% service-connected disability rating or being otherwise disabled. Female veterans are more than twice as likely as non-veteran female and over three times as likely as non-veteran female living in poverty to experience homelessness (O’Toole 2016).

BARRIERS TO USING VA HOMELESS SERVICES. Studies and/or reports done between 2013 and 2016 show consistent barriers to using VA homeless services for female veterans. Homeless female veterans have indicated the following barriers to using VA homeless

services; lack of information about available veteran benefits, housing programs, mental health care, and trauma specialists. Additional concerns discussed include limited access to programs, including the lack of gender-appropriate care; services inaccessible due to their location far from females' homes; the scarcity of long-term housing options; and the restrictive entry criteria of many interventions. The needs of female veterans should be considered separately from those of male veterans. Programs must be tailored and pay greater attention to the specific issues of service navigation and coordination. There is a great need for gender-specific programs, better screening, and increased awareness of trauma-informed care and the impact of intimate partner violence and military sexual trauma. To improve the transition for females from the military to civilian life, greater coordination is required among the VA and other government programs dedicated to serving female veterans.

### **SIGNIFICANCE**

Despite the fact that women have been serving in the military since World War II, there is still a significant disparity in services compared to their male counterparts. Texas is currently leading the nation with the largest population of female veteran and the 8th district is home to approximately 4,000 of those. This number is projected to steadily increase as more women come home from OEF/OIF service deployments. Female veterans experience several contributing factors associated with homelessness. Gender-specific programs, and specialty services are needed to improve the transition for female from the military to civilian life, and greater coordination is required among the VA and other government programs dedicated to serving female veterans. The needs of female veterans should be considered separately from those of male veterans. Programs must be tailored and pay greater attention to the specific issues of service navigation and coordination.

### **IMPLICATIONS**

While the VA appears to provide specialized services for female veterans experiencing homelessness, this cohort continues to experience major barriers to accessing said services due to lack of information being shared regarding available services. Providing specialized services specifically aimed at mitigating attributable factors to female veteran homelessness allows providers to more aptly assist our female veterans. Preventive and intervening housing programs must be tailored and pay greater attention to the specific issues of service navigation and coordination.

## **Discussion/Cross-Cutting Findings**

The previous Capstone team identified many issues of cross-cutting in their literature studies that included the VHA Strategic Plan, mental health, wait times, VA leading in veteran-specific healthcare needs, telemedicine, dual usage, and gender-specific needs for female veterans. Similar cross-cutting literature was derived from our research. Some additional cross-cutting literature findings are as follows:

1. Overall consideration for training improvements in each area of veterans' care; regarding general health and primary care, mental health, gender-specific care, etc.
2. Access to care for rural vs. urban veterans was seen throughout all themes with veterans living in rural areas having a harder time accessing care than urban veterans with more options.
3. The stigma that follows the VA healthcare system is noticed within each theme. Those that are eligible for care at VHA may or may not be aware of their eligibility based on veteran status, along with the necessary tools to encourage VHA use when applicable.
4. The experience that veterans have during their time at veteran facilities has been documented by a majority of the researched themes. The way the veterans feel they

are treated is significant topic.

5. Aging among veterans was discussed across many things as a growing number of veterans are falling over the age of 65.

6. Awareness was seen in many facets among these themes, as a growing need for understanding toward veterans returning home from duty, what is available to them within VHA and in the community, and what role VA plays in preventative measures for veterans.

7. Homelessness was within many themes as homelessness has various sources of causation; including mental health, access to care, aging, general illness, economic and financial hardships, etc.

## **Research Questions**

A. The original research question agreed upon by the group:

- What literature exists regarding the following veteran issues: similar CBOCs, overall health, women's health, mental health, substance abuse, and homelessness in addition to what the previous Capstone found?

B. After completion of our hybrid literature review, the group expanded the original question into the following 71 questions:

### **Theme: Comparative Analysis: Congressional Districts 8 and 31 and VA System in Each District**

1. How are health care expenditures documented by congressional district?

- Sub question 1: Do district VA hospitals report this information to the VA or state?  
Both?
2. How does the Central TX VHCS improve services to veterans within the 31st district?
- Sub question 1: Does the Central TX VHCS offer mental health education services for families?
  - Sub question 2: Are there more services available through this facility than in Debakey? If so, how are services different?
3. What kind of health services are the most prevalent in Conroe and Cedar Park?
- Sub question 1: Are mental health illnesses being treated more frequently compared to other ailments?
  - Sub question 2: How are health services categorized by CBOCs and VA hospitals?
  - Sub question 3: Do CBOCs and VA hospitals use the same type of documentation process for mental health patients?
5. Are Katy and Beaumont seeing statistically more health patients? Is this service or location related?
6. Has the Conroe CBOC implemented recommendations made by the 2010 report?
- Sub question 1: Has Conroe hired more staff to address limitations in women's health services?
  - Sub question 2: Has Conroe gotten worse in any of the evaluated categories?
7. Is the Cedar Park CBOC actually performing better than the Conroe CBOC?
- Sub question 1: Do patients who visit Cedar Park CBOC suffer from recidivism in terms of treatment?
  - What are statistically significant demographic differences between the 8th district and TX/national averages?



- What areas does Cedar Park CBOC perform in better as measured by having women's liaisons and having family education programs for veterans and their families?
- What are the differences between Conroe and Cedar Park in terms of services? Are they statistically significant?
- Do Conroe and Cedar Park see statistically more MH patients than the TX/national averages?
- Do rural veterans receive statistically significant less care (as defined as services offered for mental health) than the TX/national averages?
- What is the projected growth rate of the 8th district veterans as compared to the TX/national averages per sex. Age, etc.? Statistical significance?
- What are average wait times for services in Conroe and Cedar Park and are they statistically significantly different?
- Is Bell County Comparable to Montgomery County in terms of poverty rates?

### **Focus Area One: Demographics and Fewer Veterans Trending at State and Local Levels**

15. What is the VA currently doing to prepare for shifts in veteran demographics?
16. How will pitfalls in the current system be improved before a demand shift?
17. How will changing demographics influence the locations and number of CBOCs available?
18. Why are some areas of Texas seeing more veteran growth than others?

### **Focus Area Two: Access and Quality of Care Performance**

19. Why are veterans utilizing more VA benefits?
- Sub question 1: Is the aging population of veterans qualifying more people for benefits?
20. Have more CBOCs hired women's health liaisons?
- Sub Question 1: Why didn't all 44 CBOCs evaluated in the CBOC review have one?
21. Does the Cedar Park or Conroe CBOC have a family education program?
22. Are rural veterans more at-risk in the 8th district than they are in the 31st district?
- Sub Question 1: Are there more services offered in Cedar Park than in Conroe?
  - Sub Question 2: Are rural veterans missing out on helpful mental health services because of where they live?
23. What kind of support groups exist for families within the DeBakey and Central Texas networks?
24. Has something like the SAFE program been implemented into the DeBakey and Central Texas VA Facilities?
25. What can be done to encourage veterans to seek help more quickly?
- Sub questions 1: Is the system broken or is this an attitudinal barrier of veterans?
26. How much coordination is going on between the federal departments within Texas?
- Sub Question 1: What is the state's role in managing services provided by these entities?
27. How have the DOD, DHHS and VA worked together in past programs?

### **Focus Area Three: Veterans Choice Act and Dual Use Implications**

- 28. How many veterans has the Veterans Choice Act helped?
- 29. How will the new legislation VA MISSION Act improve upon downfalls of the Choice Act?
- 30. How can dual use be a more efficient model for veterans?

### **Theme: Veterans Healthcare and Wellness**

- 31. What is the current VA healthcare situation?
- 32. What are the budget and expenditures government spend on VA healthcare, and what is the impact?
- 33. What is the waiting time for the appointments compare with other non-veteran medical services?
- 34. What is the reason and impact for veterans to choose other medical services more than VHA's CBOX?
- 35. The possibility to improve the overall healthcare services to veterans in district 8?

### **Theme: Women Veterans' Healthcare**

- 36. How are the younger generations targeted for successful service when leaving the military?
- 37. What educational and/or targeted training are available for the clinicians and nurses (both within and outside of the VHA)? Are these trainings required or mandatory?
- 38. What nonprofit options are available for women veterans within the 8th district?

39. What can be done to increase aide to these organizations to assist these veterans?
40. Do female veterans have a statistically higher rate of cervical cancer than the average female population?
41. What percent of District 8 female veterans are disabled?
42. Do the female veterans in District 8 utilize the VHA at the same level as female veterans in urban districts? What percentage of the District 8 female veterans use more than one medical source (dual-usage)?
43. Are the women veterans of District 8 with PTSD or depression experiencing worse or more physical/medical health conditions in comparison to women veterans without PTSD or depression?
44. Of the female veterans in District 8 that have served in the Gulf War eras or after the events of September 11, 2001, are there more mental health cases than of those female veterans in other eras of military service?

**Theme: Mental Health Services Provision to Veterans**

45. Is there a shortage of mental health providers at the Conroe CBOC as measured by wait times?
46. If so, how is the Conroe CBOC planning on overcoming the shortage of mental health service providers?
47. Do primary care providers at the Conroe CBOC also provide mental health services?
48. Are mental health professionals at the Conroe CBOC specifically trained in military mental health issues and military culture?

49. Has the Conroe CBOC established a program, or does it offer educational opportunities to regional external mental health providers on issues that relate to mental health of veterans and military culture?

**Theme: Military Sexual Trauma among Veterans in the 8th Congressional District**

50. What is driving the lower rate of reporting of MSA among male veterans?
51. Is there anything that can be done to encourage more veterans to report and then seek treatment?
52. What are the barriers to 8th district male veterans in completing outpatient treatment programs for both substance abuse and MST?
53. Is there a lower rate of MST among male veterans at the Conroe CBOC?
54. Is there a statistically significant difference between male veterans with hx of MST committing suicide and the TX/national average?

**Theme: Substance Abuse Among Veterans in the Texas 8th Congressional District**

55. Is there a lower rate of reporting of MST among male veterans at the Conroe CBOC? Is there anything that can be done to encourage more veterans to report and seek treatment?
56. What are the barriers to TX08 male vets in completing outpatient treatment for both substance abuse and MST?
57. How can the Conroe CBOC share information between VHA and Medicare/private healthcare providers to allow continuity of treatment? (Note – could be measured by reduced medication errors???)

58. Is there a SS difference between male vets with hx of MST committing suicide and the TX/national average?
59. Is there a difference between the TX08 vet suicide rate and the national average?

**Theme: Homelessness among OEF/OIF and Female Veterans**

60. What resources are currently available in the 8th District addressing veteran employment issues?
61. What percentage of total veterans in the 8th District are unemployed?
62. What is the employment rate of OEF/OIF (male and female), and female veterans in the 8th District?
63. What is the average length of time OEF/OIF (male and female), experience unemployment or time between jobs?
64. Do combat veterans, in the 8th District experience greater challenges obtaining employment?
65. How many veterans who are experiencing housing insecurity, request assistance from VA and/or community services?
66. How many homeless veterans each year do not receive housing assistance because they are not registered with the VA?
67. How is the VA working to remove barriers to housing assistance for female veterans?
68. How is the VA working to make specialized services housing assistance for female veterans?

69. What percent of female veterans experiencing housing insecurity have children with them?
70. What if any, are the best practices/solutions to veteran homelessness in the 8th district?
71. Programs specifically addressing veteran homelessness among female in in the 8th district?

## Findings

We found that veteran populations are projected to decline over time, which can be attributed to an aging demographic. This is relevant because an aging veteran population exists in the 8th district, as well as in the nation. An aging veteran population will also affect demand of healthcare services in the future, which could put pressure on the VA healthcare system. Another shift in the veteran population is the number of female veterans nationwide. Female veterans are utilizing more VA healthcare services than ever before. The change in female demographics will require more attention to female health services offered by the VA system.

Our second finding highlights the differences between the needs and challenges of veterans versus the non-veteran population. Veterans are a vulnerable population when it comes to primary care, homelessness, substance abuse, and specialty care. Within the veteran population, rural veterans still face more access challenges than veterans living in urban areas. Rural veterans are more likely to struggle with barriers to care that relate to distance from a VA facility, resources of time and money, and conceptual insurance coverage, while the veteran population as a whole faces attitudinal behavior barriers. Compared to the general population, veterans are less likely to seek care for mental health ailments because of perceived stigmas. Within this same subject matter, we found that veterans choose which

service provider to visit based on professionalism of the providers and possession of adequate insurance coverage. Veterans utilizing dual use still deal with procedural flaws when it comes to communications between VA facilities and non-VA facilities.

Despite the passage of the Veterans Choice Act and the implementation of more CBOC facilities, gaps in care still exist for both male and female veterans. Rural veterans still experience the greatest access gap. Access to care remains a predominant issue that has not yet been solved by current policy or healthcare infrastructure.

Findings from our research, have led us to potential new areas of emphasis throughout the collection process. For this reason, we have developed recommendations and research questions that narrow the scope further and identify future study objectives.

## **Conclusion**

Our initial research question guided us to find current research available and identified gaps in research within our designated theme areas. Findings from our initial research, helped us learn what is currently available and what requires further explanation. Additionally, we have identified focus areas within our themes. We have written several research questions that help identify areas of need within our research that will help provide more detail for our work next semester.



## BIBLIOGRAPHY

Abrams, Allison. 2017. "Enhancing Mental Health for Veterans through Technology."

"Actions Needed to Improve Access to Primary Care for Newly Enrolled Veterans." 2016.

*GAO Reports* (04/19):1.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=f5h&AN=114671632&site=eds-live>.

Amara, Jomana. 2018. "Military and Veterans' Health, Health Care, and Wellbeing." *Defense and Peace Economics* 29 (1):1-5.

Amaral, et al. 2018. "Current and Future Demographics of the Veteran Population, 2014–2024." *Population Review* 57(1):28-60.

Ann. 2014. "Development and Validation of an Instrument to Assess Imminent Risk of Homelessness among Veterans." *Public Health Reports* (1974) 129(5):428.

Ann, et al. 2016. "Factors Associated with Veterans' Access to Permanent Supportive Housing." *Psychiatric Services* (8):870.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edpspy&AN=edpspy.appi.ps.201500248&site=eds-live>.

Banducci, et al. 2017. "Associations between Residential Treatment Length, PTSD, and Outpatient Healthcare Utilization among Veterans." *Psychological Services*.

Banducci, et al. 2017. "Associations between Residential Treatment Length, PTSD, and Outpatient Healthcare Utilization among Veterans." *Psychological Services*.

Barry, et al. 2016. "Innovating Team-Based Outpatient Mental Health Care in the Veterans Health Administration: Staff-Perceived Benefits and Challenges to Pilot Implementation of the Behavioral Health Interdisciplinary Program (BHIP)." *Psychological Services* 13 (2) (05):148-155.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2016-21027-004&site=ehost-live>.

Bastian, et al. 2014. "Association between Women Veterans' Experiences with VA Outpatient Health Care and Designation as a Women's Health Provider in Primary Care Clinics." *Women's Health Issues* 24 (6):605-612.

Beehler, Clark, and Eisen. 2014. "Participant Experiences in Peer- and Clinician-Facilitated Mental Health Recovery Groups for Veterans." *Psychiatric Rehabilitation Journal* 37 (1) (03):43-50.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2014-09950-006&site=ehost-live>.

Beehler, et al. 2018. "Factors Contributing to the Effective Functioning of Veterans Mental Health Councils." *Psychological Services* (05/10).

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2018-20978-001&site=ehost-live>.

Belote, Fulton, and Brooks. 2012. "Patient Satisfaction as a Function of in-House Versus Contract Staffing Models in Veterans Affairs Community-Based Outpatient Clinics." *Military Medicine* 177 (1) (01):23-26.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2012-01765-001&site=eds-live>.

Bergland, Christopher. 2013. "Two New PTSD Treatments Offer Hope for Veterans."

Bergman, et al. 2015. "Challenges with Delivering Gender-Specific and Comprehensive Primary Care to Women Veterans." *Women's Health Issues* 25 (1):28-34.

Borsari, et al. 2017. "Student Service Members/Veterans on Campus: Challenges for Reintegration." *The American Journal of Orthopsychiatry* 87 (2):166-175.

- Bovin, et al. 2018. "Veterans' Experiences Initiating VA-Based Mental Health Care." *Psychological Services* (05/21).  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2018-23404-001&site=ehost-live>.
- Brady, Kevin. 2018. "8th District." <https://kevinbrady.house.gov/district/>.
- Brennan. 2017. "Challenges in Veteran Mental Health Care: What's Not Talked about."
- Brennan. 2017. "Identifying Challenges Effecting Veteran Mental Healthcare."
- Brignone, et al. 2016. "Differential Risk for Homelessness among US Male and Female Veterans with a Positive Screen for Military Sexual Trauma." *JAMA Psychiatry* 73 (6) (06): 582-589.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2016-34326-010&site=eds-live>.
- Brooks, et al. 2014. "Rural Women Veterans Demographic Report: Defining VA Users' Health and Health Care Access in Rural Areas." *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association* (30):146-152.
- Brooks, et al. 2016. "Listening to the Patient: Women Veterans' Insights about Health Care Needs, Access, and Quality in Rural Areas." *Military Medicine* 181 (9) (09):976-981.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=118066817&site=eds-live>.
- Browne, et al. 2018. "Regular Past Year Cannabis use in Women Veterans and Associations with Sexual Trauma." *Addictive Behaviors* 84 (September 2018):144-150.
- Brunner, et al. 2018. "Timely Access to Mental Health Care among Women Veterans." *Psychological Services* (04/05).

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2018-14481-001&site=ehost-live>.

Bumgarner, et al. 2017. "Mental Health Care for Rural Veterans: A Systematic Literature Review, Descriptive Analysis, and Future Directions." *Journal of Rural Mental Health* 41 (3) (07):222-233.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2017-46226-003&site=ehost-live>.

Businelle, et al. 2009. "Using Vouchers to Increase Continuing Care Participation in Veterans: Does Magnitude Matter?" *American Journal on Addictions* 18 (2) (Mar):122-129.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=37140915&site=eds-live>.

Byrne and Thomas. 2013. "Homelessness among Female Veterans: A Systematic Review of the Literature." *Women & Health* 53 (6):572-596.

Byrne, et al. 2015. "Screening for Homelessness in the Veterans Health Administration: Monitoring Housing Stability through Repeat Screening." *Public Health Reports* 130 (6) (Nov):684-692.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ssf&AN=116674993&site=eds-live>.

Callegari, et al. 2014. "Associations of Mental Illness and Substance Use Disorders with Prescription Contraception use among Women Veterans." *Contraception* 90 (1) (July 2014):97-103.

Calvo and Ahmed. 2012. "Geographic Proximity of HRSA, VA, and DOD Clinics: Opportunities for Interagency Collaboration to Improve Quality." *Journal of Health Care for the Poor and Underserved* 23 (3):125-135.

- Caplan and Paula. 2011. "Where has all the Funding Gone for Suffering War Veterans? Missing Money and Lack of Social Support for War Veterans. .".
- Caplan and Paula. 2015. "The Naked Emperor and the Vanishing Veteran. it is Essential to Expose the Hidden and Tragic Loss of Support for Veterans."
- Carter and John. 2018. "All About Texas' 31st District."  
<https://carter.house.gov/all-about-texas-31st-district/>
- Chandra, et al. 2016. "Treatment of Dyslipidemia with Statins by Primary Care Providers in Veterans with and without Chronic Hepatitis C." *American Journal of Health-System Pharmacy* 73 (03/02): S30-34.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=113258281&site=eds-live>.
- Chang, et al. 2016. "Job Satisfaction of Department of Veterans Affairs Peer Mental Health Providers." *Psychiatric Rehabilitation Journal* 39 (1) (03):47-54.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2015-44646-001&site=ehost-live>.
- Chapman and Wu. 2014. "Suicide and Substance use among Female Veterans: A Need for Research." *Drug and Alcohol Dependence* 136 (1 March 2014):1-10.
- Clinical assessment program review of the Michael E. DeBakey VA medical center Houston, Texas.* 2017. U.S. Department of Veterans Affairs: Department of Veterans Affairs Office of Inspector General.
- Cohen, et al. 2012. "Reproductive and Other Health Outcomes in Iraq and Afghanistan Women Veterans using VA Health Care: Association with Mental Health Diagnoses." *Women's Health Issues* 22 (5): e461-471.

*Combined assessment program review of the Central Texas Veterans Health Care System, Temple, Texas.* 2015. U.S. Department of Veterans Affairs: Department of Veterans Affairs Office of Inspector General.

*Community based outpatient clinic reviews Branson, MO, Harrison, AR, Conroe and Lufkin, TX, Hammond and Houma, LA.* 2011. Department of Veterans Affairs Office of the Inspector General.

*Community based outpatient clinic reviews at Central Texas Veterans Health Care System Temple, TX and Texas Valley & Coastal Bend Health Care System, Harlingen, TX.* 2013. U.S. Department of Veterans Affairs: Department of Veterans Affairs Office of Inspector General.

Conard, and Armstrong. 2016. "Advocating for Deployed Women Veterans' Health Differences, Difficulties, and Disparities." *Nursing Forum* 51 (4):225-232.

Congressional Research Service. 2018. "The Veterans Choice Program (VCP): Program Implementation" <https://fas.org/sgp/crs/misc/R44562.pdf> (October 1, 2018).

Cordasco, et al. 2016. "Health and Health Care Access of Rural Women Veterans: Findings from the National Survey of Women Veterans." *Journal of Rural Health* 32 (4) (Fall 2016):397-406.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=eue&AN=118513870&site=eds-live>.

Cunningham, et al. 2015. *Veterans Homelessness Prevention Demonstration evaluation: Final report prepared for U.S. Department of housing and urban development office of policy development and research Washington, D.C.* The Urban Institute.

Currier, et al. 2017. "Applying Trauma-Informed Care to Community-Based Mental Health Services for Military Veterans." *Best Practice in Mental Health* 13 (1) (Spring 2017): 47-64.

---

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=asn&AN=123489096&site=eds-live>.

---

Davis, et al. 2018. "Recent Cannabis use among Veterans in the United States: Results from a National Sample." *Addictive Behaviors* 76 (January 2018):223-228.

Davis, Burkett, and Hart. 2017. "Mental Health Services for Veterans at the Birmingham Veteran Affairs Medical Center." *Alabama Nurse* 44 (4) (Dec 2017):9.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=126794926&site=eds-live>.

Davis and Wood. 1999. "Substance Abuse and Sexual Trauma in a Female Veteran Population." *Journal of Substance Abuse Treatment* 16 (2) (March 1999):123-7.

Decker, et al. 2013. "Military Sexual Assault and Homeless Women Veterans: Clinical Correlates and Treatment Preferences." *Women's Health Issues* 23 (6) (11): e373-380.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=fyh&AN=91726417&site=eds-live>.

DeViva, et al. 2016. "Correlates of VA Mental Health Treatment Utilization among OEF/OIF/OND Veterans: Resilience, Stigma, Social Support, Personality, and Beliefs about Treatment." *Psychological Trauma: Theory, Research, Practice, and Policy* 8 (3) (05):310-8.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2015-35558-001&site=ehost-live>.

Draper. 2016. "Va Health Care." *GAO Reports* (04/18):1.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pwh&AN=114611102&site=eds-live>.

Edwards. 2017. "Preventing Hospitalization with Veterans Affairs Home-Based Primary

- Care: Which Individuals Benefit most?" *Journal of the American Geriatrics Society* 65 (8):1676-1683.
- Executive Office of the President*. 2011. Strengthening Our Military Families: Meeting America's Commitment Report Michael E. DeBakey VA Medical Center – Houston Texas. 2016. "Conroe VA Outpatient Clinic."  
[https://www.houston.va.gov/locations/Conroe\\_VA\\_Outpatient\\_Clinic.asp](https://www.houston.va.gov/locations/Conroe_VA_Outpatient_Clinic.asp) (July 25, 2018).
- Fargo and Jamison. 2017. "Homelessness Following Disability-Related Discharges from Active Duty Military Service in Afghanistan and Iraq." *Disability and Health Journal* 10 (4):592-529.
- Frayne, et al. 2013. "The VA Women's Health Practice-Based Research Network: Amplifying Women Veterans' Voices in VA Research." *JGIM: Journal of General Internal Medicine* 28 (2) (07/02):504-509.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=104079596&site=eds-live>.
- Friedman, et al. 2015. "Travel Time and Attrition from VHA Care among Women Veterans: How Far is Too Far?" *Medical Care* 53 (4 Suppl 1): S15-22.
- Friedman, et al. 2011. "New Women Veterans in the VHA: A Longitudinal Profile." *Women's Health Issues* 21 (4): S103-111.
- Gaglioti, et al. 2014. "Non-VA Primary Care Providers' Perspectives on Comanagement for Rural Veterans." *Military Medicine* 179 (11) (11):1236-1244.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=2014-51970-007&site=eds-live>.
- Gellad and Walid. 2016. "The Veterans Choice Act and Dual Health System use." *Journal of General Internal Medicine* 31 (2):153-154.



- Gellad, et al. 2018. "Impact of Dual use of Department of Veterans Affairs and Medicare Part D Drug Benefits on Potentially Unsafe Opioid use." *American Journal of Public Health* 108 (2) (02):248-255.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=gft&AN=127233472&site=eds-live>.
- Ghosh, Negrusa, and Warner. 2018. "Health Insurance, Health Conditions, and Veteran Health Care Utilization." *Defense and Peace Economics* 29 (1):24-43.
- Gilmore, et al. 2016. "Military Sexual Trauma and Co-Occurring Posttraumatic Stress Disorder, Depressive Disorders, and Substance Use Disorders among Returning Afghanistan and Iraq Veterans." *Women's Health Issues* 26 (5) (September–October 2016):546-554.
- Goldstein, et al. 2017. "Characteristics and Health Care Preferences Associated with Cardiovascular Disease Risk among Women Veterans." *Women's Health Issues* 27 (6) (November–December 2017):700-706.
- Goodman. 2005 (2016). "Bringing the Battle Home. A Good Percentage of Soldiers Return from Iraq Emotionally Troubled. Is the Military Failing Traumatized Veterans?"
- Goodyear 2018. "The Crisis of Rural Despair. The Mental Health Needs of Rural America are Acute and Complex. Last-Ditch Solutions are on the Table. Can they Work?"
- Grubaugh, et al. 2014. "Providers' Perspectives regarding the Feasibility and Utility of an Internet-Based Mental Health Intervention for Veterans." *Psychological Trauma: Theory, Research, Practice, and Policy* 6 (6) (11):624-631.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2014-21930-001&site=ehost-live>.

- Hamilton, et al. 2012. "Barriers to Psychosocial Services among Homeless Women Veterans." *Journal of Social Work Practice in the Addictions* 12 (1) (/ 01 / 01 /):52-68.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edselc&AN=edselc.2-52.0-84858650433&site=eds-live>.
- Hamilton, Poza, and Washington. 2011. "'Homelessness and Trauma Go Hand-in-Hand': Pathways to Homelessness among Women Veterans." *Women's Health Issues* 21 (4) (Jul): S203-209.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2011-14100-023&site=eds-live>.
- Healthcare inspection: Evaluation of community-based outpatient clinics fiscal year.* 2011. Department of Veterans Affairs Office of Inspector General.
- Henry, et al. 2017. PART 1: Point-in-time estimates of homelessness. The 2017 annual homeless assessment report (AHAR) to Congress. The U.S. Department of Housing and Urban Development OFFICE OF COMMUNITY PLANNING AND DEVELOPMENT.
- Hester 2017. "Lack of Access to Mental Health Services Contributing to the High Suicide Rates among Veterans." *International Journal of Mental Health Systems* 11 (1) (08/18):1-4.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=asn&AN=124726753&site=eds-live>.
- Hoggatt, et al. 2017. "Prevalence of Substance Misuse among US Veterans in the General Population." *American Journal on Addictions* 26 (4) (06):357-365.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=s3h&AN=122988310&site=eds-live>.

- Howren, Cozad, and Kaboli 2015. "Considering the Issue of Dual-use in Veterans Affairs Patients: Implications & Opportunities for Improved Communication & Counseling." *Health Communication* 30 (8) (08):838-842.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cms&AN=102270743&site=eds-live>.
- Jameson, et al. 2011. "VA Community Mental Health Service Providers' Utilization of and Attitudes Toward Telemental Health Care: The Gatekeeper's Perspective." *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association* 27:425-432.
- Jay, et al. 2015. "Barriers and Facilitators to Providing Primary Care-Based Weight Management Services in a Patient Centered Medical Home for Veterans: A Qualitative Study." *BMC Family Practice* 16 (11/14):1-12.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=127837740&site=eds-live>.
- Jing Shi 2014. "Simulation Analysis on Patient Visit Efficiency of a Typical VA Primary Care Clinic with Complex Characteristics." *Simulation Modelling Practice and Theory* 47:165-181.
- Jordan, Jay R. 2015. "New Conroe VA clinic open for veterans Monday."  
<https://www.yourconroenews.com/neighborhood/moco/news/article/New-Conroe-VA-clinic-open-for-veterans-Monday-9506595.php> (July 25, 2018)
- Karuza and Jurgis 2017. "National Structural Survey of Veterans Affairs Home-Based Primary Care Programs." *Journal of the American Geriatrics Society* 65 (12):2697-2701.
- Kashdan 2014. "11 Reasons that Combat Veterans with PTSD are being Harmed."

- Kearney, et al. 2018. "Veterans Health Administration's (VHA) National Mental Health Leadership Mentoring Program: A Pilot Evaluation." *Training and Education in Professional Psychology* 12 (1) (02).  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2017-36187-001&site=ehost-live>.
- Kearney, et al. 2017. "Mental Health Productivity Monitoring in the Veterans Health Administration: Challenges and Lessons Learned." *Psychological Services* (07/17).  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2017-30684-001&site=ehost-live>.
- Kelley, et al. 2015. "Drug use and Childhood-, Military- and Post-Military Trauma Exposure among Women and Men Veterans." *Drug and Alcohol Dependence* 152 (1 July 2015):201-208.
- Kiernan, Moran, and Hill. 2016. "Understanding Why Veterans are Reluctant to Access Help for Alcohol Problems: Considerations for Nurse Education." *Nurse Education Today* 47 (December 2016):92-98.
- Kimbrel, et al. 2017. "Cannabis use Disorder and Suicide Attempts in Iraq/Afghanistan-Era Veterans." *Journal of Psychiatric Research* 89 (June 2017):1-5.
- Kimerling, et al. 2011. "Military Sexual Trauma and Patient Perceptions of Veteran Health Administration Health Care Quality." *Women's Health Issues* 21 (4, Supplement) (July– August 2011): S145-151.
- Kimerling, et al. 2011. "Original Article: Military Sexual Trauma and Patient Perceptions of Veteran Health Administration Health Care Quality." *Women's Health Issues* 21 (-): S145- 151.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edselp&AN=S1049386711000922&site=eds-live>.

- Koblinsky, Leigh, and Cook. 2014. "Treating Behavioral Health Conditions of OEF/OIF Veterans and their Families: A State Needs Assessment of Civilian Providers." *Military Behavioral Health* (2):161-172.
- Koppen and O'Rourke. 2017. "Outlook for Federal Mental Health Policy in the 115th Congress." *Psychiatric Times* 34 (2) (02):1-3.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ssf&AN=121335158&site=eds-live>.
- Lagro. 2015. "Creating a Roadmap for Delivering Gender-Sensitive Comprehensive Care for Women Veterans Results of a National Expert Panel." *Medical Care* 53 (4): S156.
- Laws, et al. 2017. "Posttraumatic Stress Symptom Change After Family Involvement in Veterans' Mental Health Care." *Psychological Services* (12/21).  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2017-57164-001&site=ehost-live>.
- Luca et al. 2016. "Mental Health Care Utilization: How Race, Ethnicity and Veteran Status are Associated with Seeking Help." *Community Mental Health Journal* 52 (2) (02):174-179.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=112692574&site=eds-live>.
- Maiocco, and Davidov. 2017. "Rural Veterans' Utilization of Non-Veterans Administration Community Health Care Services." *The Journal for Nurse Practitioners* 13 (2) (February 2017): e91-93.
- Manhapra, Stefanovics, and Rosenheck. 2015. "Treatment Outcomes for Veterans with PTSD and Substance use: Impact of Specific Substances and Achievement of Abstinence." *Drug and Alcohol Dependence* 156 (1 November 2015):70-77.

- Matarazzo, et al. 2016. "Barriers and Facilitators in Providing Community Mental Health Care to Returning Veterans with a History of Traumatic Brain Injury and Co-Occurring Mental Health Symptoms." *Community Mental Health Journal* 52 (2) (02):158-164.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=112692579&site=eds-live>.
- Mattocks. 2017. "The Veterans Choice Act A Qualitative Examination of Rapid Policy Implementation in the Department of Veterans Affairs." *Medical Care* 55 (7): S71.
- McDaniel, et al. 2018. "Mental Health Outcomes in Military Veterans: A Latent Growth Curve Model." *Traumatology* (04/05).  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2018-13932-001&site=ehost-live>.
- Meis, et al. 2013. "Interest in Partner-Involved Services among Veterans Seeking Mental Health Care from a VA PTSD Clinic." *Psychological Trauma: Theory, Research, Practice, and Policy* 5 (4) (07):334-342.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2012-22116-001&site=ehost-live>.
- Mengeling, et al. 2011. "Evolving Comprehensive VA Women's Health Care: Patient Characteristics, Needs, and Preferences." *Women's Health Issues* 21 (4, Supplement) (July–August 2011): S120-129.
- Metraux, et al. 2013. "Risk Factors for Becoming Homeless among a Cohort of Veterans Who Served in the Era of the Iraq and Afghanistan Conflicts." *American Journal of Public Health* 103 (12/02): S255-261.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bsu&AN=92519083&site=eds-live>.

- Metraux, et al. 2017. "Pathways into Homelessness among Post-9/11-Era Veterans." *Psychological Services* 14 (2) (05):229-237.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2017-19411-014&site=ehost-live>.
- Mohr, et al. 2011. "Telephone-Administered Cognitive Behavioral Therapy for Veterans Served by Community-Based Outpatient Clinics." *Journal of Consulting and Clinical Psychology* 79 (2) (04):261-265.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2011-02227-001&site=ehost-live>.
- Monteith, et al. 2016. "The Influence of Gender on Suicidal Ideation Following Military Sexual Trauma among Veterans in the Veterans Health Administration." *Psychiatry Research* 244 (30 October 2016):257-265.
- Montgomery, et al. 2015. "Demographic Characteristics Associated with Homelessness and Risk among Female and Male Veterans Accessing VHA Outpatient Care." *Women's Health Issues* 25 (1):42-48.
- Montgomery, et al. 2016. "Research Article: Services Receipt Following Veteran Outpatients' Positive Screen for Homelessness." *American Journal of Preventive Medicine* 50:336-343.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edselp&AN=S074937971500416X&site=eds-live>.
- Montgomery, et al. 2015. "Original Article: Demographic Characteristics Associated with Homelessness and Risk among Female and Male Veterans Accessing VHA Outpatient Care." *Women's Health Issues* 25:42-48.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edselp&AN=S1049386714001261&site=eds-live>.

- Morral, Andrew R., Kristie L. Gore and Terry L. Schell. 2015. *Sexual assault and sexual harassment in the U.S. military volume 2. estimates for department of defense service members from the 2014 RAND military workplace study*. The Rand Corporation, .
- Moreau, et al. 2018. "The use of Telemental Health to Meet the Mental Health Needs of Women using Department of Veterans Affairs Services." *Women's Health Issues* 28 (2) (March–April 2018):181-187.
- Narain, et al. 2018. "Access to Care and Health Outcomes among Women Veterans using Veterans Administration Health Care: Association with Food Insufficiency." *Women's Health Issues* 28 (3) (May–June 2018):267-272.
- National Center for Veterans Analysis and Statistics. 2017. U.S. Department of Veterans Affairs.
- National Center for Veterans Analysis and Statistics. 2017. "Geographic Distribution of of VA Expenditures 2017." <https://www.va.gov/vetdata/Expenditures.asp> (July 22, 2018).
- National Center for Veterans Analysis and Statistics. 2016. "VetPop 2016 Living Veterans By 115th Congressional District, state, age group, gender, 2015-2045." [https://www.va.gov/vetdata/Veteran\\_Population.asp](https://www.va.gov/vetdata/Veteran_Population.asp) (June 25, 2018).
- Executive Order -- Improving Access to Mental Health Services for Veterans, Service Members, and Military Families. EXECUTIVE ORDER (2012);, <https://obamawhitehouse.archives.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service>.
- Office of Research and Development. 2014. "New Initiatives. Improving Rural Veteran Access to Mental Health Care; Boosting Primary Care Communication." *VA Research Quarterly Update* (Fall 2014):2.



Obama, Barack. 2012. Executive Order -- Improving Access to Mental Health Services for Veterans, Service Members, and Military Families.

<https://obamawhitehouse.archives.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service>

(accessed 7/2/2018).

O'Hanlon, et al. 2017. "Comparing VA and Non-VA Quality of Care: A Systematic Review." *Journal of General Internal Medicine* 32 (1):105-121.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edswsc&AN=000392203200025&site=eds-live>.

Ohl. 2018. "Availability of Healthcare Providers for Rural Veterans Eligible for Purchased Care Under the Veterans Choice Act." *BMC Health Services Research* 18.

Oishi, et al. 2011. "National Variations in VA Mental Health Care for Women Veterans." *Women's Health Issues* 21 (4, Supplement) (July–August 2011): S130-137.

O'Toole. 2016. *Women veterans and homelessness*. VA National Center on Homelessness Among Veterans.

O'Toole and Pape. 2015. "Innovative Efforts to Address Homelessness among Veterans." *North Carolina Medical Journal* 76 (5) (11/20):311-314.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=26946863&site=eds-live>.

Painter. 2018. "High Inpatient Utilization among Veterans Health Administration Patients with Substance-use Disorders and Co-Occurring Mental Health Conditions." *The American Journal of Drug and Alcohol Abuse* 44 (3):386-394.

*Report on homelessness among veterans*. 2016. The Texas Department of Housing and Community Affairs (TDHCA).

- "Rural Women Veterans Demographic Report: Defining VA Users' Health and Health Care Access in Rural Areas." 2014. *Journal of Rural Health* (2).  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edsagr&AN=edsagr.US201400082697&site=eds-live>.
- Schry and Beckham, The VA Mid-Atlantic MIRECC Workgroup, and Patrick S. Calhoun. 2016. "Sexual Revictimization among Iraq and Afghanistan War Era Veterans." *Psychiatry Research* 240 (30 June 2016):406-411.
- Shen and Sambamoorthi. 2012. "Associations between Health-Related Quality of Life and Financial Barriers to Care among Women Veterans and Women Non-Veterans." *Women & Health* 52 (1):1-17.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=22324355&site=ehost-live>.
- Sherman and Fischer. 2012. "Provider, Veteran, and Family Perspectives on Family Education in Veterans Affairs Community-Based Outpatient Facilities." *Psychological Services* 9 (1) (02):89-100.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2012-03629-004&site=ehost-live>.
- Slack and Donovan. June 6, 2018. "Trump Signs VA Law to Provide Veterans More Private Health Care Choices."  
<https://www.usatoday.com/story/news/politics/2018/06/06/trump-signs-law-expanding-vets-healthcare-choices/673906002/>.
- Springer. 2016. "Reflections on Veteran Suicide, Veteran Resilience and Tribe."
- Suburban Stats. 2018. "Population Demographics for The Woodlands, Conroe, Round Rock, Temple, Fort Hood, Texas in 2017, 2018."  
<https://suburbanstats.org/population/texas/how-many-people-live-in-the-woodlands>.

- Tan, et al. 2013. "Improving Access to Care for Women Veterans Suffering from Chronic Pain and Depression Associated with Trauma." *Pain Medicine* 14 (7) (07):1010-1020.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=asn&AN=89047551&site=eds-live>.
- Tanielian, Batka, and Meredith. 2017. *Bridging Gaps in Mental Health Care: Lessons Learned from the Welcome Back Veterans Initiative*. Santa Monica CA: RAND Corporation.
- Taylor, et al. 2016. "Meeting the Mental Health Needs of Rural Veterans through Primary Care Providers." *Journal of Rural Mental Health* 40 (2) (04):124-135.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2016-37498-004&site=ehost-live>.
- Teich, et al. 2017. "Utilization of Mental Health Services by Veterans Living in Rural Areas." *Journal of Rural Health* 33 (3) (Summer 2017):297-304.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=123929044&site=eds-live>.
- Texas Workforce Investment Council. "Veterans in Texas: A Demographic Study."
- Thomas, et al. 2018. "Mental Health Needs of Military and Veteran Women: An Assessment Conducted by the Service Women's Action Network." *Traumatology* 24 (2) (06):104-112.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2017-44050-001&site=ehost-live>.
- True, et al. 2014. "Teamwork and Delegation in Medical Homes: Primary Care Staff Perspectives in the Veterans Health Administration." *Journal of General Internal Medicine* 29 (S2):632-629.

- Tsai, Rosenheck, and Kane. 2014. "Homeless Female U.S. Veterans in a National Supported Program: Comparison of Individual Characteristics and Outcomes with Male Veterans." *Psychological Services* 11 (3) (01 / 01 /):309-316.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edselc&AN=edselc.2-52.0-84905090651&site=eds-live>.
- Tsai, Kaspro, and Rosenheck. 2014. "Alcohol and Drug Use Disorders among Homeless Veterans: Prevalence and Association with Supported Housing Outcomes." *Addictive Behaviors* 39 (2) (02):455-460.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2013-08845-001&site=eds-live>.
- Tsai, et al. 2016. "Homelessness among a Nationally Representative Sample of US Veterans: Prevalence, Service Utilization, and Correlates." *Social Psychiatry and Psychiatric Epidemiology* 51 (6) (06):907-916.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2016-18706-001&site=eds-live>.
- Tsan, et al. 2012. "Primary care–mental Health Integration and Treatment Retention among Iraq and Afghanistan War Veterans." *Psychological Services* 9 (4):336-48.
- United States Census Bureau. "Age By Veteran Status By Poverty Status In The Past 12 Months By Disability Status For The Civilian Population 18 Years And Over."  
[https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=AC\\_S16\\_5YR\\_C21007&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=AC_S16_5YR_C21007&prodType=table) (September 18, 2018).
- U.S. Census Bureau. 2016. "115th Congress My Congressional District: Texas 31."  
<https://www.census.gov/mycd/>.
- U.S. Census Bureau. 2016. "115th Congress My Congressional District: Texas 8."  
<https://www.census.gov/mycd/>.

United States Government Accountability Office. 2017. *VA health care. Improvements needed in data and monitoring of clinical productivity and efficiency.*

"VA Adds Primary Care Services to Contract Program for Veterans' Health." 2014. *American Family Physician* 90 (7):440.

Wallace. 2018. "Where are My Donors. with Few Americans Giving to Charity, some Nonprofits are Planning for an Uncertain Future." *The Chronicle of Philanthropy* (June 2018):9-17.

Washington, et al. 2015. "Assessment of the Healthcare Needs and Barriers to VA use Experienced by Women Veterans Findings from the National Survey of Women Veterans." *Medical Care* 53 (4): S23-31.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edswsc&AN=000380657800006&site=eds-live>.

Watkins. 2016. "The Quality of Medication Treatment for Mental Disorders in the Department of Veterans Affairs and in Private-Sector Plans." *Psychiatric Services* 67 (4):391-396.

Weigel, et al. 2016. "Variation in Primary Care Service Patterns by Rural-Urban Location." *The Journal of Rural Health* 32 (2):196-203.

Whealin, Kuhn, and Pietrzak. 2014. "Applying Behavior Change Theory to Technology Promoting Veteran Mental Health Care Seeking." *Psychological Services* 11 (4) (11):486-494.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2014-45739-011&site=ehost-live>.

- Wilensky. 2016. "The VA Continues to Struggle-especially in Terms of Improved Access." *Milbank Quarterly* 94 (3) (09):452-5.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=118056639&site=eds-live>.
- Wilk, and Jones. 2014. "To Extend or Not to Extend the Primary Care ‘‘Fee Bump’’ in Medicaid?" *Journal of Health Politics, Policy & Law* 39 (6) (12):1263-1275.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ssf&AN=100644107&site=eds-live>.
- Wong, et al. 2017. "Longer Wait Times Affect Future use of VHA Primary Care." *Healthcare*.
- Woolsey and Naumann. 2015. *Review of the literature related to homeless veteran reintegration: Final report submitted to Chief evaluation office U.S. Department of labor Avar Consulting, Inc.*
- Wray, et al. 2012. "Implementation of Primary Care-Mental Health Integration Services in the Veterans Health Administration: Program Activity and Associations with Engagement in Specialty Mental Health Services." *Journal of Clinical Psychology in Medical Settings* 19 (1) (/ 03 / 01 /):105-16.  
<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edselc&AN=edselc.2-52.0-84859645850&site=eds-live>.
- Yalch, Hebenstreit, and Maguen. 2018. "Influence of Military Sexual Assault and Other Military Stressors on Substance Use Disorder and PTS Symptomology in Female Military Veterans." *Addictive Behaviors* 80 (May 2018):28-33.
- Yano and Hamilton. 2017. "Accelerating Delivery of Trauma-Sensitive Care: Using Multilevel Stakeholder Engagement to Improve Care for Women Veterans." *Families, Systems, & Health* 35 (3) (09):373-5.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=2017-42080-002&site=ehost-live>.

Yano, Haskell, and Hayes. 2014. "Delivery of Gender-Sensitive Comprehensive Primary Care to Women Veterans: Implications for VA Patient Aligned Care Teams." *Journal of General Internal Medicine* 29 Suppl 2 (07): S703-7.

<http://ezproxy.library.tamu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=24715395&site=eds-live>.

Young. 2016. "Military Mental Health Understanding the Crisis." *Psychologytoday.com*.

<https://www.psychologytoday.com/us/blog/when-your-adult-child-breaks-your-heart/201606/military-mental-health>.