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

Iowa Primary Care Association

Community Health Centers of Southeastern Iowa, Inc.

VA

U.S. Department of Veterans Affairs

Veterans Health Administration

Office of Rural Health

Improving Behavioral Health Screening & Access to Treatment for Veterans in Community Care, Phase I: Screening for Veteran Status

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

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

Preface

This toolkit is a product of a multi-year effort and the guidance provided below represents the most current clinical, data sharing, and "systems" lessons learned for this evolving partnership. Sections of the toolkit will become available as they are developed for use by other Primary Care Associations, Federally Qualified Health Centers, Veterans Affairs (VA), Veteran Service Organizations (VSO), or other organizations seeking to establish partnerships to improve access to care for our nation's veterans. This toolkit represents a living document and will be updated on a biannual basis or sooner as necessary.

Additional toolkit sections can be found at this link as they are released: http://www.iowapca.org/images/Veterans/VA_Toolkit_Phase_1.pdf.

Toolkit Description and Purpose

This toolkit has been developed to capture the past, present, and future goals for project partners. This includes vetted methods, reflections on lessons learned, step-by-step descriptions of new processes established, tools and resources developed, and guidance to enable expansion to other areas of the state and country. The toolkit will be expanded and evolve over time as project aims and various phases are completed. Resources and templates will be included for use by other entities, such as other Primary Care Associations (PCAs), Federally Qualified Health Centers (FQHCs), or Veterans Affairs (VA) entities interested in replicating this collaborative programing.

Dynamics among partner organizations, forces outside partners' control such as state laws and regulations, and geographic and political circumstances must be considered and addressed for cross-sector efforts to succeed. As such, this toolkit reflects the unique elements of each partner's organizational culture and structure, thus specific details presented may not reflect the needs or goals of other partnerships. Effort was made to focus on germane interorganizational challenges and processes between the partner organizations so that the guidance contained in the toolkit may help to streamline project activity and circumvent logistical or administrative issues for others embarking on this work and ultimately condense the timeline for project implementation.

Project Implementation
Working across different administrative and provider systems can be complicated, time intensive, and/or stall altogether. This kind of collaboration requires careful planning and consideration of the consequences during each phase of planning, development, implementation, and evaluation. Collaborations across federal and state healthcare systems involve setting precedents, which initially limits the breadth of change. As systematic changes are rolled out, and workflows are developed and documented; however, partners can expect continual growth in the numbers - in this case, the number of veterans being served. For these reasons a phased approach to this project was designed to keep intentional focus on the project aims while progressing toward them.

Resources, Tools, and Templates
Throughout each phase of the project, resources, tools, and templates are being developed - such as workflows and tip sheets - which will be made available in the toolkit for use by other entities. As each work setting and collaboration is unique, workflows, processes, and templates are meant to offer a place to start. Each tool will require some customization when applied in a new setting.

Introduction

Background
Federally Qualified Health Centers (FQHCs) are community-based, patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary and preventive healthcare, including oral health and behavioral health services. FQHCs are also often referred to as health centers or community health centers (CHCs). Regardless of patients' ability to pay or health insurance status, FQHCs deliver care to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and veterans. A fundamental tenet of the health center program is improving services for marginalized populations that may struggle with access to healthcare and other supportive services. Reducing barriers to access by providing enabling services, such as interpretation and transportation, co-locating with other services, and integrating oral, behavioral and medical care are common strategies FQHCs deploy to ensure healthcare is accessible.

Nationwide in 2018, more than 1,300 health center grantees delivered care to more than 28.3 million people in the United States, including 385,222 veterans (2019 data are not yet available). In 2019, Iowa's 14 FQHCs reported seeing 226,041 patients, of which 3,650 were veterans. While health centers are responsible for identifying and reporting patient demographics as part of their federal funding, there is growing awareness among health center leaders that the number of veterans served has been historically under-reported for a variety of reasons. Early findings have confirmed this to be the case at the FQHC partner organization participating in this project.

State and Regional Primary Care Associations (PCAs) are tasked with providing support, training, and technical assistance to FQHCs. An important part of a PCA's role is to keep abreast of national initiatives, solicit and cultivate partnerships, and provide leadership on emerging and ongoing issues facing FQHCs and the populations they serve.

The Health Resources and Services Administration (HRSA) is an agency of the federal Department of Health and Human Services that is the funding agency for the health center program. Since 2012, HRSA has been supporting the hiring of veterans as well as ensuring veterans seeking care are identified and served. This commitment to serving veterans extends to cultivating partnerships with veteran-serving organizations at all levels of government.

The United States Department of Veterans Affairs (VA)/Veterans Health Administration (VHA) is the federal entity responsible for providing health services to an estimated nine million veterans annually. VA is the largest integrated healthcare system in the U.S. Yet, it is believed that millions of additional veterans are eligible for services but are not accessing healthcare through VA. Reasons for this include:

- Access: The distance between a veteran and the nearest VA-eligible provider or facility can be an obstacle to treatment.

- Stigma: Veterans in community settings may self-select to utilize non-VA services due to perceived stigma regarding having a mental health diagnosis and/or may be triggered by symbols of their service (e.g., federal buildings, paperwork, processes that remind them of their time in service). In addition, lack of self-awareness of mental health symptoms may compound this stigma.
- Complex eligibility requirements: Eligibility requirements change annually according to congressional rules, income thresholds, and shifting priorities. These changes can frustrate veterans and contribute to confusion, thereby limiting enrollment numbers.
- Attitudinal: Negative media stories or personal experiences with VA may contribute to reluctance in pursuing services from VA.

Upon identifying common interests (i.e., enhancing veteran access to healthcare) in 2015, VA's Office of Rural Health (ORH) Veterans Rural Health Resource Center in Iowa City (VRHRC-IC) and the Iowa Primary Care Association (Iowa PCA) began exploring innovative ways that the Iowa City VA could partner with FQHCs to improve and ensure access to healthcare for Iowa's veterans. The VRHRC-IC and Iowa PCA formalized this partnership in October 2016 and added a new partner - the Community Health Centers of Southeastern Iowa (CHC/SEIA)- with locations in West Burlington, Columbus City, Keokuk, Iowa; and Hamilton, Illinois. These partners came together with the goal of establishing mechanisms to ensure veterans seeking care at all CHC/SEIA locations could be systematically identified, screened for behavioral health issues, and engaged in healthcare guided by their choice to remain in the community or engage in a VA care setting.

Behavioral Health as an Area of Focus

Behavioral health services were targeted as the area of focus for this partnership, in part due to:

- Increasing suicide rates among the general population in the U.S. and the disproportionately higher rates among veterans;
- State and national shortages of mental health providers and inadequate service system infrastructure and payment mechanisms; and
- The national opioid crisis.

Behavioral health services and treatment for depression, insomnia, Post-Traumatic Stress Disorder (PTSD), substance abuse, and other "invisible wounds" are areas in which the VA is an established leader among the greater healthcare community. VA resources include an array of evidence-based treatment methodologies such as psychotherapy ("talk" or counseling treatments), a comprehensive suite of pharmacotherapies with psychiatrists, primary care mental health integration clinics, and pharmacist-run clinics that deliver delineated medications in tightly regulated settings (e.g., clozapine and anticoagulation clinics). Each of these evidenced-based practices (EBP) can be delivered across a variety of platforms either in person or through assistance of telehealth technologies, including telephone, mobile platforms via app development, and text messaging (ANNIE); effectively meeting the needs of veterans of all ages with accommodations for limited mobility. The EBP resources help veterans build powerful skills for overcoming challenges associated with serving in the military.

Providing behavioral health services is also an area in which FQHCs across the country have been ramping up capacity in recent years. In response to inadequate service systems, gaps in access, and to improve overall health outcomes, FQHCs have maximized the impact of their primary care settings to become a gateway for many individuals with behavioral health needs by integrating behavioral healthcare services into their practice settings. Many health centers can provide both mental health and substance use services, screening for mental health and substance use disorders, developmental screenings, counseling and psychiatry, crisis intervention, medication-assisted treatment for substance use disorders, detoxification, and recovery support.

Selection of Community Health Centers of Southeastern Iowa (CHC/SEIA)
CHC/SEIA joined this project in 2016 and was selected for the following reasons:

- Southeast Iowa is considered a gap area in terms of geographic access to VA facilities and census data has identified 10,000 veterans living in this area. The closest VA clinics are located in Ottumwa and Bettendorf, Iowa, and Galesburg and Quincy, Illinois. These communities are all more than a 60-minute drive away.
- The rural location fits guidelines of the funding agency, particularly as it relates to available services in the area.
- At the time the partnership was formed, CHC/SEIA was in the early stages of integrating behavioral health and primary care services to improve care for their patient population and viewed this as a complementary opportunity.
- CHC/SEIA staff recognized the need, especially following a high-profile veteran suicide in the area, and were enthusiastic about the opportunity to improve access, services, and supports to veterans.

Project Aims
With funding secured from the VRHRC-IC, a pilot project called *Improving Veterans' Behavioral Health Screening and Access to Treatment* was established in 2016 with four primary aims:

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

Partner Roles
<u>Community Health Centers of Southeastern Iowa (CHC/SEIA)</u>
Established in 2003, CHC/SEIA provides affordable, comprehensive, culturally appropriate, cost effective primary healthcare to residents of the greater southeastern Iowa region, especially those individuals/families with limited resources or with other barriers to healthcare, in order to improve their overall health status. With locations in

West Burlington, Columbus City, and Keokuk, Iowa, and Hamilton, Illinois, CHC/SEIA serves as the hub of this project. In 2019, CHC/SEIA served 17,641 patients in southeastern Iowa and western Illinois, of which more than 3.14%, or 555 patients, were veterans. It should be noted that the number of veterans identified and served in 2019 demonstrates a dramatic rise in the number of identified veterans at the onset of this project. Preliminary assessments attribute this increase to improved veteran identification efforts by CHC/SEIA that are described elsewhere in this toolkit.

CHC/SEIA is actively working with VA partners to develop work processes to meet the aims of the project. Depending on the process, it is often easier to implement certain components simultaneously at all sites - such as screening for veteran status. Other, more complex processes - such as coordinating behavioral healthcare with the VA - may be initially established at the West Burlington site. The longer-term goal is to eventually expand efforts to all adult patients presenting for care at all sites. This work is occurring under the leadership of Ronald Kemp, CEO.

"Though there are challenges in learning how to integrate the care we provide to our patients with a system as complex as the U.S. Department of Veterans Affairs, we are committed to establishing mechanisms to ensure accessible and seamless healthcare services are available to veterans. We know we can do better in serving southeast Iowa's veterans, and our work in this part of the state has implications for broader impacts in Iowa and the US."
Ronald Kemp, CEO

<u>Iowa Primary Care Association (Iowa PCA)</u>
The Iowa PCA was instrumental, along with the VRHRC-IC, in developing the area of focus and overall design of the project. On an ongoing basis, the Iowa PCA provides leadership and overall project management by planning and facilitating regular communications between partners, tracking progress, troubleshooting issues, creating tools and resources, and supporting CHC/SEIA's work at the local level, as led by Aaron Todd, CEO.

"A lack of access to services is at the core of many healthcare challenges facing veterans living in rural communities. As the U.S. Department of Veterans Affairs (VA) continues to innovate ways to deliver or create new entrance points of care for its patients, partnerships with community-based organizations often provide more inclusive and available services.-Federally Qualified Health Centers are uniquely qualified to partner with the VA to more robustly serve and support veterans in their home communities."
Theodore J. Boesen, Jr., former CEO

<u>VA Office of Rural Health Veterans Rural Health Resource Center-Iowa City (VRHRC-IC)</u>
The VRHRC-IC has provided funding support since the project's inception. Co-project lead M. Bryant Howren, PhD, MPH, former Co-Director of VRHRC-IC and current faculty member in the Florida State University College of Medicine, has been involved in this work since the onset of the earliest discussions and has provided overall leadership and

vision. The VHRHC-IC has also secured involvement of the Comprehensive Access and Delivery Research and Evaluation (CADRE) Center of Innovation, a VA Health Services Research and Development funded research organization. Specifically, co-project lead Thad Abrams, MD, MS, who is board certified in internal medicine and psychiatry, provides clinical leadership via his role with CADRE to this project. Both Howren and Abrams also serve in liaison roles to facilitate access to other VA departments and programs in order to assist CHC/SEIA in moving through the various bureaucratic processes needed to advance project goals.

"Through my work as a psychiatrist in the VA system, I hear frequent stories from veterans engaged in the community who vocalize concerns about fellow soldiers struggling with mental health symptoms. These stories serve as a powerful reminder that much work remains to be done in creating intelligent healthcare systems that can recognize and respond to these care needs in the community. Such systems should remain sensitive to the unique veteran care needs and incorporate cultural elements."
Thad Abrams MD, MS
Psychiatrist Iowa City Veterans Health Care System

While the aims of this project are clear, the path to accomplish them is not. In large part, the partners in this effort are forging new ground and working within existing bureaucracies not designed to facilitate this kind of work across systems. This requires an openness to establishing new processes across departments and organizations. The VA partner assists with leveraging VA resources and assists with navigating this complex care system. CHC/SEIA is dedicating time and resources to ensure progress occurs and remains consistent with FQHC regulations. The Iowa PCA coordinates efforts and ensures the project advances. All partners deal with many competing demands on their time and attention that slow momentum, but the common thread that keeps the project moving forward is the commitment by all involved to improve services to Iowa's veterans.

Project Timeline (To-Date)

2014-2015	Discussions between VRHRC-IC and the Iowa Primary Care Association
2016	Funding secured for project management and a part time RN Care Coordinator; partnerships formalized; initial screening for veteran status established at CHC/SEIA
2016- 2018	Project implementation and series of improvement initiatives completed to better identify and serve veterans
2018-Present	Assisting identified veterans with eligibility and enrollment in VA healthcare, screening veterans for behavioral health needs, and providing care coordination support to interested veterans regardless of involvement in VA services

Phase 1 - Screening for Veteran Status, CHC/SEIA

Overview
Federally Qualified Health Centers (FQHCs) make up the largest primary care network in the country. The VA and FQHCs share a similar set of priorities and mission for care, and each are subject to federal reporting and regulatory practices. Veterans are currently engaged in community healthcare settings; yet those settings may lack systematic strategies to identify veteran status. The VA remains actively interested in strengthening relationships with community providers, and FQHCs, through their commitment to improving access to care, represent a natural choice.

Despite the Health Resources and Services Administration's (HRSA) commitment to serving veterans and the requirement that FQHCs annually report the number of veterans served through the Uniform Data System (UDS) reporting process, the numbers reported are believed to be low in comparison with the number of veterans in the U.S. The VA is actively shifting large populations of rural, eligible veterans into community-based care settings. With this shift, building systematic screening tools to identify veteran status provides an important opportunity to better serve veterans.

Phase 1 At-a-Glance
In order to engage veterans in care, they must first be identified as such. According to the Department of Veterans Affairs, in 2016 there were around 20.4 million veterans in the U.S. Considering the lack of a formal tracking system, identifying veteran status is a complex undertaking at the national level. Establishing a consistent process to identify veteran status in this primary care setting outside of the traditional VA healthcare system was viewed to address this issue at the micro, or local, level and was the project's first and fundamental aim.

Phase 1 involved ensuring veterans presenting for care at CHC/SEIA were consistently screened for veteran status. This involved developing a process to ensure this screening would consistently occur at all locations with all adult patients. A simplified description of this process is described here. Each step summarized below required additional activities. For additional detail, information and activities undertaken within Phase 1, see the remaining content in this section.

Phase 1: To initiate consistent screening for veteran status at all sites, CHC/SEIA:

- Determined the optimal wording for the inquiry to improve veteran identification and facilitate more accurate responses. The VA provided preferred language to identify military history and veteran status, which was then incorporated at all sites.
- Decided to implement this screening at all sites (four locations) simultaneously, which included the following steps:
    - The screening question was revised and added to the EMR as a required field, so that screening for veteran status is required at registration.
    - Staff were informed of the change, trained, and rollout occurred at all sites in February 2017.
    - Reliable data were then available and the number of identified veteran patients at CHC/SEIA increased dramatically.

More detail is included in the full Phase 1 section.

Narrative Description

Phase 1

The first aim of this project was establishing mechanisms to ensure new and existing patients are screened for veteran status. The number of veterans served is a required data element to be reported by FQHCs as part of the annual Uniform Data System (UDS) submission; yet, like many demographic characteristics, to date HRSA has not offered specific guidance or preferred language health centers should use to collect this data. Though HRSA does provide exclusionary guidelines specifying who may be counted as a veteran, it is apparent that underreporting of veteran status could, and likely does, occur. Along with growing awareness of the difficulty in identifying veterans, partnerships between federal agencies aimed at improving access and services to veterans - including the VA and the U.S. Department of Health and Human Services (DHHS), FQHCs are beginning to assess current practices to identify ways to improve the screening and identification of veterans.

Identifying Veterans Presenting for Care

There are a range of reasons veterans may not identify as such or voluntarily wish to acknowledge veteran status. Research suggests those reasons include:

- Stigma - There is a history of negative views toward veterans serving in unpopular wars - the Vietnam Conflict being the most prominent example - and some continue to feel stigma against military veterans.
- Deployment status - Some veterans that did not experience deployment to foreign soils believe they do not qualify or have not earned veteran status.
- National Guard/Reserve history - There is a perception among some that serving in these military branches doesn't "count."
- Lack of injury or combat experience - There are individuals that feel undeserving of the veteran designation due to not having been wounded or serving in active combat.
- Confusion about eligibility - Lack of understanding of eligibility for veteran healthcare and other benefits can lead to under-identification of veteran status.

These reasons contribute to ambiguity about veteran status, even among veterans themselves.

Various organizations are developing initiatives to address this challenge through national awareness campaigns. While the questions posed to identify veteran status and methodologies for doing may vary among initiatives, the common goal of these efforts is to improve identification of veterans so that access to healthcare and other services is improved for this important population.

To optimize the prospects of accurate identification for this project, partners understood the importance of how the question was phrased. The VA has a site dedicated to screening for military service (see link to Community Provider Toolkit below), and based on guidance from ORH's Veterans Rural Health Resource Center—Iowa City and VA Health Services Research and Development, the recommended phrasing was used:

Have you served in the military or armed forces? This includes: Air Force, Army, Coast Guard, Marines, Navy, National Guard, or Reserves?

Yes_____ No_____

Implementing the New Screening Process

Implementing a change to a workflow in a clinical setting is generally a complex undertaking. Key decisions must be made, and careful considerations are needed prior to rolling out any new process, including impact on staff, disruption caused by making the change, ensuring potentially impacted staff are trained and prepared, as well as identifying impacts on patients/veterans. To implement a veteran identification screening question, there were three primary areas of planning and activity required:

- Determining whether to roll out the change site by site or all sites at once;
- Making changes to the health center's electronic medical record (EMR); and
- Training and preparing staff for rollout.

When partners first initiated this overall project, CHC/SEIA had planned to initiate most changes at one site prior to implementation at the organization's other three locations. As the project has evolved and progressed, however, the FQHC EMR required a more systematic approach. To ensure consistency, CHC/SEIA made the decision to implement this change at all sites simultaneously rather than starting with the main site and expanding to additional locations later.

CHC/SEIA is part of the Heartland Network - a health center-controlled network (HCCN). Most HCCNs have agreed-upon protocols in place to request adjustments to the EMR. Depending on the type and complexity of the requested change, there could be a cost to the health center or a requirement that clinical or administrative leadership from each participating health center agree to the change. Additionally, as the HCCN is receiving requests for changes from numerous health centers, prioritization occurs so the timing of the change can be impacted as well.

For this change, CHC/SEIA anticipated barriers, including cost and delays in making the change to the EMR; however, neither was the case. The EMR in place at the health center, NextGen, was programmed with a required field or "hard stop" in the registration section by CHC/SEIA's network using the recommended language above. This was accomplished relatively quickly and at no cost to the health center or impact on other members of the Heartland Network. This change ensured the veteran status question is consistently asked by front desk staff registering the patient on an ongoing basis. Patient registration staff are now unable to complete registration without populating the veteran status field.

Once it was clear that this change to the EMR could be accommodated relatively easily, there were additional steps to preparing for rollout. The Patient Registration Form, a hard copy of which is completed by new patients at their first visit to the health center, was amended with the language recommended by the VA. This is the same language that was added to the registration fields in the EMR. When amending a health center form, the change must be drafted and approved, and copies prepared for each health center site with instructions for instituting the change. Scripting was

developed for front desk staff that aligned with the language in the EMR and on the Registration form, and to facilitate consistent management of negative responses from patients.

This change primarily impacted front desk personnel and did not require an all-staff meeting. Rather, key staff, including Patient Service Representative (PSR) leads/staff and Medical Services Site Managers, were informed of this change, the reasons for it, the priority level (high), and the effective date via internal emails and memoranda from leadership, including the health center's CEO. An in-service training was held for front desk staff at all sites. Once this occurred, the "hard stop" added to the EMR was activated and the change was implemented.

Impact of Implementing the Revised Screening Question

This change in how patients were screened for veteran status at this health center has resulted in a dramatic increase in the number of patients identified as veterans. According to the UDS data for CHC/SEIA, in 2015, .32% of CHC/SEIA patients were identified as veterans. In 2016, this number rose to 1.41%, which could be attributed to greater awareness of this project due to an all staff training/overview of the project at CHC/SEIA. The required field (hard stop) in the EMR was activated on February 13, 2017, and in that year, the percentage of veterans identified was 3.01%, which amounted to 506 veterans presenting for care at CHC/SEIA. In the last two years CHC/SEIA saw a leveling off of the number of patients identified. In 2019 CHC/SEIA had 17,641 unique patients, of which 555 (3.14%) were veterans. This leveling off was expected, given that the effort to identify veterans would see a large increase until such a time that nearly all patients are identified except for new patients establishing care at the health center. These data are reflected in the table below.

Patients identified as veterans at CHC/SEIA

Reporting Year	Number of Unique Patients	Number of Veterans Identified	Percentage of Total Patients	Percentage of Adult Patients
2015	17,459	56	.32%	.46%
2016	16,221	229	1.41%	2.02%
2017	16,827	506	3.01%	4.45%
2018	17,976	527	2.93%	4.33%
2019	17,641	555	3.14%	4.84%

Source: HRSA Uniform Data System

Also, of anecdotal but significant interest to this process, CHC/SEIA learned that there are veterans on staff at the health center, and staff with family members who are veterans, that had been previously unknown. Additionally, a number of high-profile veteran suicides occurred in the geographic area as this project was implemented. This heightened awareness about veteran issues and the effort to identify and improve services to veterans has fostered collective commitment to this work among staff.

Next Steps / Subsequent Phases
As noted above, screening for veteran status was the first aim of this project. Once the veteran is identified, focus shifts to the remaining three aims:

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

Broader Impact
The previous section described the significant impact of this change on the veterans identified at CHC/SEIA. The extraordinary success of this effort to improve identification of veteran status at this FQHC will also result in a much broader impact. Based on the experience of CHC/SEIA in implementing this change and the resulting outcome, the Iowa PCA and the National Association of Community Health Centers (NACHC) recommended that HRSA strengthen requirements in UDS reporting for identification of veteran status, requiring consistent language and processes. This recommendation was subsequently accepted, and adjustments will be made to UDS reporting in FY 2020, which will be due for submission on February 15, 2021.

It is anticipated that the question phrasing utilized in this project (exact wording is not yet available) will add to the list of military branches to include all uniformed services, including the Public Health Service (PHS) and the National Oceanic and Atmospheric Administration (NOAA). Training and technical assistance on the new required language will be provided by HRSA to FQHC and FQHC Look-Alikes (i.e., organizations that do not receive a Health Center Program federal award but are designated by HRSA as meeting Health Center Program requirements) during the 2020 training period.

Tools and Resources

Community Provider Toolkit
https://www.mentalhealth.va.gov/communityproviders/screening_howto.asp

American Academy of Nursing, *Have You Ever Served in the Military?*
www.haveyoueverserved.com

American Community Survey, US Census Bureau
https://www.census.gov/acs/www/about/why-we-ask-each-question/veterans/