

Gina Capra: Hello everyone. Welcome to our national webinar in our series entitled Health Centers Serving Veterans. Thank you for being here and thank you Annie Silverman and Margaret Davis for serving as our tech hosts today. Today's education session is scheduled for one hour and we have some great content to provide, but first some introductions and housekeeping. My name is Gina Capra. I serve as your co-host for today's webinar. I'm a senior vice president at the National Association of Community Health Centers. Advocating and educating at the national level on behalf of veteran patients is not only part of my responsibility here at NAC but is also a passion and motivation for me each and every day. I know many of you share that passion to serve military veterans and their families. I cannot thank you enough for making time out of your busy day to participate in today's webinar.

NAC is very pleased to be co-hosting today's webinar with the Iowa Primary Care Association represented by Emily Vogt. Emily serves as a senior strategy and improvement consultant at the Iowa Primary Care Association, and she is my co-host and moderator today. You'll hear from Emily shortly. As for housekeeping, this webinar is being recorded and this archive of today's webinar, along with the presentation slides and other supplementary material will be sent to all registrants by NAC in the upcoming week or two. Today all lines are muted to allow our faculty the full hour for content delivery. However, we look forward to active chat box engagement. Don't hesitate to say hello to one another and provide commentary or reflections as we progress through the hour. Please feel free to enter your health center name, location, and your name now as we get started. Please submit any questions in the Q&A tab on the Zoom platform. This is different from your chat box.

Our faculty will be reviewing these through the course of the hour today and following the webinar so we can follow up with you as appropriate. I'm pleased to report that we received over 20 questions in advance of today's webinar and our faculty has incorporated responses into their presentations for today. Let's get started with today's webinar and again, welcome. Today's topic is Improving Identification of Military Veteran Patient Characteristic, which is critical for your local needs assessment and service delivery development, as well as accuracy in health center reporting to HRSA via the annual UDS. We have a robust faculty panel here today to help us achieve the learning objectives. You will hear from each of them shortly. They have prepared diligently for today's webinar so that you are well-prepared to take actionable, feasible steps at your health center following this call.

Our agenda features administrators from the Veterans Health Administration, from two local health centers, from NAC and from the Bureau of Primary Healthcare. We hope you will enjoy the content and again, thank you for being here. At this time, I'd love to turn it over to Emily Vogt, my co-host to introduce you to our faculty and provide her primary care association perspective. Emily, over to you.

Emily Vogt: Thank you, Gina. Like Gina said, I'm Emily Vogt with the Iowa Primary Care Association and I will be co-facilitating today's presentation along with Gina. I am pleased to introduce you to our presenters for today's webinar, who through

partnership and collaboration, have paved the way for a brighter, healthier future for our veterans. Bryant Howren is an investigator at the Iowa City VA Healthcare System and an associate professor in the Department of Internal Medicine in the Carver College of Medicine at the University of Iowa.

Toni Flores is the CEO of Community Health Centers of Southeastern Iowa and has been working in FQHC environments since 2008. Toni is also a U.S. Navy veteran. Mary Zelazny is the CEO of Finger Lakes Community Health since 2006. She serves on several NAC committees and the board of the Community Health Center Association of New York State and the board for the National Center for Farmworker Health. Nalani Tarrant is the director of Social Drivers of Health at NAC, where her dynamic leadership plays a pivotal role in spearheading collaborative SDOH initiatives with federally qualified health centers. Judy Van Alstyne is a dedicated federal servant and public health professional who has led functional units, teams, and projects within BIPIX data and evaluation area since early 2019.

State and regional primary care associations play a pivotal role in supporting community health centers. They provide essential training and technical assistance to support community health centers in improving the health of individuals and communities. Community health centers provide care to under-resourced and vulnerable populations, including veterans. They offer comprehensive healthcare services, reducing barriers to care and ensuring everyone receives the care they deserve. It's crucial to acknowledge that millions of veterans face barriers in accessing healthcare services. Barriers like having to travel long distances for healthcare access and stigma can prevent them from seeking the services they need and deserve. That's why collaboration is key. By joining forces with the Veterans Affairs and Primary Care Associations, community Health Centers can bridge these gaps and improve veterans access to care and engagement with health centers, ensuring that no veteran is left behind. Next, I will pass it over. We'll first hear from Dr. Howren.

Dr. Matthew How...: Hi there everybody and thanks Emily. First, I want to thank Gina and everyone at NACHC for putting together this presentation to highlight an issue that, as Gina mentioned, is something that we all feel passionate about and have worked in this space for many, many years. My part today is to talk about how we began a more systematic method of screening for veteran status and community health centers, which I hope sets up some of the more meaningful experiences from our health center colleagues who are speaking after I am. Some brief background. This actually started or this program that I'm going to talk about actually started a number of years ago around 2016 when several of us working for the VA's Office of Rural Health and I'm still affiliated with the VA Office of Rural Health, had conversations with the Iowa Primary Care Association and the Community Health Centers of Southeastern Iowa and West Burlington, which is pictured here.

This is actually how I came to know Emily and Tony on the call today. We initially did some geospatial mapping working with IPCA to identify a predominantly rural serving health center and one that had a high concentration of veterans, but no nearby VA point of care. The project really focused on two

key issues at the time. First, we wanted to improve the method of identifying veterans receiving care in the health center. It was a common refrain across the country when I talked to individuals that we know we're serving veterans but we're not always that good at finding them. Second, we wanted to screen for and connect interested eligible veterans to behavioral health services and VA if they chose that care path. And I emphasize the ability to choose throughout the process. But the overall idea was to increase access to services for veterans while also freeing up care appointments for other non-veteran patients.

But the project quickly became more than just about behavioral health and included connection to and coordination of services other than mental and behavioral health, and not just within VA, but also community wide. At the time, there was no specific recommendation regarding exactly how to ask the question about veteran status in the UDS manual for health centers other than to report, quote, those who affirmatively indicated they're veterans. And there was also some additional exclusionary criteria which still appears today. The problem with simply asking are you a veteran, is that the patient may not know what meets that definition or they may not believe themselves to be a veteran for a number of reasons. These could include things like not previously being eligible for VA services. This last point is something that actually may change year over year due to federal legislation and also really highlights, again, this need to ask the question.

I've also heard a number of other reasons over the years for things like I'm not a veteran because I wasn't deployed. I'm not a veteran because I was in the National Guard, or even I'm not a veteran because I'm too young. Even if these things are or are not true, it doesn't mean that the individual isn't a veteran, but the point is that several may not think themselves to be. So, if you simply ask, are you a veteran, they may tell you no for any reasons that you don't necessarily unpack through a conversation. Because of this, we revised the standardized screening item, which we embedded in the electronic medical record as a hard stop, and we wanted it to be more prescriptive. So, the box to the right highlights the version we're currently advocating, which you'll also note in addition to military service includes the public health service, the NOAA, and now the Space Force.

Answering yes to this item doesn't necessarily mean the patient is unequivocally a veteran. For example, a person serving in the National Guard Reserves but was not an active duty would meet this definition. And that is something that is spelled out in the UDS manual, but it does remove some degree of confusion that I mentioned above or previously and also allows for additional conversation about that status. So, through this process, the number of veterans identified rose dramatically at our partner health center in Eastern Iowa. Before we had any conversations in 2015, I show this for comparison. You'll see that the health center reporting seeing a little more than 50 veterans. You see that number rise in 2016, it's when we start having conversations. We start talking to administrators, clinic staff, and providers. I attribute that rise just from sake of awareness. By 2017 when we fully integrated this question and had it embedded in the EMR, it rose tenfold from 2015.

One way that I always like to present this is so if you think about the number of adult patients that you see in your health center in this particular pilot site or partner site, it went from one in 200 to about one in 20 adult patients. And this stops at 2019. This is from a paper that we had published a couple years ago, but if you go out and look and I did recently, that number stayed around 500 consistently since then. Very quickly, there's some implications of this screening that I always like to highlight, one is that paying attention to veterans served outside of the UDS requirement, it has implications for workforce training and development and some other issues that I'm going to highlight very quickly. There is research that indicates non-VA providers want to know more about how to help veterans in their communities.

This could include things to community reintegration, mental health issues, and also available services in the community. There also exists opportunities to develop communities of practice in which providers and staff share knowledge and resources that are meant to help veterans. A good colleague of ours in the VA Office of rural health, Dr. Carolyn Turvey is leading a program designed to develop such communities of practice and connect veterans to services for social determinants of health in both VA and their communities. This program has expanded to a number of health centers and critical access hospital clinics resulting in several hundred additional care and service opportunities for veterans. These SDOH needs are obviously a big focus of what we're talking about today. And if anybody's interested in learning more about the Community of Practice program, I'll add her name to the chat when I get done here or you can reach out to me directly and I'll be happy to connect.

There's also the possibility that a veteran patient may be eligible for services or programs in their own communities that are not necessarily tied to VA. So, I don't want this emphasis to be that it's about moving people to VA. It's about getting care to veterans. This sort of distinction comes up a lot. This is not about again, funneling patients to VA, but recognizing that veteran status may suggest the presence of certain issues or eligibility for certain programs with a specific veteran focus. I think through this program collectively as a group, we've all discovered that there are a lot of programs that are focused on veterans that even I didn't know about. I've worked in VA since 2007 and focused on veterans' issues since then. And continually you start to learn about these programs that in the community, some that are federally funded and some that are state funded. Some of these are things, they exist with housing, utility payments, transportation, food, other things like this that are specifically focused on veterans.

And then lastly, screen for veteran status, again may suggest the need to screen for other issues. And I want to talk about a couple specifically. These could be things like PTSD or military sexual trauma. These do come up. A few years ago, at our West Burlington partner site, there was a female veteran who disclosed her MST status to our program nurse through this very conversation that we developed around this screening item. The nurse care coordinator was then able to improve that veteran's care by connecting her to services not in VA, but actually in the community there that she didn't otherwise know about. So, simply recognizing that someone has served can open up the door for other possibilities

to get them care and services. I know that some of our next speakers have similar stories. So, with that, I will turn it back over to Emily.

Emily Vogt: Thank you, Dr. Howren for providing that background on this VA and FQHC collaboration and the results of those efforts. Next, we'll hear from Mary Zelazny.

Mary Zelazny: Thank you so much. I really appreciate it. Next slide please. I'm going to talk about our journey as a rural health center program and how we came to really understand how to better serve our patients who identified as veterans. We're a rural health center program in upstate New York. We started out early in our life as a freestanding migrant health center. As you can see, it's a beautiful part of New York state. We now provide a lot of services for the general community, but our history has defined our lack of understanding with our veterans as we built our practices. As I said, we were a freestanding migrant health center until 2009, and the reason we became a full community health center at all was because so many of our farm workers had settled out into our communities and we had others wanting to come to our services and we couldn't share the federal benefits with all our patients. So, we went to be a full community health center.

But up until that point, there were very few farm workers that were veterans, maybe five and all the time that we were really looking into this, because most of these folks came from another country and that wasn't why they were here, and they did not serve in the United States doing any kind of work other than farm work. It took us a while to really understand how we would ask those questions, but also as a funded migrant health center program, we had to make sure that our front end staff screened for if people were eligible for the farm worker program because of HRSA's definition of who would be eligible. So, we were hyper focused on that. We had trainings by the National Center for Farm Worker Health. We drilled it into our staff so that we would make sure that we were counting our farm workers appropriately and doing it right for the UDS.

So, it put us in a funny place up until... Once we became a community health center, we started thinking, okay, well now we've got to start really opening our thinking about all this. But also, our EMR system allowed us to click one box, and we really struggled with that trying to figure out how somebody could be in a couple of different categories. So, we had to pick, and it was always a challenge. In 2015, we hired two people that came on board. One was a new, he was an MD. His family was from the Dominican Republic, but he grew up in West Virginia and he was a Navy guy. When he showed up, he had all kinds of stuff on his desk about Navy. Then right after he came on board, we hired a family nurse practitioner who was still in the army.

She retired, but she was a major. We had this Army-Navy rivalry going. But what really benefited us from those two hires was the fact that we had no clue about how to deal with veterans, how to provide them services, how to provide them education, and how to tie in with their other care that they might've gotten from the VA, and how we could be a good partner there. But these two people really helped us open our eyes and understand how do we ask the questions, when do we ask the questions and what do we need to know when we're serving

veterans in the primary care space, and how we need to somehow connect with the VA as well, because they went to both places for their care.

Based on a lot of education from our two providers that we hired, we built a training program and really pushed our front-end staff. Yes, you got to do the ag worker questionnaire, but you also have to ask people the veteran question and you also have to ask them if they're homeless. Some of those things that we all needed to know because we wanted to really know who we were serving and how we might be able to serve them better. We did a whole training specifically on the expanded veteran question so that we could encompass all because that was the big lesson we learned from our medical staff, was that we were asking the question wrong. Just asking somebody, are you a veteran? A lot of people did not answer that in the way that would be positive when they could have. We just were asking it wrong. There was nothing wrong with the patient, it was us.

We really pushed that, and we have all of our front-end staff are trained, but we also have our kiosk. You can't advance in the kiosk until you answer that question. We're really trying to make a concentrated effort to get that information into our system. And then our chief quality officer, who was this nurse practitioner that we have brought on board, she is extremely active currently with the VFW. They're doing all kinds of things. She works with a lot of vets to get them into primary care, get them over to the VA. We have a VA hospital that's about 40 miles from us, and there's buses that provide transportation. We're trying to work with them. And we also just recently had one of our nurses, our RNs got a really great opportunity at our VA hospital down in the southern tier of New York state.

I have been talking a lot to her because there's a lot of ways that we can work together, but we have to figure out how to do that because the way the VA does documentation and all that doesn't always jive with how we do it. So, we're working on that, and she's really helped us understand their system a lot better. This is what our data shows. So, if you look at 2016, not bad, this as far back as we went, and we did pretty good up through until COVID hit and not too bad in '21, and then it started going down. We think partially why it went down was because as a lot of health centers had, we've had incredible turnover at our front end. So, we're just trying to get them out on the floor and get our trainings in place as best we can.

It's so hard, as you all know, to keep people and making sure that they understand all the little nuances of their role. But it's so important that we ask. We just did another big training in January for our team, and we did some role playing with our staff, our front end staff, so that they felt comfortable answering the question. We were really pumped because by the end of February, we are up to 319 people who identified as, yes, they were veterans and with 1,435 visits, and I just checked and we're up over 400. So, I'm really hoping that by the end of the year, we're going to really capture who we saw over this year that identified as veterans so that we can report accurately because they've been our patients. We just didn't ask the right questions. I thank you for allowing me to talk about what we're doing. Emily, I guess I'll turn it back over to you.

Emily Vogt: Thank you, Mary for sharing your experiences with implementing the VA recommended screening question at your health center. Next, we'll hear from Tony Flores.

Antonio Flores: Thank you. Today what I'm really going to focus on is how are we sustaining our VA program at Community Health Center, Southeastern Iowa. As you heard, Dr. from Dr. Howren. This project started back in 2016, and since then we've done a lot of improvements, but oftentimes what we see is that we start projects, but then they get dwindled down or there's no additional funding. And really, what I'm trying to focus on is keeping up with what our mission statement is, and that's really to help everybody in our communities. I'm going to start with just key staff that we actually have put in place. We started with two community health workers and really being deliberately about making sure that this program was sustainable. So, we added the two certified community health workers that they have continued working on identifying and assisting interested and eligible veterans to really connect them to resources out in the communities.

In addition to that, we do have our in care managers within the primary care side of things, but we were really being deliberate to making sure that the project was sustainable from making sure that veterans were being screened on the behavioral health side of things and being able to be connected also to those additional resources. We did add another FTE embedded within behavioral health to really focus on tracking the patients and these veterans that we were identifying. As community health workers we're starting to engage with them around their eligibility, things like that. The RN care manager was actually focusing on more of the healthcare, more focusing on the mental health aspect of things, and then coordinating those services either through the VA or through our services, through the health center. Really, it's a team effort, and I know that these three individuals work really hard out in the communities with our partners and things like that, and we also have them out in the community to promote the services.

They go to other areas in the communities and really promote the service. So, really, it's the ability to build the relationships and follow up with veterans that are overwhelmed. The VA is a very complex system, and a lot of the times these veterans just need the assistance to get them connected, get them what they need to go through the steps and things like that. Also, as we're thinking about sustaining the program is really ongoing staff training. On an annual basis, we actually are deliberate, providing annual staff training, really making sure that our mission stays true to helping everyone and then also our veterans. Once we identify a veteran, what do we do? So, we have, like I said, annual staff trainings. And not only that, but making sure that we're bringing this, that we're making that personal touch. We actually acknowledge our staff members within our group.

I myself am a veteran and I like to make sure that everybody knows that we have other people that are veterans within our group. Yes, so we acknowledge all of our team members who are veterans that they have served in the different branches and things like that. It's also part of the onboarding process to ensure that new staff members are aware of the services. It's not just going through and

saying, yeah, here's the registration process, but really making it meaningful to making sure that they're asking and they're continuing to ask the right questions to get more in-depth information from the patients in order to identify and connect them to services. Really, personalizing the experience for the veterans. And really also one of the things that we have incorporated, and we incorporated this early on as we were going through the process, is we develop a patient survey specifically for the veterans so that they felt more comfortable sharing their experiences, sharing where areas of improvement can be and things like that. It's really personalizing that experience for the veteran.

One of the other things that we have really tried to focus on is also telling the patients' stories. This has really impacted not just the staff but also our board members. Our board members like to hear these stories of how we've been incorporating new services, new lines, and how we're assisting our community. So, through the veteran program, as you saw, we did incorporate a new patient survey. Through those, we really capture a lot of the feedback from the patients. As you can see here, here's just two examples that our nurses provide a lot of feedback as they're talking to patients, as the veterans are telling them their stories, and not only just the veterans but their extended families and how that is impacting their health and things like that. Really, one of the things is telling the patient story so that we're able to really find it meaningful and make it meaningful for the staff and our patients too.

One of the other things is really advertising, making sure that we are, we're putting it out there that we're here to serve you. So, we have these brochures at our health centers that our patients can see that if they're veterans, if they didn't answer the question right that they still have other opportunities to know that we're here for them. If they didn't answer the question the first time, maybe they can take this brochure, read through it, and then they can connect directly to one of our community health workers, and then they tie them back to resource. Really, being deliberate about how we are promoting and advertising the service has really impacted just a way to improve the care for our veterans. And I think I will pass it back to Emily.

Emily Vogt: Thank you, Tony, for sharing about how your health center has sustained the veteran-focused efforts and care coordination for veterans. Next, we will hear from Nalani Tarrant.

Nalani Tarrant: Great, thanks so much. We know that veterans face unique health challenges arising from their military service. For instance, during their service, they may encounter deadly occupational hazards, and upon their return, they may struggle with mental health, reintegration among other concerns. As such, veterans are at a heightened risk for certain health outcomes, and therefore by collecting information on military experience, is going to help flag exposure to health and occupational hazards, assist with reintegration into civilian society, and also identify any potential eligibility for benefits and referrals. At NAC we developed a tool with other stakeholders to engage patients in assessing and addressing social drivers of health. This tool is known as PREPARE, which stands for the protocol for responding to and assessing patients' assets, risks, and experiences.

One of our core questions does ask about veteran status. Currently, the question is worded, have you been discharged from the armed forces of the United States?

And we realize that this question is worded in a way which may have a negative effect on data capturing or negative connotation for the person responding to the question. So, we are actually in the process of changing the language to what you see on the slide. Have you served in the United States military armed forces or uniformed services? This includes Air Force, Army, Coast Guard, Marines, Navy National Guard or Reserves or the USPHS and NOAA. We're meeting the national, PREPARE team in addition to an advisory board that included health centers, PCAs, primary care associations, and other healthcare sectors who are using PREPARE, decided to revise this question to elicit more accurate responses and improve data accuracy. We decided to remove the notion of the phrase discharge because we want to remove the need for the patient to have to guess if it's referring to a negative discharge.

In addition, we want to make sure that health centers and others who are using the tool are serving their patients regardless of being honorably or dishonorably discharged. We believe that this is a layer that can be uncovered through a conversation between the individual and the care team member when appropriate, such as discussing benefit. As part of the revised question, we also plan to include optional questions in our toolkit that a care team member can explore asking as part of a follow-up conversation. For example, when did you serve or where did you serve? And because health centers cater to populations that may not necessarily be native to the United States but may still have a military background, we also aim to incorporate additional optional questions that recognize their service and could help the care team member understand their status better, such as, where did you serve in the military or have you worked as a contractor in the armed forces. These optional questions and additional educational material will be located in our revised PREPARE action and implementation toolkit.

I'll wrap up here by saying that we are currently aligning and fine-tuning our language with AHIP, the American Health Insurance Plans, and we are hopeful that this new version of prepare in English and in the 20 plus languages along with our revised toolkit will be available this fall. If you are interested in learning more about PREPARE, please visit our website prepare.org. It's also here where you can sign up to be part of our monthly newsletter to stay up to date on PREPARE events, or you can also email me directly and I'll make sure that my contact information is available. And with that, I'll go ahead and hand things back over to our facilitator. Thank you.

Emily Vogt: Thank you for describing the connection between veterans and the PREPARE screening tool. And next we'll hear from Judy Van Alstyne.

Judy Van Alstyne...: Great, thanks everyone. I must start out by sharing deep appreciation for care and service provided for generations of veterans. And this gratitude comes from the deepest professional and personal place. Personal support of health centers affects the lives of veterans and communities across the country. Last year, and according to the most recently released 2022 UDS data, HRSA-funded health

centers reported serving more than 395,000 veterans. We saw what was realized, I think, as an unsurprising dip during the height of the pandemic years, and we are seeing what we hope as the upward trend back on track in service. While I share numbers, these numbers represent lives, lives of people, lives of individuals who have served and sacrificed for the protection and ideals of this country. Health centers serve anyone who comes through the metaphorical doors and deliver on the promise of accessible, equitable, high-quality, integrated cost-conscious primary care, another worthy, ideal.

Accurate capture of patient characteristics, veteran status information matters. We commend NAC's partnership, the Department of Veterans Affairs, Veterans Health Administration, and fellow colleagues such as those we've heard from in Iowa and New York today in supporting training and technical assistance offerings to support health centers and partners with accurate, timely, and complete reporting. Now, we'll do a quick peek really at the evolution of reporting of our total veterans line within the UDS highlighting guidance provided via our UDS manual and from the same time frames that are spanned as the data trends on the prior slide.

In 2018, health centers were asked to report the total number of patients who have been discharged from uniformed services in the United States. In 2020, we did some updates specifying by name, such uniformed services within the active military as well as commissioned officer of the U.S. Public Health Service or National Oceanic Administration or served in the National Guard Reserves on active duty. And I think a couple others have hit on those high points. In 2021, we again expanded the named uniformed services to include the Space Force. And now, I think, the big reveal here and I'm pleased to share this as a preview. As our 2024 UDS manual has not been released and is coming out this spring, we are now recommending the wording of veteran status screening to improve accuracy. And we are suggesting the use of NAC's recommended language for veteran status screening questions and health centers. A new FAQ as part of the UDS manual in the section dedicated to table four related to patient characteristics will be front and center.

Beyond our classic or legacy UDS reporting, which was really the pieces I was hitting on here, and our instrument UDS patient level submission known as UDS Plus brings along another ideal, one where through UDS data we can assess the relationship of patients' socio-demographic characteristics with clinical measures, helping us to better understand needs as well as HRSA investments at work. With the 2023 UDS rollout coming up this summer and 2024 UDS reporting requirements in the works, I'm also going to share a few notes on timelines of what to expect as well as links to key resources for information. In terms of production milestones, 2023 UDS plus submissions are coming in still from our cohort one and cohort two, the early adopters of UDS Plus. For 2024 the UDS final changes, program assistance letter and manual, we anticipate releasing those both this spring. Keep an eye out because the final changes PAL is coming, as Jim would say, soon and shortly.

We also will be hosting on June the 5th, the 2024 UDS changes webinar, which is a great opportunity to hear directly, and it's recorded as well from folks about

the changes and really what to expect for 2024 UDS reporting mostly for the legacy system. We also are excited as we get closer to August and National Health Center week in preparation for the release and rollout of our 2023 UDS data. And then of course, we'll head into the 2024 UDS reporting TA webinar period for September and November. I've also shared, I think slides are going around, some links to both publicly available UDS data. And again, that goes through 2022 UDS data at this point. A link to our UDS trading and technical assistance pages with chock-full of great TA resources dedicated to UDS reporting, as well as a link to our UDS modernization information, which also gives some great information related to our UDS Plus. Again, that's uniform data system, patient level reporting efforts under the umbrella of our modernization initiative.

Just as I wrap, again, just want to extend sincere appreciation from the Bureau for all the work you all are doing supporting communities across the country and certainly in service to our veterans. Thank you.

Emily Vogt: Thank you for sharing the importance of accurately reporting veteran status. Again, thank you to all of our presenters for the work that you've done to ensure that veterans are receiving quality healthcare. I will pass it back to Gina.

Gina Capra: Thanks Emily. I really want to thank Judy and the UDS team at the Bureau of Primary Healthcare for their due diligence and the exciting preview today that there will be a technical note coming out in the UDS manual 2024 to promote this screening question that we've discussed here today. We are thrilled that the Bureau is supporting these efforts to improve identification of military veteran patient population. The importance of both local and national accuracy has been well discussed today. NAC has a supplementary PowerPoint presentation available to all to help deliver some of this very education we learned today to your staff and to community partners. It's available on NAC's webpage and is spotlighted in the deck today. On the screen you see before you the slide you see before you and also Judy's slide linked to it as well.

We are pleased to have a second webinar coming up in our Health Centers Serving Veterans series scheduled for June 12th from 2:00 to 3:00 p.m. Eastern Time. It will provide an overview of the new graduate medical education pilot recently authorized by Congress through the Mission Act. Community health centers are named as eligible organizations to be involved in this pilot, particularly in rural, Indian serving and other underserved communities. So, please register for our June 12th event. The registration link is available here on this slide, but also on the NAC website, and it will be sent directly to all of today's registrants. NAC is pleased to provide a variety of resources to support health centers serving veterans and their families. Please take advantage of these free services, which include signing up for the NAC Veterans Interest Group, an informal affinity group, and multiple technical assistance resources on the Health Center Resource Clearinghouse at www.healthcentrinfo.org.

We've now come to a very short Q&A portion of today's webinar, but before I ask our faculty to respond to a question submitted by one of our participants today, I want to first thank each and every faculty presenter today. Your

knowledge, commitment, and excellent delivery was interesting, informative, and actionable. Speaking of action, here is the three-point call to action for everyone on today's webinar. First, utilize the recommended screening question that we've discussed as part of your health center's intake or social determinants of health process. Second, complete today's webinar evaluation please, so that NAC can provide the best possible training to meet your needs. And third, sign up for our June 12th webinar on the Veterans Health Administration's Graduate Medical Education pilot.

Now, we have one question and I'd like to ask each faculty member round-robin style, we'll go from the top of our agenda. Please reflect on the following question. Annie, maybe we can take a look at each other here for this one, what can be done to care for and advocate for veterans who might not qualify for VA Healthcare? I'll ask that one more time to our faculty. Not all veterans qualify for VA Healthcare. What can be done to care for and advocate for these veterans? Emily, we'll start with you and then go to Dr. Howren and then go to Mary, then Tony, Nalani and Judy. Emily, over to you.

Emily Vogt: Thank you, Gina. Thank you. I would say that community coordination and connecting them with other services in the community that might meet their needs as well as within the health center.

Gina Capra: Thank you very much, Emily. And I think we heard about some of that community coordination today. Shout out to Tony and his team. Bryant, how about for you over at the VA there? What would you say?

Dr. Matthew How...: I would completely agree with what Emily said, raising awareness around community-based programs. There are, I mentioned even, not to say that I know every program out there, no one does, but you start to learn more about what's going in the community and there are resources that you might be able to bring in for some sort of in-service training. And I'm thinking about VSOs or veteran service officers who are in your local areas who may know about these things. There are oftentimes other organizations like American Legion for example, where they may have a high veteran presence. If there's any way to connect with those, you can start to learn more about other resources. Sometimes this happens through word of mouth. One veteran says, I was able to take advantage of this. And they're talking to us on the program side and we're like, "I didn't realize that exists." And then we're able to pass that along to others. It can be a slow build at times, but there are resources in the community that can help you understand what's available.

Gina Capra: Bryant, I really want to call out your reference to veteran service officers and ensure that today's participants understand that a VSO or a veteran service officer is a certified trained individual whose job it is to help connect a veteran and their family to the very many variety of benefits and services available to them. What the U.S. Department of Veterans Affairs has on offer to whatever criteria a veteran they set can be different from what a state Department of Veterans affairs might have on offer, which can also be different from even at the county level. So, it's so important to locate your veteran service officer, and that's an easy Google search, find my VSO and you will be guided accordingly. Your local

American Legion, Disabled American Veterans or Veterans of Foreign War posts often have dedicated VSO as well.

Thank you so much for that. We did have some discussion in the Q amp A about the role of VSO is particularly in toxic exposure screenings, which have increased attention through the PACT Act in which we really want to encourage veterans to go through the screening process for benefits that may be now available to them. Thank you, Bryant, for that. Mary, over to you. What could be done to care and advocate for our veterans who are not eligible for VA Healthcare?

Mary Zelazny: I think it's really important for FQHCs and our PCA is that we have in each of our states to really dig in and understand the whole VA system so that we can advocate for people that may or may not be eligible because I don't think a lot of us know a whole lot about those systems. I believe that the VA and FQ should work really closely together. And I think that it's really important that we reach out, we get training, we talk to our PCA is, hey, can you educate us on this? Because there's a lot to know to everybody's point, and I think it'd be really important for our patients.

Gina Capra: Mary, thank you. And thank you for the training you've instituted at your health center. We appreciate that. Tony, what are your thoughts on this? And I must also say thank you for your service, sir. You bring a very personal connection to this topic.

Antonio Flores: Absolutely. You have to get passionate people to really work with our veteran population. We have a lot of aging veterans. I know that we see them all the time. Really bringing this call forward to our legislative people as well, working with your local representatives and just really bringing attention to the fact that there are people that are not being served, here's the data. And providing that information so that something can be done at the legislative side of things.

Gina Capra: Tony, thank you so much. Nalani, any reflections?

Nalani Tarrant: Yeah, two come to my mind, which is really echoing what Emily and Matthew were indicating earlier, but community resources and community-based programs is really great way to start. Many of these organizations can provide various forms of assistance and maybe even app programs, specific programs that are already tailored to veterans' needs. And also, peer support networks. Consider maybe hosting a peer support network, whether in person or online. This is where veterans can connect with other veterans and share those experiences. Because a lot of times, it is word of mouth about a resource that's available in a community, and it's also coming from maybe a trusted veteran as well, which would open up the door for another veteran to say, hey, I'm going to go and look into this resource. So, those are my two things I would consider.

Gina Capra: Nalani, thank you so much. I know you and your team have done some work in the medical-legal partnership space as well, which is another great resource in supporting veterans. Judy, how about for you?

Judy Van Alsty...: I'm going to steer clear Federal regulations. [inaudible 00:51:23]. I think patient characteristics, it is all very important. And the population served by the health centers all are very important. Regardless of what one may qualify or not qualify, it's about really caring for that patient where that patient is, patient-centered care and this approach. And I think, and even some of the examples Nalani just shared, and that was more the individual, almost peer-to-peer engagement, but also learning from each other. Learning from like organizations of how they are handling, supporting folks who may or may not qualify, but very well have these true needs. Thanks.

Gina Capra: Judy, thank you. I think we've discussed systems, we've discussed programs, and those pieces are so essential. I just want to end with saying, we've got 400,000 individual human beings that health centers have identified as veterans, and they are part of friend and family networks who are very important to their health and wellbeing. Health centers serve those individuals as well. So, let's keep on going, identifying our veterans and providing that support and connection that they've earned and deserve. So pleased to spend this hour with you. Thank you everyone. Hope to see you on June 12th and fill out your evaluation. Thanks all. Webinar adjourned.