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Kristin Brawn

University of Southern Maine, Muskie School of Public Service

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An Assessment of the Health Needs of Maine Veterans
and Their Access to Veterans Health Administration Health Care Services

Kristin Brawn

Health Policy and Management Masters program

Muskie School of Public Service

University of Southern Maine

Professor David Hartley, Capstone Advisor

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This Capstone is a research project to assess the current health needs of veterans in the state of Maine and their access to U.S. Department of Veterans Affairs (VA) Veterans Health Administration (VHA) health care services. On a national level, since the beginning of the Afghanistan and Iraq conflicts (Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), respectively), the inadequacy of the VHA to meet the health needs of these veterans has been widely publicized. The VHA system is being stressed at unprecedented levels by a substantial increase in the number of new veterans returning home with physical and mental wounds from multiple deployments, the increasing prevalence of post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) and the dramatic increase in the suicide rate among U.S. soldiers. On a state level, only a few assessments have been conducted, which indicate that Maine veterans are also experiencing similar mental and physical health issues; however, it does not appear that the adequacy of Maine's VHA services to meet the needs of Maine's veterans has been comprehensively evaluated. It is unknown whether the physical and mental health needs of Maine's veterans are currently being met. Therefore, this project proposes to determine if there is a similar problem among Maine's veterans in regard to health issues and lack of access to VHA health services, as has been reported at the national level. To assess the health needs of Maine's veterans and the adequacy of VHA services to meet those needs, this project involved analysis of a survey data set provided by the Maine Army National Guard regarding soldiers' perceptions of the quality and accessibility of VHA services and key informant interviews with veteran advocacy groups, VHA officials and VHA providers, as well as a statewide geographic inventory of VHA health services locations. The results of this project provide valuable information to Maine VA officials and state government policymakers to identify and address potential issues with Maine's VHA services and ensure that the physical and mental health needs of Maine's veterans are being adequately addressed.

Background/Literature Review

In conducting research for relevant articles on veterans' health issues and VHA health services, the following research questions were applied:

- How many veterans are living in Maine?

- What are prevalent health issues among veterans nationally?
- What are the health issues for Maine veterans?
- What are problems with accessibility to VHA services for veterans nationwide?
- What are problems with accessibility to VHA services for veterans in Maine?

According to the VA's National Center for Veterans Analysis and Statistics website, there are approximately 136,500 veterans currently living in the state of Maine (*Veteran Population*, 2012). The largest portion of the veteran population is Vietnam veterans, at 36%, with the next largest population being Gulf War veterans, at 23%. Korean and World War II veterans compose 10% and 7% of the state's veteran population, respectively. Post Gulf War veterans, which would include both Afghanistan and Iraq veterans, compose less than 1% of Maine's veterans. In regard to age, the largest population among Maine veterans is the elderly, with 46% of Maine veterans over the age of 65. The next largest population group is age 55 to 64 at 21%. Approximately 16% of veterans are age 45 to 54, 10% are age 35-44, 6% are age 25 to 34, and less than 1% are age 18 to 24. The veteran population in Maine is predominantly male (92% men, 8% women).

Veterans' Health Issues

Research on veterans' health issues identified many articles regarding veterans' health issues on the national level, and a few reports were found on the health issues of Maine veterans. The following paragraphs summarize literature on veterans' health issues at both the national and state levels that was found to be relevant to this project.

According to the *National Survey of Veterans*, a report prepared for the VA based on a nationwide survey of veterans, 72.3% of veterans reported that their health was "excellent," "very good" or "good" (U.S. Department of Veterans Affairs [VA] & Westat, 2010). Approximately 28.4% of veterans reported using VA services (p. 125).

According to a previous report of the *National Survey of Veterans*, health issues among veterans ranged from immune deficiencies (0.3%) to eye or vision issues, which were reported by 55.8% of veterans (VA & Westat, 2001). Other common issues that were prevalent among the veteran population included high blood pressure

(34.5%), arthritis or rheumatism (26.8%), heart trouble (15.9%), and severe chronic pain (15.1%). Nearly 4% (3.8%) reported treatment for PTSD, and 6.2% reported treatment for other mental or emotional problems. Slightly more than 1 percent (1.2%) reported getting treatment for drug or alcohol problems (VA & Westat, 2001).

In addition to these health issues identified in the veteran population overall, there are also service-specific health problems that are specifically related to the particular period in which the veterans have served. The Veterans Health Council identifies some of the most prevalent conditions on its website. The most common health issues experienced by Vietnam veterans include PTSD, health issues from exposure to Agent Orange and other toxic chemical herbicides, Hepatitis B, Hepatitis C, HIV/AIDS, substance abuse and military sexual trauma (sexual harassment or sexual assault). Service-related illnesses for Gulf War veterans include PTSD, Gulf War Illness, Leishmaniasis, amyotrophic lateral sclerosis (ALS), exposure to chemical smoke, chemical and biological agents and depleted uranium, illness from immunizations, substance abuse and military sexual trauma. Service-connected illnesses among Global War on Terror (OEF/OIF) veterans include PTSD, TBI, Acinetobacter, Leishmaniasis, vision loss, hearing loss, tinnitus, traumatic amputation, exposure to depleted uranium, substance abuse and military sexual trauma (Veterans Health Council, 2009).

Recent studies have also focused on OEF/OIF veterans and the health issues experienced by this population. A RAND Corporation study of OEF/OIF veterans' post-deployment health-related needs found that of the 1,965 individuals surveyed post-deployment, 14% screened positive for PTSD and 14% for major depression (Tanelian & Jaycox, 2008). Approximately 19% reported a probable TBI during deployment (Tanelian & Jaycox, 2008). A study by the Institute of Medicine (IOM) (2010) reported a similar prevalence of PTSD and TBI among veterans. The IOM report also discussed the escalating suicide rate among OEF/OIF veterans. According to the IOM report (2010), in 2003, the suicide rate among U.S. soldiers was estimated at 10–13 per 100,000 troops, depending on the branch of the military, compared with 13.5 per 100,000 civilians aged 20–44 years and 20.6 per 100,000 civilians 20–34 years old, the demographic that covered most U.S. soldiers serving in Iraq. However, more recent data from the National Violent Death Reporting System indicated that the suicide among male veterans 18-29 years of age was 45.0 per 100,000 in 2005 compared with 20.4 for that age group in the general population, and as

of October 2009, there were already 133 reported suicides (90 confirmed and 43 pending), which was the record for a year (IOM, 2010).

In regard to health issues among Maine's veterans, a joint study was conducted in 2006 by the Community Counseling Center, located in Portland, Maine, and the Maine Army National Guard of 532 National Guard members, 292 of whom were Iraq veterans. The study reported that of the National Guard members surveyed, 81% of Iraq veterans had experienced enemy fire, 70% knew someone who was killed or injured and 79% had been in danger of being wounded or killed (Wheeler, 2006). The study also found that 24.7% of Iraq veterans met screening criteria for PTSD, major depressive disorder or alcohol abuse, and 33.9% of Iraq veterans reported issues with their physical health (Wheeler, 2006).

Access to VHA Health Services

Literature research found several reports and studies at the national level regarding the accessibility of VHA services for veterans and barriers to accessing VHA health care services. National studies indicate issues with accessibility to VHA services for U.S. veterans. A report from the VA Office of Inspector General (OIG) (2006) found that VHA facilities were not establishing effective measures to ensure that all newly enrolled veterans would receive care within the VA's acceptable timeframe, which is within 30 days of the veteran's desired appointment date. In addition, the OIG found that veterans were not receiving clinically indicated specialty care within reasonable timeframes (VA OIG, 2006).

The *National Veterans Survey* (2010) reported that 28.4% of veterans surveyed indicated that they did not use VHA health care services, and the reasons for not using VHA services included lacking awareness of VHA benefits (42.3%), did not know how to apply for benefits (26.4%), experience too much trouble or red tape (9.8%), use other sources for health care (41.2%) or VHA care is difficult to access (4.8%).

Studies of access to VHA services identified barriers to care for veterans in accessing VHA mental health and medical services. A 2006 study of veterans in VA Capital Health Care Integrated Service Network (VISN 5,

which includes Maryland, Virginia, West Virginia and Washington DC) with serious mental illness reported that approximately 67% of study participants experienced at least one barrier to accessing VHA mental health services and 60% of participants experienced at least one barrier to VHA medical services (Drapalski, Milford, Goldberg & Brown, 2008). Personal factors, such as personal crisis, inability to explain self, lack of knowledge about how to make an appointment, were reported most frequently, at 56% for mental health care and 43% for medical care. The next most common barrier identified among study participants was transportation, both physical distance and lack of transportation. Approximately 24% of veterans reported transportation as a barrier to mental health care and 19% as a barrier to medical care. Institutional constraints (appointment wait times and ability to get an appointment) were also reported as a barrier by 21% of veterans, in regard to both mental health care and medical care (Drapalski et al., 2008).

A review of studies at the state level of access to VHA services by Maine's veterans also indicates issues with access to VHA health care services here in Maine. A legislative study to examine the adequacy of services at the Togus VA Hospital reported several issues with access to care, including concerns with lengthy wait times between making and getting medical appointments at Community-Based Outpatient Clinics (CBOC's), inadequate access to care for veterans living in Southern Maine, and inadequate communication to veterans about the benefits to which they are entitled, how to access services and changes in service delivery (Daggett, Tuttle, Carey, Ferguson, Chizmar, Fisher, ... & Fox, 1999).

A 2007 article in the *Portland Press Herald* reported difficulties with access to services at Togus for veterans. According to the article, despite the central location of the Togus VA Hospital in the state, many veterans found the travel distance to Togus for appointments difficult, with some requiring eight hours of travel or more, and some even an overnight stay. The article stated that this distance makes Togus impractical as a primary health care provider for some veterans due to the geographic expanse of the state. Accessing some specialty care, such as vascular surgery and organ transplants, is even more difficult, as it requires a trip to the VA hospital in Massachusetts (Wack, 2007).

Analytical Framework

The analytical framework that was utilized for this project was the Aday and Andersen framework for the study of access, as well as a 21st century update of this framework, which reflects the recent digital applications in the healthcare system and places the framework in the context of VHA health services. The original framework begins with the health policy objectives, proceeding through the characteristics of the health delivery system and of the populations at risk (inputs) and ending in the outputs of actual utilization of health care services and consumer satisfaction with these services (Aday & Andersen, 1974). According to Aday and Andersen (1974), the health delivery system is divided into two main components—resources (providers, institutions, and equipment and materials used) and organization (entry—the means by which the patient gains entry to the system and continues treatment; and structure). The characteristics of the population at risk are predisposing (age, sex, race, religion and health beliefs), enabling (the means available to utilize services); and need (illness level) (Aday & Andersen, 1974). Accounting for the recent digital enhancements to the 21st century healthcare system, the revised model includes a digital dimension of access (telemedicine, e-mail, computerized health applications), as well as temporal, financial and cultural dimensions (Fortney, Burgess, Bosworth, Booth and Kaboli, 2011). In the Fortney et al. model, the digital dimension of access pertaining to the characteristics of the health system includes synchronous and asynchronous patient-to-provider communication systems, digital peer-to-peer communications and computer health applications. The digital dimension of access in the context of the characteristics of the individual includes computer literacy and availability and sophistication of personal communication technologies (Fortney et al., 2011). The cultural dimension of access in the Fortney et al. model is similar to the characteristics of the population at risk in the Aday and Andersen model and includes characteristics such as age, race and ethnicity, marital status, health literacy, coping style, religiosity and spirituality, social support and community embeddedness (Fortney et al., 2011).

These frameworks were applied in the design of the key informant interview questions, and the National Guard survey data was examined in the context of these frameworks. The National Guard survey asked veterans about their perceived service-connected health needs (inputs), if they use VA services for those needs (utilization), which services they use (utilization) and their satisfaction with VA services, including wait times for

appointments, travel times and other patient satisfaction indicators. Population characteristics (age, gender, county of residence and conflicts served) were also collected from the survey. The analysis of these indicators in the access framework obtained from the key informant interviews and the National Guard raw survey data is discussed in detail in the Results section of this report.

Methods

As mentioned previously, data pertaining to Maine veterans' health issues and accessibility of VHA services was obtained from a raw survey data set provided by the Maine Army National Guard. The survey was conducted by the National Guard in February 2011 to assess Maine soldiers' perceptions of accessibility and the quality of VHA health services. Survey questions included demographic characteristics, health status, VHA user status, and rating the accessibility and quality of VHA services on various dimensions of quality and access on a 1 to 5 scale. There were also sections provided for comments on how the federal government and the state could help to improve access to VHA health care services. An outline of the survey questions is included as **Attachment A**. Survey data were entered into an Excel spreadsheet for analysis. The original data set contained survey responses from 238 soldiers, 155 (34.9%) of whom identified themselves as veterans. Non-veteran survey responses were removed from the data set, so that the analysis would focus solely on the 155 responses from veterans. Survey data were compared by demographics, health status and VHA user status to determine if there were any significant differences in the accessibility and quality ratings of VHA services based on these factors.

To supplement the National Guard veteran survey data set, key informant interviews were conducted with six individuals who are representatives of Maine veteran service organizations (VSO's), veteran advocacy groups and the VA. Interviews were conducted in person or by telephone from October through January 2014. Key informants were asked a series of open-ended questions about veteran's health issues, whether the health services of the VHA adequately address those issues, perceived barriers to accessing care, how the federal government or the state could provide assistance to veterans and identification of potential models to improve access. Copies of the key informant interview questions and informed consent forms are included as **Attachment B**. Key

informants' responses were examined to identify common themes expressed regarding Maine veterans' health issues and the accessibility of VHA health services.

In addition, to further evaluate accessibility of VHA health services, an inventory was taken of existing VHA health services across the state of Maine. Utilizing GIS software, this information was compiled into a population density map of Maine veterans to determine if existing VHA services are adequately sited to serve Maine's veteran population. A service area analysis was also conducted for each VHA facility utilizing an online GIS subscription service to determine if the facilities are located within VA distance guidelines for all of Maine's veteran population. Copies of the maps are included as **Attachments C, D, E and F**.

The maps used in this report were created using ArcGIS® software by Esri and ArcGIS® Online Network Analysis Service. ArcGIS® and ArcMap™ are the intellectual property of Esri and are used herein under license. Copyright © Esri. All rights reserved. For more information about Esri® software, please visit www.esri.com.

Results

As mentioned previously, the results of the survey data set, key informant interviews and VHA health service inventory analyses will be discussed in the context of the Aday and Andersen and Fortney et al. access frameworks. As mentioned previously, the Aday and Andersen (1974) framework organizes access into five dimensions: health policy, characteristics of the population at risk, characteristics of the health delivery system, utilization of health services and consumer satisfaction. The Fortney 21st century update to this framework adds digital and cultural components to the dimensions of access.

Population Characteristics

Demographics

Of the 155 National Guard soldiers surveyed who identified themselves as veterans, approximately 95% responded that they were Afghanistan (OEF) and/or Iraq (OIF) veterans. The remaining 5% indicated that they had served in the Persian Gulf, in Bosnia or in other conflicts. Some Iraq and Afghanistan veterans reported that

they had also previously served in the Persian Gulf, Bosnia or Kosovo. In regard to age, the largest percentages of soldiers were in the 26-35 (41.9%) and 36-45 (36.8%) age ranges. The next largest portion of veteran soldiers was within the 46-55 age range, at 12.9%. Only a small percentage of veterans reported that they were age 18-25 (5.2%) or age 56-65 (2.6%). The sample population was predominantly male, at 96.8%. In regard to location, over 40% of soldiers lived in either Kennebec County (21.3%) or Aroostook County (20.6%), with the next largest percentages being from Cumberland (11.0%), Androscoggin (9.0%) and York (8.4%) counties.

In contrast to the sample population of National Guard soldiers, who are predominantly age 26-45, interviews with key informants indicate that the Maine veteran population is mostly age 65 and over. Key Informant 3, a representative of the VHA, stated that the veteran population is “heavily tilted towards older men, with an average age of 65.” Key Informant 4, also a VHA representative, said that Maine veterans are an “aging population, with World War II veterans in their 80’s and Vietnam veterans in their 60’s and 70’s.” Key Informant 4 also stated that the veteran population in Maine is “mostly male but [the VHA] is getting more and more women in all the time.”

Health Status

Among the sample population of Maine National Guard veterans, 41.3% reported that they had a service-connected medical condition. Of those who reported a service-connected medical condition, 67.2% indicated that the condition was physical, 4.7% indicated a mental health condition and 28.1% indicated a condition that was both physical and mental health-related.

Conversations with key informants revealed a variety of physical and mental health issues among Maine’s veteran population. Key Informant 1, a veteran and veterans’ advocate, stated that the most prevalent health issue among Maine veterans is “PTSD - I deal with a lot of veterans that have it.” Key Informant 2, a veteran and veterans’ advocate stated that for the male veteran population, the most common health issues are “prostate issues and heart conditions. A lot of diabetes and high blood pressure, and that is related to weight. For women, the most common issue is “depression and I would generally say gynecological issues. A lot of fibromyalgia in women as well.”

Key Informant 2 also mentioned substance abuse as a problem for both women and men. Key Informant 3, a

VHA representative, stated that the most common issues are “diabetes, congestive heart failure and COPD [chronic obstructive pulmonary disease]. For Iraq and Afghanistan veterans – traumatic brain injury and PTSD, a significant percentage. It runs the full spectrum of disorder, on a wide range of severity.” Key Informant 4, a VHA representative, said that the VHA “sees a lot of issues to do with aging as well as issues having to do with neglecting health . . .those that come from a predominantly male population that don’t pay as much attention to healthcare as women do.” Key Informant 4 also discussed service-connected issues: “they range from prosthetics to hearing problems from being near guns and working in engine rooms, spinal problems from people jumping out of airplanes.” Key Informant 4 also mentioned PTSD and other mental health issues. Key Informant 5, a representative of a VSO, stated that pain management was a prevalent issue among Maine’s veteran population. Key informant 6, also a VSO representative, said that he sees a lot of PTSD and depression in the younger veteran population and some PTSD in the older veteran population, but more geriatric issues and physical health issues, such as hip and knee replacements. Key Informant 6 also said that alcohol abuse is more prevalent in the younger veteran population than the civilian population.

Characteristics of the Health Delivery System

According to the VHA website (www.maine.va.gov/locations), the VHA health delivery system in Maine consists of the Maine VA Medical Center(Togus) located in Augusta; eight Community-Based Outpatient Clinics (CBOCS) located in Bangor, Calais, Caribou, Lewiston/Auburn, Lincoln, Portland, Rumford and Saco; two part-time primary care Access Points in Fort Kent and Houlton and a mobile medical unit, which provides services in Bingham. There are also five Vet Centers located in Bangor, Caribou, Lewiston, Portland and Springvale, which are not VHA owned or operated, but maintain a close relationship with the Maine VHA system. In addition, the VHA also provides electronic access to health care for veterans, including telehealth services and MyHealtheVet, an online electronic personal health record service for veterans. A brief description of each of the aforementioned VHA facilities and services and additional VHA services follows.

Maine VA Medical Center (Togus)

According to the VA website, Togus is a 67-bed hospital with general medical/surgical, intermediate and mental health beds, as well as a 100-bed nursing home (50 skilled and longer stay beds and a 50-bed dementia unit). The hospital provides both comprehensive outpatient and inpatient care. Outpatient care includes primary care, wellness and preventive health services including smoking cessation, cardiovascular fitness, preventive cardiology, women's health and special clinics to assist primary care providers in managing diabetes, lipids and anticoagulation. Medical services include General Internal Medicine, Cardiology, Gastroenterology, Hepatology, Endocrinology, Hematology, Oncology, Chemotherapy, Infectious Disease, Pulmonary Medicine, Rheumatology, Tele-Dermatology, Dialysis, Nephrology, Neurology, Spinal Cord Injury, Sleep Disorders, Home Oxygen Program and a Critical Care Unit. Surgical services include General Surgery, Thoracic, Otolaryngology, Ophthalmology, Urology, Orthopedics, Neurosurgery, Pain Management, Podiatry, Optometry, Gynecology, Anesthesiology and Audiology. Mental health services include Acute Inpatient, General Psychiatry, day hospital programs for PTSD and Day Treatment Center, Mental Health Intensive Case Management, Neuropsychology and Testing, General Psychology, Outpatient Substance Abuse and Smoking Cessation Program. Dental services are also available. Ancillary services include General Radiology, Audiology, Ultrasound, CT Scan, Neuroradiology (noninvasive), General and Cardiovascular Nuclear Medicine, Pathology and Laboratory Medicine, Pharmacy, Prosthetics and Sensory Aides, Respiratory Therapy, Nutrition, Visually Impaired Services and a Women Veterans Program. Specialized treatments, such as radiation therapy and Magnetic Resonance Imaging (MRI) are provided via contractual arrangements with local providers (fee-based care).

Community-Based Outpatient Clinics (CBOCs)

According to the VA website, there are eight outpatient clinics located across the state of Maine:

- Bangor – Provides primary care and preventive health services, mental health services, health promotion/disease prevention, medical benefits counseling, laboratory services and smoking cessation.
- Calais – Provides primary care and preventive health services, mental health services, health promotion/disease prevention, medical benefits counseling and laboratory services.

- Caribou – Provides primary care and preventive health services, mental health services, health promotion/disease prevention, medical benefits counseling, laboratory services, tele-retinal imaging, home-based primary care team and smoking cessation.
- Lewiston/Auburn – Provides primary care and preventive health services, health promotion/disease prevention, medical benefits counseling and laboratory services.
- Lincoln – Provides primary care and preventive health services, mental health services, health promotion/disease prevention and home based primary care team.
- Portland – Provides primary care and preventive health services, mental health services, health promotion/disease prevention, medical benefits counseling, laboratory services and smoking cessation.
- Rumford – Provides primary care and preventive health services, mental health services, health promotion/disease prevention, medical benefits counseling, laboratory services and home-based primary care.
- Saco – Provides primary care and preventive health services, mental health services, Endocrinology, laboratory services, home-based primary care and smoking cessation.

Primary Care Access Points and Mobile Medical Unit

According to the VA website, there are two part-time primary care access points which are open one day per week: one in Houlton that provides primary care and preventive services and mental health services, and one in Fort Kent that provides primary care and preventive services. The Mobile Medical Unit (MMU) is located in Bingham, and is open two days per week. The MMU provides routine and follow-up primary care appointments with limited availability for walk-in visits, prescription refills/renewals, lab draws, mental health and social work services, imaging services (provided on a fee basis for patients seen in MMU only) and eligibility and enrollment services.

Vet Centers

According to the VA website, there are five Vet Centers located across the state in Bangor, Caribou, Lewiston, Portland and Springvale. According to the *Federal Benefits for Veterans, Dependents and*

Survivors(a VA benefits guide), the Vet Centers provide individual, group and family readjustment counseling to combat veterans to assist them in making a successful transition from military to civilian life, including treatment for PTSD and help with any other military related problems that affect functioning in everyday life. Veterans who have served in active duty in a combat theater during World War II, the Korean War, the Vietnam War, the Gulf War, or the campaigns in Lebanon, Grenada, Panama, Somalia, Bosnia, Kosovo, Afghanistan, Iraq and the Global War on Terror are eligible for services. Because Vet Centers are not part of the VHA system, enrollment in the VHA system is not required. The Vet Centers were established in 1979, when the VA was directed by Congress to provide readjustment counseling services to eligible combat veterans to address the significant number of Vietnam veterans experiencing readjustment issues. The VA VHA established a nationwide system of community-based Vet Centers. These centers were established as separate from the VA medical centers on the premise that many Vietnam veterans were so distrustful of government institutions that they would not go to a VA medical center for care (American Legion, 2012).

Telehealth, MyHealtheVet and Other Digital Services

According to the key informants who are VHA representatives, in addition to the geographically dispersed clinics, the VHA is enhancing access to care through telemedicine. According to Key Informant 3, there are approximately 200 patients (mostly congestive heart failure patients) using the Maine VHA system's telehealth services, and the VHA provides clinical video telehealth (CVT) as well. According to Key Informant 1, a veteran and a veterans' advocate, all new mental health appointments are also now being conducted via CVT. The VHA also provides an online personal health record, MyHealtheVet for veterans and their families. According to *Federal Benefits for Veterans, Dependents and Survivors* (2012), in addition to developing a personal health record, with upgraded access, veterans can transmit secured messages to their VHA providers, request prescription refills online, view key portions of Department of Defense military service information, get VHA

wellness reminders, view VHA appointments, view VHA lab results and view VHA allergies and adverse reactions.

Non-VHA Care

For veterans who require health care services that are unavailable within the VHA system, the VHA provides fee-based care through contractual arrangements with local providers. According to the VA website (<http://www.nonvacare.va.gov/>), non-VHA care may be used when VHA medical facilities are not “feasibly available.” Utilization of the non-VHA care program is subject to federal laws containing eligibility criteria and other policies specifying when and why it can be used. The local VHA medical facility uses these criteria in determining whether non-VHA care is necessary. If a veteran is eligible for certain medical care, the VA hospital or clinic should provide it as the first option. If they are unable to provide the service due to a lack of available specialists, long wait times or extraordinary distances from the veteran’s home, the VHA may consider non-VHA care with local providers in the veteran’s community. Non-VHA care requires a pre-authorization for treatment, unless the medical event is an emergency, which may be reimbursed on behalf of the veteran in certain cases.

Enrollment for VHA Services

According to the *Federal Benefits for Veterans, Dependents and Survivors* (2012) guide, most veterans are required to enroll into the VHA system to receive health services. Veterans must fill out the enrollment application form (VA Form 1010EZ) online, via telephone, or at a VA facility or VA regional benefits office. During enrollment, each veteran is assigned to a priority group, which the VA uses to balance demand for VA health care enrollment with available resources. **Figure 1** lists the eight priority groups and the eligibility criteria for veterans within each priority group:

Figure 1: VA Priority Groups

Group 1	Group 2	Group 3	Group 4
<ul style="list-style-type: none"> Veterans with service-connected disabilities rated 50% or more and/or veterans determined by VA to be unemployable due to service- 	<ul style="list-style-type: none"> Veterans with service-connected disabilities rated 30 or 40%. 	<ul style="list-style-type: none"> Veterans who are former POWs. Veterans awarded the Purple Heart Medal. Veterans awarded the 	<ul style="list-style-type: none"> Veterans receiving increased compensation or pension based on their need for regular aid and attendance or by reason of

Group 1	Group 2	Group 3	Group 4
connected conditions		<p>Medal of Honor.</p> <ul style="list-style-type: none"> • Veterans whose discharge was for a disability incurred or aggravated in the line of duty. • Veterans with VA service-connected disabilities rated 10% or 20%. • Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation." 	<p>being permanently housebound.</p> <ul style="list-style-type: none"> • Veterans determined by VA to be catastrophically disabled.

Group 5	Group 6	Group 7	Group 8
<ul style="list-style-type: none"> • Nonservice-connected veterans and noncompensable service-connected veterans rated 0%, whose annual income and/ or net worth are not greater than the VA financial thresholds. • Veterans receiving VA pension benefits. • Veterans eligible for Medicaid benefits. 	<ul style="list-style-type: none"> • Compensable 0% service-connected veterans. • Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki. • Project 112/SHAD participants. • Veterans who served in the Republic of Vietnam between Jan. 9, 1962 and May 7, 1975. • Veterans who served in the Southwest Asia theater of operations from Aug. 2, 1990, through Nov. 11, 1998. • Veterans who served in a theater of combat operations after Nov. 11, 1998, as follows: <ul style="list-style-type: none"> ○ Veterans discharged from active duty on or after Jan. 28, 2003, for five years post discharge; ○ Veterans who served on active duty at Camp Lejeune for not fewer than 30 days beginning Jan. 1, 1957 and ending Dec. 31, 1987. 	<ul style="list-style-type: none"> • Veterans with incomes below the geographic means test income thresholds and who agree to pay the applicable copayment. 	<ul style="list-style-type: none"> • Veterans with gross household incomes above the VA national income threshold and the geographically-adjusted income threshold for their resident location and who agrees to pay copayments. Veterans eligible for enrollment: Noncompensable 0% service-connected and: <ul style="list-style-type: none"> ○ Subpriority a: Enrolled as of Jan. 16, 2003, and who have remained enrolled since that date and/ or placed in this subpriority due to changed eligibility status. ○ Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10 percent or less ○ Veterans eligible for enrollment: Nonservice-connected and Subpriority c: Enrolled as of Jan. 16, 2003, and who remained enrolled since that date and/ or placed in this subpriority due to changed eligibility status ○ Subpriority d: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less ○ Veterans NOT eligible for enrollment: Veterans not meeting the criteria above: Subpriority e: Noncompensable 0% service-connected Subpriority f: Nonservice-connected

The map in **Attachment C** shows the density and the distribution of the veteran population in the state of Maine based on American Community Survey 5-year population estimates. As shown, the veteran population is concentrated mostly in the central and southern areas of the state (southern Penobscot, Kennebec, Androscoggin, Cumberland and York counties).

The map in **Attachment D** displays the location of Maine VA Medical Center (Togus), VHA CBOCs and Vet Centers in relation to the veteran population. As shown, the VHA facilities are distributed across the state, located in areas with the highest concentration of veterans, as well as the more sparsely populated Aroostook and Washington counties.

The map in **Attachment E** displays the results of the GIS service area analysis of the VHA primary care facilities. The VA has established specific guidelines for health care facilities to be considered accessible to veterans, and has outlined these guidelines in its Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan. According to the CARES Plan, the guideline for primary care facilities is within a 30-minute drive time radius for both urban and rural areas (CARES, 2003). **Attachment E** displays the 30-minute drive time radiuses for each VHA primary care facility in relation to the veteran population. As shown, there are still many veterans, even in the more densely populated areas, that fall outside of the 30-minute guideline, and one entire county, Piscataquis County, does not fall within any of the clinics' service areas. This map shows that although the VHA primary care facilities are distributed across the state, there may still be veterans who live too far away to access these facilities.

The map in **Attachment F** displays the results of the GIS service area analysis for the only VHA hospital in the state, Maine VA Medical Center (Togus). According to the CARES Plan, the guideline for acute care hospitals is 60 minutes for an urban area and 90 minutes for a rural area (CARES, 2003). According to VA definitions, the Maine VA Medical Center is located in a rural area (U.S. Department of Veterans Affairs, Office of Rural Health, 2014). **Attachment F** shows the 90-minute drive time radius for Maine VA Medical Center in relation to the veteran population. As shown, most of the central and northern portions of the state, and the densely populated

York County fall outside of the 90-minute drive time service area. This map shows that although the Maine VA Medical Center is centrally located within the state, according to VA distance guidelines, it is considered inaccessible for veterans in many parts of the state, particularly in the northern and eastern counties of the state.

Utilization of Health Services

Of the National Guard veterans who were surveyed who reported a service-connected medical condition, 67.2% reported that they used VHA health services for their condition, while 32.8% reported that they did not use VHA services. For those that reported using VHA services, 69.8% received their care from the Maine VA Medical Center only, 9.3% received care at CBOCs only, 4.7% received care at Vet Centers only and the remaining 16.3% received care from a combination of the Maine VA Medical Center, CBOCs, Vet Centers and/or the VA Medical Center in Boston.

Interviews with key informants also provided some information about utilization of VHA services by veterans in Maine. According to Key Informant 3, a VHA representative, of the approximately 130,000 veterans in Maine, approximately 90,000 are eligible for VHA services, but only 40,000 use VHA services.

Perceived Access to Care

In examining the National Guard survey and key informant interview responses, there appear to be differing opinions on whether the existing VHA system in Maine is adequate to serve veterans' health care needs.

Figure 2 shows the results from the National Guard survey from the section where soldiers were asked to rate various aspects of VHA services on a 1 to 5 scale, with 1 being not satisfied and 5 being very satisfied. **Figure 2** shows the average ratings from veterans who reported a service-connected medical condition ($n=64$) and compares the average ratings of VHA users and non-users.

Figure 2: Comparison of Access Ratings for VHA Users and Non-Users ($n=64$)

	Ease of getting an appointment	Travel to receive services	Convenience of appointment	Affordability	Access to appropriate care	Opportunities to see a specialist

			times			
Users (<i>n=43</i>)	3.5	3.3	3.5	3.9	3.7	3.4
Non-Users (<i>n=21</i>)	3.0	2.5	3.0	3.1	3.4	3.4

As shown, most of the ratings for both users and non-users fall within the mid-range of the satisfaction scale, except for Travel to Receive Services, which was rated by non-users at 2.5, indicating dissatisfaction with the travel distance to receive services. The unfavorable ratings of travel distance may be an indicator of why some of those who reported a service-connected medical condition also reported that they did not use the VHA for treatment of those conditions.

To further evaluate the sample population's perceptions of accessibility of VHA services, the accessibility ratings data were compiled and analyzed by county to determine if there were geographical differences in how access was rated. However, due to the small sample sizes ($n < 10$ for most counties), the results of this analysis were inconclusive and could not be used.

The following comments from survey respondents also indicate issues with access (Note: comments are presented verbatim and have not been edited for grammar or spelling):

- Provide more outreach centers in other parts of the state for veterans to receive care.
- More facilities and personal
- Have more advocates for veterans, to help them to know where to get started with the paperwork. Better help for those with any eating problems.
- More medical treatment stations situated throughout the states Providing a VA center closer to the North or allow better travel compensation due to increased fuel prices
- Fully equipped stations so there is less of a gap between doctor patient, and specialist patient appointments
- Have more access to health care services closer to home.
- More flexibility for people who live far from Togus.

- Shorter amount of time to receive medical appointments.
- More mental health, be there for the soldier
- Care at local clinics rather than traveling
- Travel pay for more appointments when having to see a specialist
- Yeah you could get me a doctor when I ask for one.
- Veterans should receive free health benefits. Open up more VA hospitals.
- Put a VA treatment center in Aroostook County so travel wouldn't be so far. Increase travel pay to better compensate for mileage with the increasing cost of fuel.
- More accessible. Drive 2 hours to nearest facility.
- VA center like Togus in Portland area.
- Have more healthcare services locations to meet veterans traveling needs
- More satellite locations
- Maintain the current level, plus expanding the VA clinics in Maine.
- Provide them with more locations to receive care.

From these comments, a majority of which suggest the need for additional VA facilities to minimize travel times, it appears that there may be gaps in services, and veterans may not perceive the current level of services and geographic dispersion of VA facilities and affiliated Vet Centers to be adequate to meet their needs.

However, during several of the key informant interviews, when asked if they felt that the VA was adequately addressing the health needs of veterans, they acknowledged the issues with travel distances and responded that they felt that the VA was adequately meeting veterans' health care needs. Key Informant 3, a VHA representative stated that with chronic disease, "the key is to engage patients in treatment and follow patients over the course of time. The VA is well-equipped to do that. We have the potential to have the patient throughout their lifetime."

Key Informant 3 also said that to address the geographic access challenges the VA is "doing a pretty good job of covering the state with outpatient clinics. . . We have reached a saturation point in where we can put primary care clinics." Key Informant 3 said that to justify each clinic, a patient population of at least 1,200 veterans is needed

for the two providers that would staff the clinic. Key Informant 3 also stated that telemedicine clinics and clinical video telehealth were additional tools that the VA has used to address the issue of geographic barriers to care for veterans and expand access. Key Informant 1, a veteran and veterans' advocate, also praised the VA's telehealth services. Key Informant 4, a VHA representative, also stated that the CBOCs are addressing the geographic barrier to care. "Generally, if you are in the VA healthcare system, we do a wonderful job, and we are making it more and more accessible. 20 years ago, if you needed care from the VA, you had to go to Togus. If you are in Caribou, etc. there are places where we are providing primary care and specialty care. We are doing our best to expand it so that it works. If you are in the government system, you have so much capacity and after this capacity is filled, you just need to wait your turn. If we can't find someone to take care of you in a reasonable amount of time, we will send you out to a specialist to get the care you need. In the government world, this is the decision of the provider rather than the insurance company. I really hesitate to think that anyone isn't getting good care, but there are times that you have to wait." "There is a transportation problem. If you want to get surgery, you may have to go to Togus or Boston, but if you have a [civilian] family member, they might have to go to Maine Med or Deaconness, so it's not that different." Key Informant 5, a VSO representative, said that the VA "had clinics all over the state to mitigate the geographic issue. . . There are reasonable and non-reasonable expectations. The VA does not have unlimited funds. If we had no restraint, I am sure that there are other things they could do. You have to be a good fiduciary of federal money and balance that with taking care of veterans."

Although some key informant interview responses indicate that the VA is adequately addressing veterans' health care needs or as well as it can within its limited resources, other key informant responses indicate that there are still barriers that prevent access to VA health services for Maine veterans.

Some key informants identified the entry process into the system is a barrier to care. Key Informant 2, a veteran and veteran's advocate, identified the enrollment application process as a barrier to care. "Many need a "buddy who can navigate the massive bureaucracy . . . it can be overwhelming – completing the health care (VA Form 10-10 EZ). Key Informant 1 stated "You have got to understand the VA system and you have to be service-connected in order for the problem to be treated."

Another barrier to care identified by key informants is the characteristics and culture of the veteran population themselves. Key Informant 5, a VSO representative, stated that for the aging veteran population “it is difficult for them to get out. They have to depend on friends and family for transportation. Once they are in the system, transportation is easier. The VA has transportation and Disabled American Veterans offers transportation.” Key Informant 5 also said that some veterans with psychological issues may be distrustful of the system and that it is challenging to work with them. Key Informant 2, a veteran and veterans’ advocate, stated that because of the predominantly male culture, it has been difficult to get women to go to the VA. Key Informant 2 also stated that however, women’s healthcare in the VA is getting better. “They now have a women’s clinic, a women’s veteran program manager and a women’s primary care doctor and a part-time ob/gyn. Women were going all the way to Boston for a simple gynecological surgical procedure. Now, the part-time ob/gyn does the procedures.” Key Informant 2 also said that “the degree to which a service member was disenfranchised while serving directly impacts the degree to which they will consider connecting with the VA and other government agencies. We hear this in one form or the other all the time when we do statewide outreach. Some would call this a self-inflicted wound, but it usually is not. It’s all about what did or did not happen while serving.” Key Informant 2 also said that the “whole psyche of the military man. Hypermasculinity [is the] most significant barrier to care.”

While technology was cited by some key informants as a tool for enhancing health care access for veterans, other key informant responses indicate that the VA’s use of technology can be a barrier as well. Key Informant 2, a veteran and veterans’ advocate, stated that those who “cannot or do not use computers are very left out of what is happening with the VA unless VA and veteran service organizations do community-based, grassroots outreach, have family members or friends who go on-line for them or they are already “users.” Key Informant 5, a VSO representative, stated that the age gap among veterans, from the younger population who regularly use smartphones to the elderly veterans who do not use computers, makes it challenging to communicate information about VA services. Key Informant 6, a VSO representative, said that the VA is “using innovative approaches to provide health services, but individuals who served after the 90’s are very well connected to the internet, but older veterans, it’s not as beneficial because their capacity to use the internet is not there. Their method of outreach is

very selective toward the younger population.” Key Informant 1, a veteran and veteran’s advocate stated that in regard to the telehealth mental health appointments “The first two or three appointments need to be in person so that the veteran can get comfortable with the person. The therapist needs to be able to read body language and the vet needs to be able to read the therapist’s body language. How can you get comfortable with someone when you are talking over a TV?”

In examining responses from key informants, it also appears that there may be issues with access to mental health providers. Key Informant 1, a veteran and veterans’ advocate, said that “accessibility is limited because the VA does not have enough mental health workers to handle the problem in its entirety. You’re hanging anywhere for 30 days to 6 months for an appointment . . .Mental health workers and psychiatrists are overbooked and you are limited to 15-20 minutes in their office. How can anything get done in that time?”

Consumer Satisfaction

Figure 4 shows the satisfaction and quality ratings of survey respondents with service-connected conditions who identified themselves as VHA users.

Figure 4: User Satisfaction Ratings (n=43)

Quality of healthcare received	Coordination of care with other services	Overall satisfaction
3.5	3.5	3.7

As shown, all satisfaction ratings fell within the mid- range, with overall satisfaction scoring slightly higher.

Comments from VHA user survey respondents reflect both favorable and unfavorable views of VHA health care services:

- Get new drs in Caribou. Secretarys are rude. Be there for use, not there wallet
- Be proactive, use past medical data to predict future healthcare needs. War produces physical and mental medical needs for the long term.

- Better coordination and communication between specialist @ Togus. Always feel like I'm pushed through appointments.
- Make it a better environment for veterans to seek healthcare. The visits are met by ignorant employees that feel they need to disqualify your every claim of a health issue at every chance. The system is not user friendly. Instead of allowing a pertinent amount of evidence to speak for itself they will deny you to the point of giving up. Thus leaving the soldier to search for alternative care on their own.
- The VA has been great and I am very thankful for them.
- Stay the course

Interviews with key informants also revealed both favorable and unfavorable views of VHA services. Key Informant 1, a veteran and veteran's advocate, stated that "If it wasn't for the social worker I was seeing in the VA, I would probably not be there today . . . The social workers are doing a hell of a job, but they are overwhelmed." However, Key Informant 1 stated in regard to other VHA providers: "The psychiatrist in the VA doesn't do a lot of therapy but writes a lot of prescriptions. Treat the pain but not treat the condition." Key Informant 2, a veteran and veterans' advocate, also mentioned the overprescription of pharmaceuticals: "The whole issue of psychopharmacology in the VA. I feel it is significantly abused. They are taking 15-20 pills. There is no coordination of care." In regard to quality of care, Key Informant 2 stated, "Can you go to the VA and assume it will be top of the line care? No. Can you assume it is all bad? No." Key informant 2 mentioned an incident at Togus where the podiatrist on staff wasn't really a podiatrist and had been performing surgeries for years on people. "This happens more often than you think. When that happened, they sent out a letter to patients of this individual: we will set you up with a non-VA physician to get an appointment and assess what needs to be done. The doctor wasn't a non-VA person, it was a VA doc out of Boston. The trust was gone in the first place, and this has compounded the distrust." Key Informant 2 also said that "there are good things going on, but you have these bad issues overshadowing them. The bad is usually really bad and it is not confidence building . . . It is a very old bureaucracy that can be entrenched in self-protection. Why would you be entrenched if you didn't have something to hide?" However, in regard to the Vet Centers, Key Informant 2 said that they "are phenomenally successful. They have a lot of saves."

Health Policy

During the key informant interviews, when key informants were asked what the federal government or the state of Maine could do to help improve access to VHA services for Maine's veterans or if they could recommend any models to help increase access, several key informants offered suggestions. Key Informant 1, a veteran and veterans' advocate said that the federal government could help to increase access by increasing the number of federal mental health specialists.

Key Informant 3, a VHA representative, suggested that the Department of Defense could provide assistance by doing a better job with sharing information with the VA. Key Informant 3 said it would help to have a shared electronic health record (Department of Defense and VA health records are currently separate systems), which would facilitate service-connected issues. Key Informant 3 stated that the State could help the VA with identification of eligible veterans because the State has records that the VA doesn't. The goal, according to Key Informant 3, is to have information about every veteran in Maine. Key Informant 3 also mentioned that other states, such as Washington, are not allowing veterans to enroll in Medicaid if they are a veteran and eligible for VA services. According to Key Informant 3, Maine does not have such a law. Key Informant 2, also mentioned the enrollment of VA-eligible veterans in Medicaid as an issue. Key Informant 3 suggested that the MaineCare applications, which have a check-off box where the applicant can indicate that they are a veteran, be more closely monitored so that veterans who are applying for Medicaid are directed to apply for VHA health services.

Key Informant 3 also suggested that in order to further address the geographic challenges of health service delivery in Maine, particularly in frontier areas, that the VA partner with local Federally Qualified Health Centers (FQHCs) to provide VA health care to veterans. FQHCs are comprehensive primary care centers that are located in underserved areas that receive federal funding to provide care to low-income and other vulnerable populations. According to Key Informant 3, the Maine VA has looked into this, but there are issues with mental health care with expertise in PTSD care lacking at FQHCs.

Key Informant 5, a VSO representative, suggested additional outreach services in the civilian healthcare system to get information about VA services to the veteran population. Key Informant 5 suggested installing a VA liaison at every hospital in the state, perhaps as an expansion of the veteran service officer program. However, Key Informant 5 stated that this would be challenging because you have to build that into the admissions procedure and would require agreements with health providers.

Key Informant 6, a VSO representative, suggested expanding upon existing transportation services to address geographic barriers. According to Key Informant 6, Disabled American Veterans currently provides transportation for veterans to travel to medical appointments; however, the transportation services are limited.

Conclusions/Recommendations

It is difficult to evaluate the overall accessibility of VA services for the 136,500 veterans living in Maine by analyzing opinions about VA health care services and accessibility from a small sample population of 155 Maine Army National Guard veteran soldiers and six interviews with key informants who are representatives of veterans' advocacy groups, VSO's and the VHA. However, although this analysis represents only a microcosm of Maine's veteran population, it brings to light some important issues, the most striking of which is the apparent disconnect between how VA representatives feel that the VA is adequately serving its veterans and how data obtained from veterans and their representatives shows that there is still much room for improvement. A survey of the entire veteran population of Maine was beyond the scope of this project; however, the VA and the State may have the resources to conduct such a needs assessment of a larger sample of the veterans living within the state of Maine so that state and VA officials may obtain adequate information about the accessibility of VA services for veterans in Maine and ensure that each veteran is receiving the care that they need.

However, analysis of the Maine National Guard survey results, key informant interviews and the veteran population and VHA facility maps do indicate that health and access issues in Maine's veteran population are similar to veterans nationwide. Similar to the national studies, service-connected mental health issues including depression and PTSD are prevalent among Maine's veteran population. Maine veterans are also experiencing

many geriatric and chronic health issues characteristic of an aging population. There also appear to be significant geographic barriers to accessing care despite the distribution of VHA facilities across the state. Based upon the results of this assessment, this report makes the following recommendations to increase access to VHA health services for Maine veterans:

- The VA should continue to work with the Maine Primary Care Association to examine the possibility of contracting with FQHCs to provide VHA health care services to veterans not currently being served by existing VHA facilities. Based on the gaps in service identified by the service area map analysis, potential contracts should include the following FQHCs:
 - Sebasticook Family Doctors, Dover-Foxcroft (Piscataquis County), Pittsfield (Somerset County), Dexter and Newport (Penobscot County)
 - Harrington Family Health Center, Harrington (Washington County)
 - Bucksport Regional Health Center, Bucksport (Hancock County)
 - Sacopee Valley Health Center, Kezar Falls (York County)
 - Bethel Family Health Center, Bethel (Oxford County)

A map showing how contracting with these FQHCs may fill in some of the gaps identified in the primary care service area analysis for VHA facilities (see **Attachment E**) is included as **Attachment G**. The same 30-minute drive time radius guideline was applied to the FQHCs in generating this map.

- The VA should look into contracting with acute care hospitals, particularly in the northern and eastern Maine counties to provide VHA hospital services to address the distance of the Maine VA Medical Center from these areas.
- The VA should work with transportation providers, such as Disabled American Veterans and other organizations (perhaps Kennebec Valley Community Action Program and Penquis Community Action Program) to provide transportation services to veterans in areas where services are not currently available.
- The VA should continue to work with the state of Maine to identify veterans who may be eligible for but not currently receiving services, particularly those veterans who are enrolled in Medicaid.

- In addition to continuing to provide innovative ways of providing care and outreach through technology, the VA should also look into non-technological ways to provide outreach and care, especially for older veterans who may not be as computer literate as the younger veteran population.
 - Non-technological methods of outreach could include distribution of written materials at American Legion and Veterans of Foreign Wars (VFW) halls, mailings to veterans regarding VA benefits, or presentations by VA representatives at American Legion and VFW halls, or other locations where veterans gather.

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Maine Veterans Health Care Survey Questions Outline

1. What Maine county do you live in?

2. What is your age group?

18-25 46-55

26-35 56-65

36-45 66 or over

3. What is your gender?

Male Female

4. Which wars/conflicts have you served in? (Please check all that apply)

World War II

Korean Conflict

Vietnam

Persian Gulf War

Afghanistan

Iraq

Other (Please specify) _____

5. Do you currently have a medical condition that is connected to your military service?

Yes No

6. If yes, is it physical, mental, or both?

Physical Mental Both

7. Do you receive medical treatment from the U.S. Veterans Administration (USVA) for this condition?

Yes No

8. At which USVA facilities do you receive treatment? (Please check all that apply)

- Togus VA Hospital
- Community-Based Outpatient Clinic
- Vet Center
- Private provider (through fee-based care)
- Boston VA Hospital
- Other (Please specify) _____

9. Please rate your overall USVA medical care on a scale of 1 to 5, with 1 being NOT SATISFIED, and 5 being VERY SATISFIED

	Not Satisfied (1)	(2)	(3)	(4)	Very Satisfied (5)
Ease of getting an appointment					
Travel to receive services					
Convenience of appointment times					
Affordability					
Access to appropriate care					
Quality of healthcare received					
Opportunities to see a specialist					
Coordination of care with other services					
Overall satisfaction					

10. Please tell us what the federal government could do to improve healthcare services for veterans.

11. Please tell us what the state of Maine could do to improve healthcare services for veterans.

Key Informant Telephone Interview Informed Consent Script

HPM Capstone: An Assessment of the Health Needs of Maine Veterans and Their Access to Veteran's Administration Health Care Services

Hi, my name is Kristin Brawn. I am a graduate student at the University of Southern Maine, Muskie School of Public Service, pursuing an M.S. degree in Health Policy and Management. I am currently working on my master's capstone project, An Assessment of the Health Needs of Maine Veterans and Their Access to Veteran's Administration Health Care Services. The purpose of this project is to examine the health care needs of and accessibility of U.S. Veterans Administration health services for Maine's veterans. As part of this project, I am planning to interview key informants from the VA, veterans' organizations and veterans' advocacy groups who have expertise in Maine veterans' health issues and the accessibility of VA health care services for Maine's veterans. Through my preliminary research, you have been identified as a potential key informant for this project.

Your participation in this project is voluntary. If you decide to take part in this project, you will be asked to answer a series of questions about veterans' health care needs and veterans' access to U.S. Veterans Administration Health Services. The duration of the interview will be approximately 30 to 45 minutes.

There are no foreseeable risks associated with participation in this study. There are no direct benefits to you for participating in this study. There are no costs associated with this study.

There are safeguards in place to ensure your privacy and confidentiality of the data you provide. You will be interviewed in a location which ensures privacy. The results of the project will be published by the University of Southern Maine as a Muskie Capstone project; however, the results of the project will not contain any personally identifying information.

This study is designed to be anonymous, this means that no one, can link the data you provide to you, or identify you as a participant. Research records will be kept confidential. Research records will be kept in a locked file in the locked office of the principal investigator. Data will be coded. No individually identifiable information will be collected.

Please note that the Institutional Review Board may review the research records.

The following are your rights as a research participant:

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University.
- You may skip or refuse to answer any question for any reason.
- If you choose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive. You are free to withdraw from this research study at any time, for any reason. If you choose to withdraw from the research there will be no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You may choose not to participate.

The researchers conducting this study are Kristin Brawn and David Hartley, PhD. M.H.A., Faculty Advisor. For questions or more information concerning this research you may contact David Hartley at 207-780-4513, davidh@usm.maine.edu

If you choose to participate in this research study and believe you may have suffered a research related injury, please contact David Hartley, Ph.D., M.H.A., 207-780-4513, davidh@usm.maine.edu

If you have any questions or concerns about your rights as a research subject, you may call the USM Human Protections Administrator at (207) 228-8434 and/or email usmirb@usm.maine.edu.

Do you have any questions? Do you agree to participate in this study?

Yes: Document oral consent below and continue with the interview questions.

No: Thank them for their time.

Name of Subject:

Person Obtaining Consent

I have read this form to the subject. An explanation of the research was given and questions from the subject were solicited and answered to the subject's satisfaction. In my judgment, the subject has demonstrated comprehension of the information. The subject has provided oral consent to participate in this study.

Name (Print)

Signature of Person Obtaining Consent

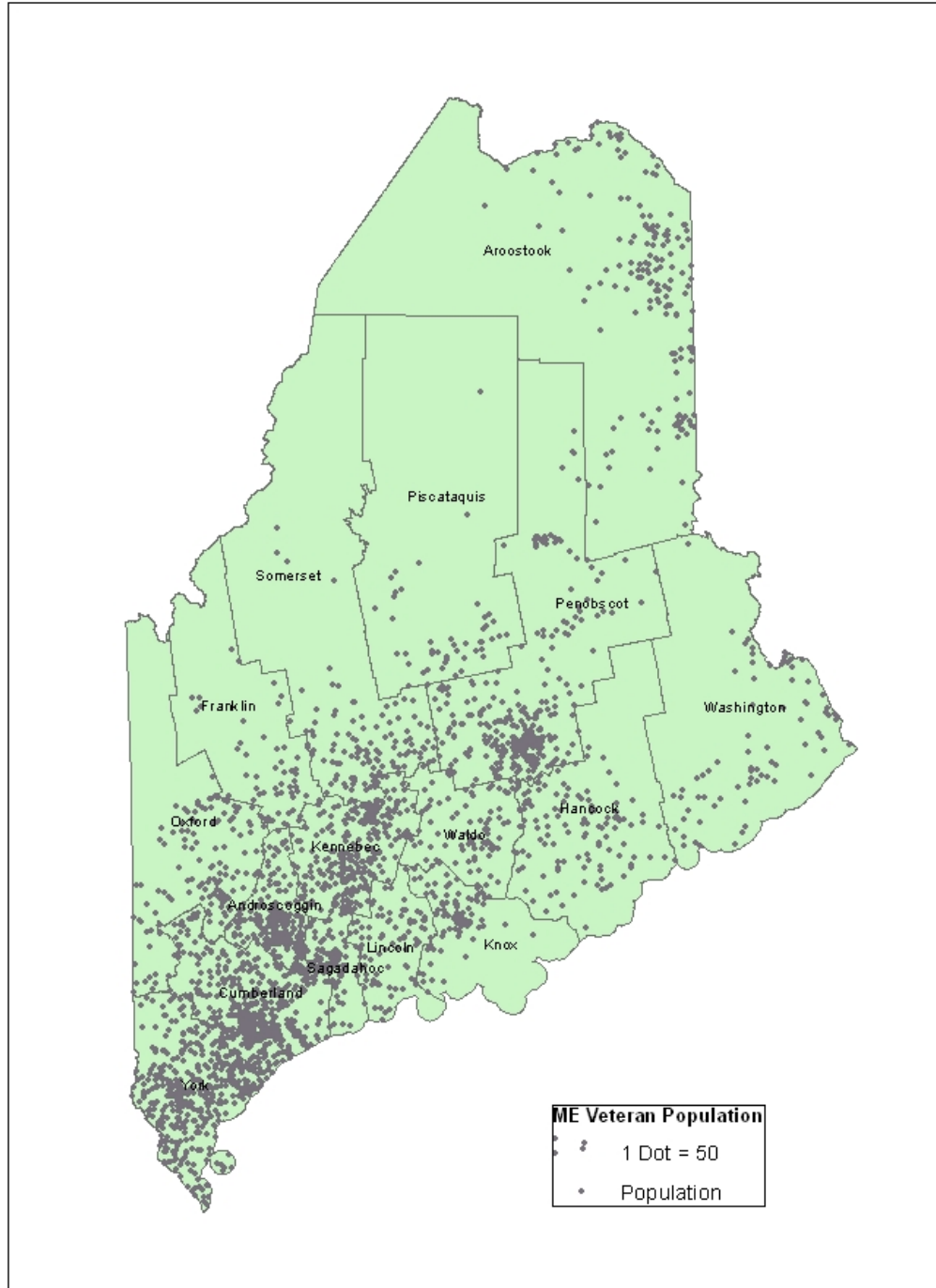
Date

**HPM Capstone Project: An Assessment of the Health Needs of Maine Veterans and Their Access to
Veteran's Administration Health Care Services**

Key Informant Interview Questions

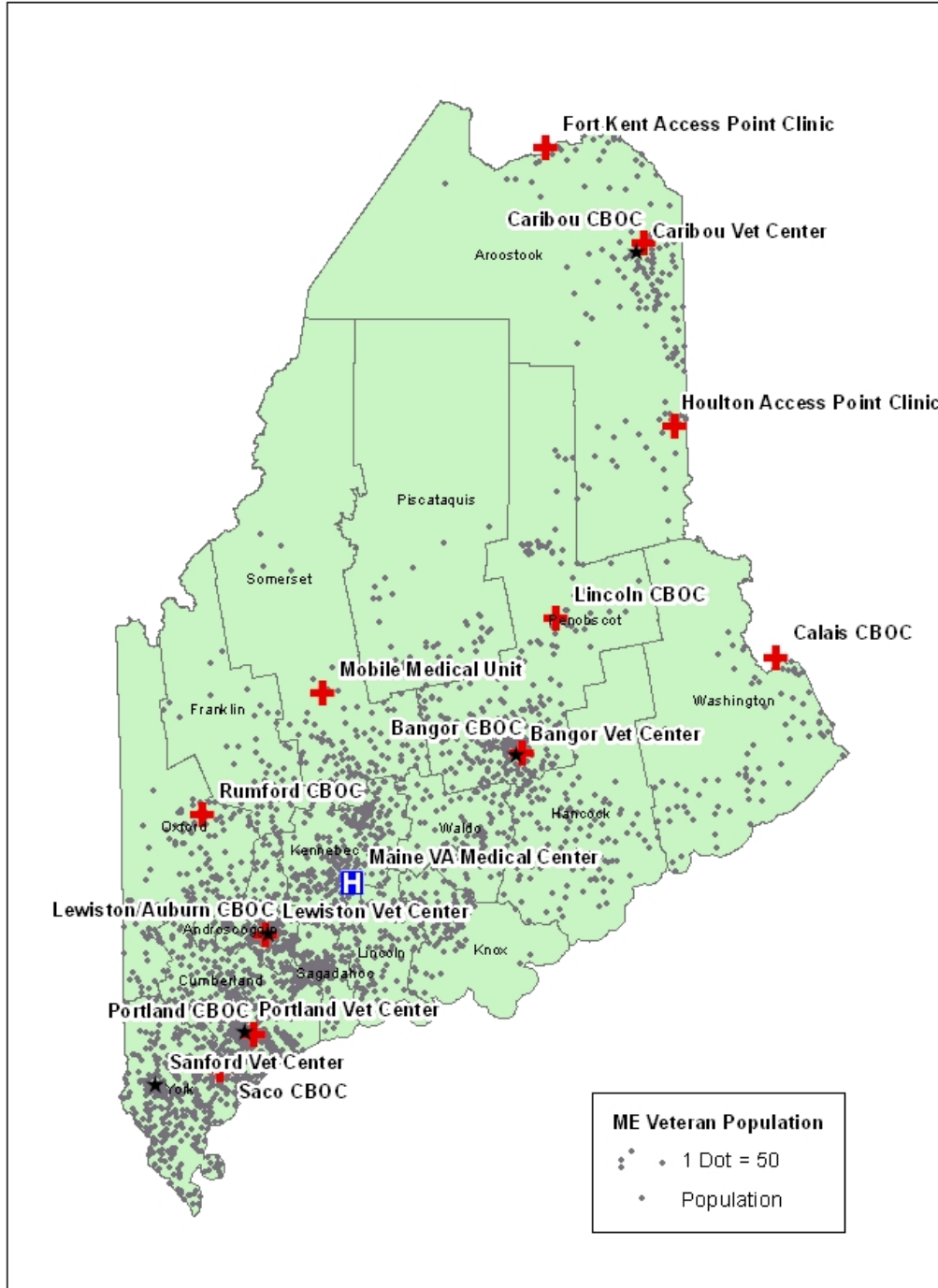
1. What do you see as the most common health issues for veterans in the state of Maine?
2. Do you feel that the health services of the Veterans Administration (VA) adequately address those needs?
Why or why not?
3. Please identify issues with accessibility or barriers to care for VA services.
4. How can the federal government or the state of Maine address these barriers or issues with access?
5. Can you identify any state or national models to help increase access?

Maine Veteran Population Density Map



Sources: 2006-2010 American Community Survey 5-Year Estimates, Table S2101: Veteran Status; U.S. Census, TIGER/Line Shapefiles (<http://www.census.gov/geo/maps-data/data/tiger-line.html>)

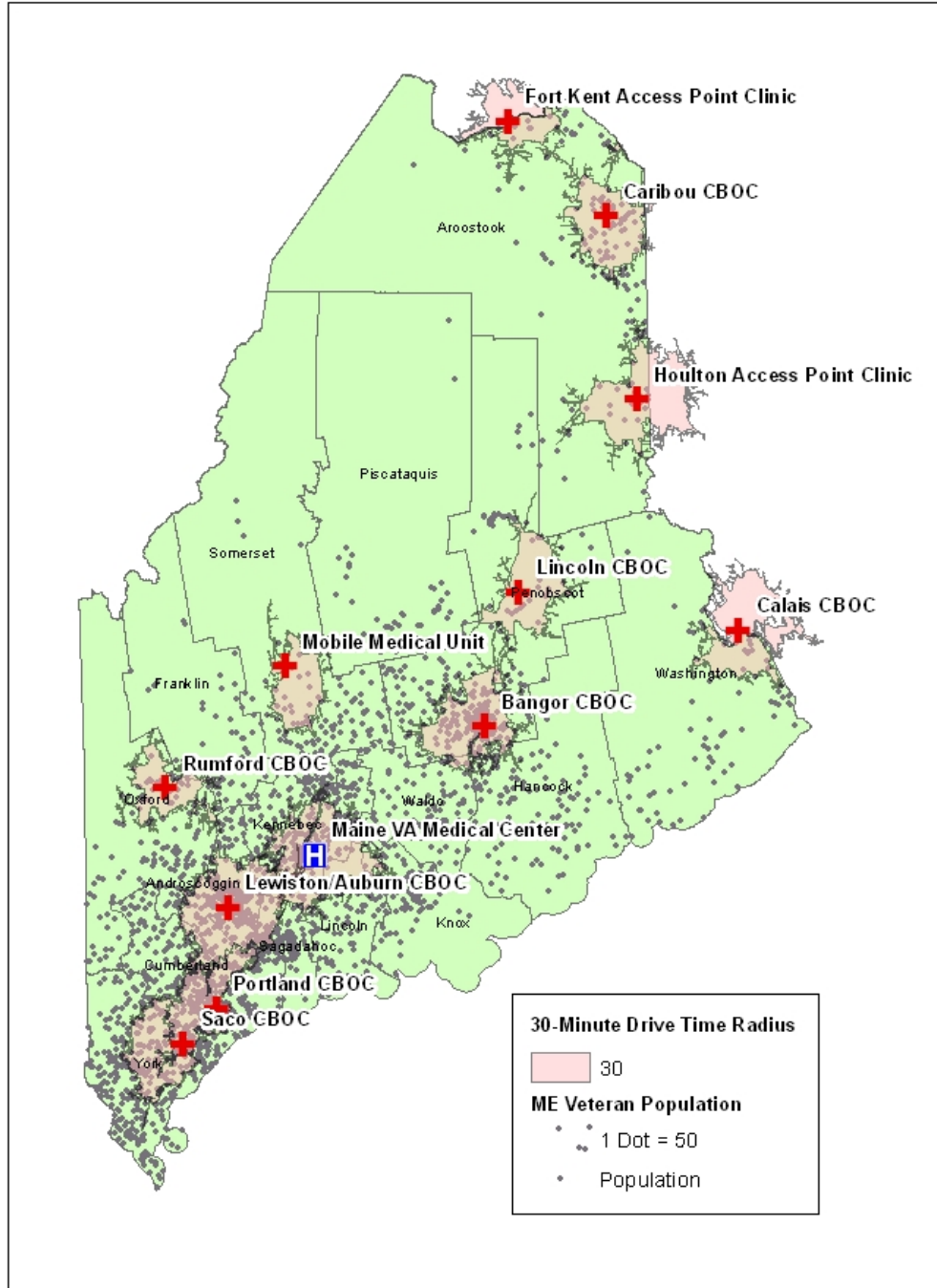
Map of Maine VHA Facilities



Sources: 2006-2010 American Community Survey 5-Year Estimates, Table S2101: Veteran Status; U.S. Census, TIGER/Line Shapefiles (<http://www.census.gov/geo/maps-data/data/tiger-line.html>); U.S. Department of Veterans Affairs, Maine VA Healthcare System (<http://www.maine.va.gov/>)

Attachment E

Map of VHA Primary Care Facility Service Areas within a 30-Minute Drive Time Radius



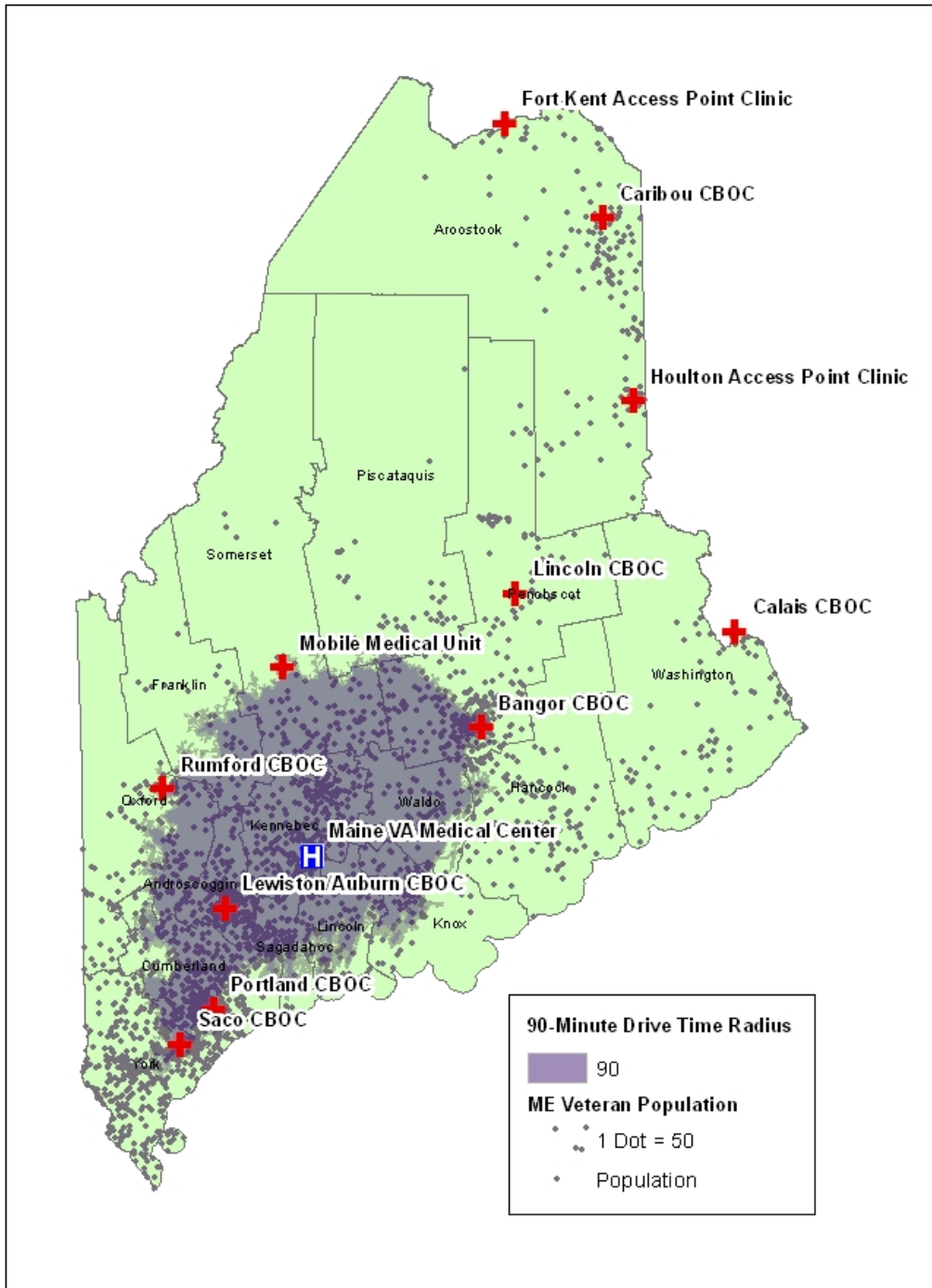
Attachment E

Sources: 2006-2010 American Community Survey 5-Year Estimates, Table S2101: Veteran Status; U.S. Census, TIGER/Line Shapefiles (<http://www.census.gov/geo/maps-data/data/tiger-line.html>); U.S. Department of Veterans Affairs, Maine VA Healthcare System (<http://www.maine.va.gov/>); ArcGIS Online, Network Analysis Service, Esri (<http://www.esri.com>)

Attachment E

Map of Maine VA Medical Center Service Area within a 90-Minute Drive Time Radius

Attachment E



Sources: 2006-2010 American Community Survey 5-Year Estimates, Table S2101: Veteran Status; U.S. Census, TIGER/Line

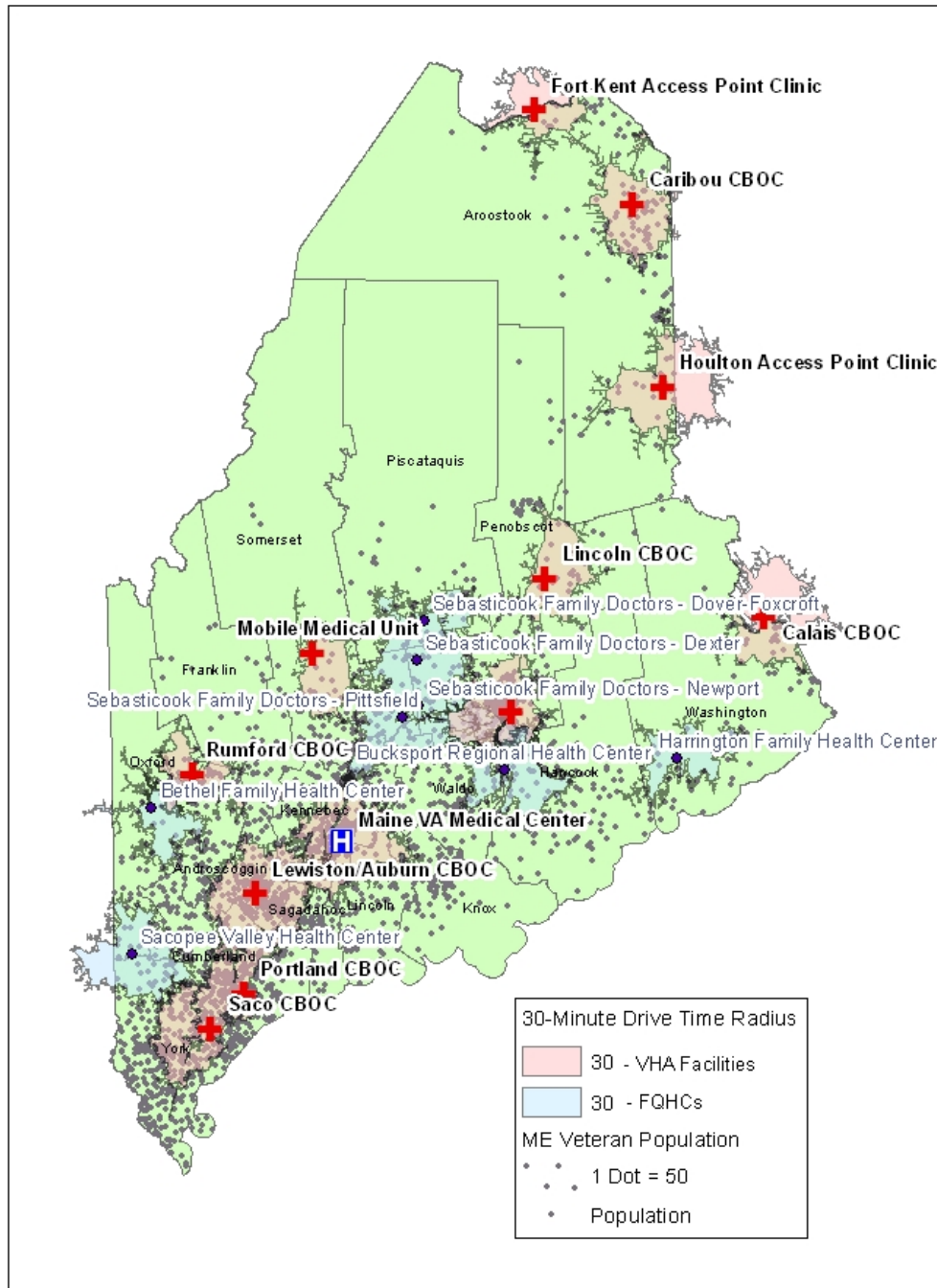
Attachment E

Shapefiles (<http://www.census.gov/geo/maps-data/data/tiger-line.html>); U.S. Department of Veterans Affairs, Maine VA Healthcare System (<http://www.maine.va.gov/>); ArcGIS Online, Network Analysis Service, Esri (<http://www.esri.com>)

Attachment E

**Map of VHA Primary Care Facility Service Areas and FQHC Service Areas
within a 30-Minute Drive Time Radius**

Attachment E



Sources: 2006-2010 American Community Survey 5-Year Estimates, Table S2101: Veteran Status; U.S. Census, TIGER/Line Shapefiles (<http://www.census.gov/geo/maps-data/data/tiger-line.html>); U.S. Department of Veterans Affairs, Maine VA

Attachment E

Healthcare System (<http://www.maine.va.gov/>); ArcGIS Online, Network Analysis Service, Esri (<http://www.esri.com>); Health Resources and Services Administration Data Warehouse (<http://datawarehouse.hrsa.gov/>)