

Palliative Care Rural Initiative Dissemination Model and Implementation Guide

Veterans Integrated Service
Network (VISN) 23
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I. Project Overview

In 2011, The National Rural Health Resource Center (The Center), a national nonprofit organization based in Duluth, MN, was awarded a contract from the Department of Veterans Health Administration, Veterans Integrated Service Network (VISN) 23, which covers states in the Upper Midwest Region, including Iowa, Minnesota, Nebraska, North Dakota, South Dakota, along with portions of Illinois, Kansas, Missouri, Wisconsin and Wyoming. The contract, Palliative Care Rural Initiative (PCRI) was designed to address end-of-life care for Veterans in rural areas.

The following guide articulates the procedures created from the Palliative Care Rural Initiative (PCRI) project and is intended to serve as a framework for replicating the PCRI project within other VISNs across the country. This guide also captures the best practices and lessons learned from five community hospice organizations that strived to create awareness of the unique end-of-life care needs of Veterans living in rural communities.

The primary motivation for developing the PCRI project is to address the grave concern that one out of every four dying Americans is a Veteran; yet 96% of Veterans are cared for outside of the Veterans Affairs (VA) health care network, according to the National Hospice and Palliative Care Organization. This means, the majority of Veterans are cared for by hospice and health care professionals in their home town. If you are a rural community health care provider, are you aware that 25% of the men and women you are caring for at the end-of-life, has likely served in our **Country's military? Do you know** how to best serve the unique end-of-life care needs of these Veterans?

As health care providers, we work diligently to assess each patient as an individual and deliver high quality, customized care. No time is more crucial to provide this level of customized service than hospice, where treatment is designed to relieve symptoms and provide comfort and support to individuals with life-limiting illnesses. It has been pointed out time and again that when people reach the last chapter of their life journey, there is a natural tendency to reminisce, resolve issues, and reference previous experiences of emotional **intensity, including one's history in the military.**

Unique End-Of-Life Care Needs of Rural Veterans

Both research and evidenced-based practices **demonstrate that one's military** history can exacerbate physical, psychological, social and spiritual symptoms of a patient towards end-of-life. For instance, Vietnam Veterans may still be **suffering from "trench foot"**- a bacterial infection of the feet from walking in wet conditions; symptoms of Post-Traumatic Stress Disorder may surface; social isolation and distrust towards authority may develop from the lack of support upon readjusting from military to civilian life; and spiritual questions may arise now that the individual is encountering death outside of the battle

field; as noted by the Department of Veterans Affairs. Some of the contributing factors cited by the VA that may influence a Veterans behavior and response towards end-of-life care include:

- Entry status: enlisted or drafted
- Branch of service and rank
- Combat or non-combat experience
- Type of war or time served
- Prisoner of War experience
- Post-Traumatic Stress Disorder experience

For health care providers, being aware of an individual's military history and the elements for which the Veteran was exposed could assist in proper diagnosis and intervention as there are many challenges in meeting the unique end-of-life care needs of Veterans, not only from a clinical standpoint, but also from a system-wide perspective, including:

- Accessing care at a VA facility is difficult for rural Veterans as the distance and travel time can be costly and laborious
- If inpatient care is provided at the VA, rural Veterans may not be surrounded by family and friends during their remaining months
- Navigating the VA system and the correct entry point of contact can be confusing
- Understanding VA benefits and enrollment procedures is complicated
- Coordinating and transitioning care between the VA and local providers is not well established in many areas
- Receiving timely, accurate VA reimbursement for services as a provider can be cumbersome

Contrary to common logic, "rural" does not equate to "small urban," and the needs of Veterans living in rural communities are very unique. Disparate access to specialty health care, long travel times to VA facilities, coupled with transportation challenges, makes accessing health care for Veterans in rural communities difficult.¹ Statistically, rural Veterans also have fewer financial resources than their urban counterparts. Also, in general, patients living in rural areas tend to struggle with challenges, especially economic challenges, due to unemployment, lack of health insurance, lower education levels, and overall poorer health statuses. That is compounded with rural Veterans who are dealing with combat-related stressors and diseases, including post-traumatic stress disorder (PTSD).

VISN 23 is a highly rural VISN. As of March 2012, there were 423,172 enrolled Veterans in VISN 23.² The total (i.e., non-enrolled and enrolled) Veteran population of VISN 23 is projected to be 939,163, meaning an

¹ Department of Veterans Affairs, Health Services Research & Development Service, Forum October 2010. <http://www.hsrp.research.va.gov/publications/forum/oct10/oct10-1.cfm>

² Department of Veterans Affairs, Veterans Health Administration, VISN Support Services Center (VSSC). (2012). Current Enrollment, Enrollment Priority 1 to 8D [Data file]. Retrieved from <http://vssc.med.va.gov>

estimated 45% of the total population is currently receiving VA benefits.³ Of the enrolled Veterans, 64% (274,467) are rural with the majority (81% or 223,383) living in counties where less than 10% of the Veteran population is urban. The VISN 23 counties with the largest numbers of rural/highly rural enrolled Veterans are Blue Earth, MN (4,696); Hancock, IL (3,477); Sibley, MN (3,229); Pepin, WI (3,014); and Cass, IA (2,709). Because the area is so large and VISN 23 is the third most rural VISN, issues facing the rural Veterans in VISN 23 are significant and the need to address those issues is amplified.

Opportunities to Improve Veterans Needs

The Center's contract with VISN 23 was designed to develop a Palliative Care Rural Initiative (PCRI) that implements care coordination models that effectively serve the unique health care needs of a rural Veteran requiring end-of-life care. Through collaborations with five community hospice organizations in the Upper Midwest Region of the United States, (VISN 23), the project goals were to enhance communication, coordination and streamline community hospice services for Veterans residing in rural communities by implementing various models of care in rural communities. Specific deliverables of the contract included:

- Conducting a needs survey in VISN 23 and detailed briefing;
- Identifying four community hospice organizations and the care coordination model selected and one organization with a new model of care;
- Describing at least three outcome measures, strategies, and timelines selected by the communities and methods to measure outcomes;
- Preparing quarterly and final reports utilizing project tracking and outcome evaluations on community hospice activities;
- Detailing the current reimbursement system and strategies to improve the reimbursement mechanisms between the VA and each community partner;
- Completion of a final report with the model implemented by each organization, the successes and challenges faced and the outcome measures achieved by each community partner, and
- Development of a dissemination model and implementation plan.

Administration of a Veterans Community Hospice Care Survey

The process began with The Center staff conferring with the VISN 23 hospice and palliative care division to design and distribute a Veterans Community Hospice Care Survey to assemble information from community hospice organizations regarding:

- Location and type of hospice facility

³ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. (2007). VetPop 2007 [Data file]. Retrieved from http://va.gov/vetdata/Veteran_Population.asp

- Awareness of hospice services available to Veterans
- Level of interest in receiving funding to support a local Veterans hospice initiative.

The survey was sent electronically to community hospice organizations identified within a database of hospice and palliative care organizations within the VISN 23 region. The survey was also sent to VA staff, State Offices of Rural Health, State Hospice Associations, State Hospital Associations, State Aging and Resource Centers, State Hospice Veteran Partnership contacts and rural health networks across the VISN 23 region for their awareness, support, and leadership in forwarding on the survey to community hospice organizations. VISN 23 covers states in the Upper Midwest Region, including Iowa, Minnesota, Nebraska, North Dakota, South Dakota, along with portions of Illinois, Kansas, Missouri, Wisconsin and Wyoming.

One hundred and one surveys were completed providing a 42% response rate of the 270 surveys sent. Based on the sample size, surveyors are 95% confident that the responses are representative of the service area population, with a margin of error of 7.33%. The majority of respondents appeared to provide hospice services to a geographic area of 6+ counties, many of which lie in rural communities where they report driving 11-30 miles one-way to reach Veteran patients requiring hospice care. Many of the **respondents' are affiliated with a hospital or medical system** and contract with their local hospital or clinic for general inpatient care for Veterans.

Survey respondents have observed an increase in patient referrals from VA staff over the past two years and 64% (n=64) rank the coordination of hospice, nursing home, or respite care with the VA as either good or very good. Respondents rank the process of seeking reimbursement for care from **the VA as good. However, respondents' ability to use the Military History Checklist** within their current hospice documentation /software was rated as very poor. This could be viewed as an opportunity to create awareness and improve education of this tool. Eighty three respondents requested information to apply for the funding opportunity to develop or expand care coordination models for the Veteran hospice or end-of-life care organization.

Community Hospice Selection

Upon analysis of the survey results, The Center electronically distributed a Request for Proposal within 23 through state offices of rural health, state hospice associations and state Hospice Veteran Partnership groups. Rural community hospice organizations were invited to complete a brief, competitive online application aimed towards enhancing communication and coordination of care for rural Veterans using one of the Reaching Out Care Models, designed by the National Hospice of Palliative Care Organization.

Eligible organizations for the project funding included these types:

- Free-standing hospice agency
- Hospice within a home health agency
- Hospice is part of a hospital or medical system
- Other (applicants must be nonprofit or local government entities offering hospice and/or palliative care)

Appropriate activities within the four Reaching Out Models for the PCRI funding included:

- Meeting facilitation
- Staff time for building collaborations, partnerships and training Veteran volunteers
- Meeting expenses (space, speaker fees, AV) for training sessions
- Staff, manager and/or volunteer training
- Projects or engaging specialized consultants for identifying needs related to building collaborations and partnerships and reimbursement
- Projects or engaging specialized consultants to assist with planning and implementation of evidence-based strategies for improving quality
- Assessing and implementing Veterans hospice needs and improvements such as:
 - Disparities in access or outcomes
 - Discharge planning or other continuum of care projects
- Development of new models for local and regional systems of hospice care for rural veterans
- Development and dissemination of educational materials

Organizations awarded the contract were selected by a review committee based on their applications which demonstrated diversity in their selection of the Reaching Out Care Models, a variety of states in the region, a presence of rural Veterans, positive leadership, capacity to address a new initiative, and geographic location.

The five organizations selected were:

- HealthConnect at Home—Grand Island, NE
- Hospice of Siouxland—LeMars, IA
- Hospice of Southwest Iowa—Council Bluffs, IA
- Lakewood Health System—Staples, MN
- Regional Hospice Services, Inc.—Ashland and Hayward, WI

These facilities all demonstrated an ability and commitment to build replicable and sustainable methods of collaboration between the VA and rural community hospice providers to address the challenges of meeting Veterans hospice needs. The experience with community partner collaboration was limited for one of the organizations and the knowledge of successful marketing and outreach methods varied from strong to weak. The Center staff coached the organizations that exhibited challenges with these activities and shared approved PCRI outreach materials across the communities.

Rural Community Hospice Model Organizations for PCRI

The five community hospice organizations represented not only a variety of states in VISN 23 and 4 different care coordination models, but also diversity in the type of hospice organizations. Rural health care delivery is generally structured through formal and informal collaborations to maximize limited resources of workforce, funding, transportation, volunteers and equipment. Within the PCRI project, the selected organizations included a hospice within a Critical Access Hospital health system, a regional hospice organization representing three hospices affiliated with five Critical Access Hospitals, two community hospices owned by a health system and one non-profit standalone community hospices. They had a varied amount of previous experience in serving rural Veterans in hospice care with some already active in the We Honor Veterans program of the National Hospice and Palliative Care Organization (NHPCO).

Tracking PCRI Outcomes

The Center worked with VISN 23, the PCRI community organizations and the contracted evaluator to develop outcome measures. The contract required at least three specific outcome measures to target the specific models and reimbursement measures, a total of 60 measures. The areas of measurement represented:

- VA referrals to Community Hospice Care
- Non-VA referrals to hospice care
- Veteran enrollment in hospice care
- Non-VA hospice care
- Staff/volunteer participation
- Quality of care measures
 - Protocol compliance (use of Military History Checklist)
 - Family satisfaction
 - Outreach measures
 - Partnership collaboration measures
- Reimbursement measures
 - Timeliness of invoicing and payment
 - Timeliness of changes/modification to level of care in VA paid hospice
- Specific community measures
 - Number of Native American Veterans who are also enrolled in Indian Health Services
 - Number/percent of Veterans receiving peer volunteer service
 - Number of Veteran volunteers recruited and trained
 - Number of Veterans referred by VA to community palliative care
 - Number of Veterans transferred from community palliative to community hospice care
 - Number of Veterans receiving VA-paid palliative care

VA Structure and Variability between VA Facilities' Programs

As the PCRI project occurred within a VISN which is a component of the VA, Veterans Health Administration (VHA) Central Office, the activities were important to coordinate with the VA Medical Facility, Hospice and Palliative Care Interdisciplinary Team. The VISN 23 Contract Officer Technical Representative and VISN 23 Hospice and Palliative Care Coordinator developed an overview of the structure for project activity communication within these levels of the VA and created a fact sheet for each community with the nearest VA Medical Center, Hospice and Palliative Care Contact, description of the hospice program at the VA Medical Center, the contact for expedited benefits enrollment and hospice care approval and the County Veteran Service Officer contact for the county to be served or state. The overview and fact sheet were presented to each community hospice organization on a kick-off call for the project. It is critical for the success of the implementation of the model, for the community hospice to have an introduction to the VA Medical Center and Community Based Outpatient Clinic facilitated by the VISN Hospice and Palliative Care Coordinator.

What is Hospice and Palliative Care?

Hospice care is care provided to people facing a life-limiting illness or injury. Hospice's utilize a team-based approach to expert medical care, pain management, and emotional and spiritual support uniquely tailored to the **patient's needs and wishes.**⁴ Support is also provided to the family members and loved ones of the patients. Hospice care is based on the premise that everyone has the right to die with dignity and without pain. Hospice care can be administered in a patient's home or in a variety of care settings.

Palliative care extends the hospice care model to individuals earlier in their illness or disease process than hospice patients. Ideally, palliative care services would seamlessly tie into hospice services as the disease progresses.

Recommendations for Improving Rural Veterans End-Of-Life Care

- Implement the Military History Checklist upon intake
- Utilize resources from www.wehonorveterans.org
- Become a We Honor Veterans partner
- **Connect with the VA's entry point of contact**, County Veteran Service Officers, to seek eligibility criteria for enrolling a Veteran in the VA
- Build professional and organizational capacity to provide quality care for Veterans

⁴ National Hospice and Palliative Care Organization. Accessed: <http://www.nhpco.org/i4a/pages/index.cfm?pageid=4648>

- Develop and/or strengthen partnerships with VA and other Veteran organizations
- Increase access to end-of-life services for Veterans in your community
- Network with other providers to learn about best practices and models

II. Reaching Out Models

Community-Based Outpatient Clinic (CBOC) Program

Description: The purpose of the Community-Based Outpatient Clinic (CBOC) Program is to increase Veterans' access to hospice and palliative care services, with a special emphasis on those who are homeless and living in rural areas. The program will collaborate with the local VA CBOC to develop protocols for referring, enrolling, transitioning, and providing services for eligible Veterans; create a coalition of VA and community health care providers, homeless shelters, government and nongovernment organizations, Veterans groups and others to address issues faced by area Veterans and returning soldiers; and conduct outreach activities to inform the community about Veterans and the benefits to which they may be entitled.

Suggested objectives:

1. Establish protocols for health care and hospice referrals, admissions, transitions across care settings, enrolling eligible Veterans in VA, and reimbursement for VA-paid community services
2. Inform and engage hospice staff about the special needs of Veterans, especially those who have experienced combat, dangerous duty assignments or traumatic events
3. Create a coalition of VA and community organizations, including agencies that serve homeless and rural areas, to address issue-area Veterans and returning soldiers
4. Disseminate educational materials that can be used by VA and community agencies to help resolve challenges facing area Veterans and their families.

Target population: Veterans living in the service area with an emphasis on those who are homeless and living in rural areas

VA partners: Community-Based Outpatient Clinic (CBOC) staff, VA staff from the Palliative Care Program and others working in a VA facility; Veterans Integrated Service Network (VISN) palliative care leaders; Vet Centers and Mobile Vet Centers

Community partners: Community health care providers and service organizations, government agencies, County Veteran Service Officers; Veterans Service Organizations; State Veterans Homes

Potential outcomes/measure of success:

- Protocols will be established, tested and refined for the following processes: referrals to and from VA and the hospice agency; transitions between VA and community settings, particularly for respite and General Inpatient levels of care; expedited enrollment in VA; expedited approval of VA-paid hospice services; billing procedures for reimbursement of VA-paid hospice services; procedures for providing concurrent community hospice and VA-provided services
- Provide education/outreach presentations that include some **information about Veterans' end-of-life** benefits will be conducted
- Veteran-specific presentations for hospice staff will be conducted
- Process in place to identify Veterans upon admission and include Veteran-specific interventions in individualized care plan
- A minimum of one staff member will be appointed as a Veteran liaison

Community Partnership Program

Description: The purpose of the Community Partnership Program is to increase community and hospice staff awareness of Veterans and establish educational and outreach programs to address their specific end-of-life needs. This comprehensive program uses a community partnership model to educate Veterans about the VA hospice benefit and community resources, advocate for local hospices to implement the military history checklist to identify their Veteran patients, assist first responders and homeless shelter staff, identify Veterans in need of hospice and palliative care services, help health care and community groups identify at-risk Veterans and teach them how to connect Veterans to needed services, and publicize community resources.

Suggested objectives:

1. Raise awareness of community health care and service providers, first responders, and other community organizations about Veterans living in a defined geographic area, the unique end-of-life needs they may have and the benefits to which they may be entitled
2. Disseminate educational materials that can be used by VA and community agencies to help Veterans access services and benefits
3. Inform and engage hospice staff about the special needs of Veterans, especially those who have experienced combat, dangerous duty assignments or traumatic events
4. Develop mechanisms to facilitate the transition of Veterans across community and VA settings
5. Address reimbursement of VA-paid community services

Target population: Veterans living in the service area with an emphasis on those who are homeless and living in rural areas

VA partners: VA staff from the Palliative Care Program and others working in a VA facility; Community-Based Outpatient Clinics; Vet Centers

Community partners: Emergency Medical Services; fire departments; police departments; government agencies; community hospitals/emergency departments; County Veteran Service Officers; Veterans Service Organizations; State Veterans Homes; other community organizations and health care providers

Potential outcomes/measure of success:

- Provide education/outreach presentations that include some **information about Veterans' end-of-life** benefits will be conducted
- Veteran-specific presentations for hospice staff will be conducted
- **Relationships with** first responders will be established to facilitate identification of Veterans who are homeless or in need of assistance from VA and to provide information about available resources
- **Protocols with a VA facility will be established to expedite enrollment** for eligible Veterans and facilitate approval of hospice services, transitions across care settings, and billing procedures for VA-paid community services
- **Processes will be established to identify Veterans upon admission** and include Veteran-specific interventions in individualized care plans
- **A minimum of** one staff member will be appointed as a Veteran liaison

Community Foster Home Hospice Program

Description: The purpose of the Community Foster Home Hospice Program is to provide a home environment where terminally ill Veterans can live with the support of a committed family, community and VA medical professionals, friends and volunteers. This project recruits and utilizes private homes in the community that meet the needs of terminally ill Veterans. A support team that includes the home host, hospice professionals, family, friends and **volunteers works together to meet Veterans' needs and care for them** through the end of life. The Veteran pays room and board to the host based on the amount of his/her income. This project requires close collaboration with the local VAP Care Program and other staff as designated by VA.

Suggested objectives:

1. Establish comprehensive policies and procedures for the Community Foster Home Hospice Program
2. Establish processes for collaborating with the local VA facility or Community Based Outpatient Clinic
3. Recruit, screen and train host families
4. Develop outreach activities to market the program to potential referral sources, including community organizations, health care providers, government entities and Veterans organizations

5. Inform and engage hospice staff about the special needs of Veterans, especially those who have experienced combat, dangerous duty assignments or traumatic events
6. Develop mechanisms to facilitate the transition of Veterans across community and VA settings
7. Address reimbursement of VA-paid community services

Target population: Veterans living in the service area with an emphasis on those who are homeless and living in rural areas

VA partners: VA staff from the Palliative Care Program and others working in a VA facility; Community-Based Outpatient Clinics; Vet Centers

Community partners: Community health care providers and service organizations, government agencies, County Veteran Service Officers; Veterans Service Organizations; State Veterans Homes Emergency Medical Services; fire departments; police departments; government agencies; and community hospitals/emergency departments

Potential outcomes/measure of success

- **Program policies and** procedures are in place and staff trained to implement them consistently
- Host families are recruited, screened and trained
- **Hospice services are provided to homeless and/or rural veterans** who are eligible for hospice care
- **100% hospice staff participating** in the program receive Veteran-specific clinical training
- **Quality control measures are in place to monitor and address patient** safety and emergency procedures
- **Quality improvement processes are in place to monitor and address** patient and host family satisfaction, VA staff satisfaction, and hospice staff satisfaction
- **A minimum of** one staff member will be appointed as a Veteran liaison

Vet-To-Vet Program

Description: The purpose of the Vet-to-Vet Program is to recruit and train Veterans to be hospice volunteers for fellow Veterans as well as participate in community outreach activities targeting fellow Veterans; increase community awareness of hospice and home care palliative care services available to Veterans in the community and VA; and improve coordination of services between these settings. The program will recruit Veterans for both patient care and outreach activities. Veterans will receive Veteran-specific volunteer training, be placed with Veterans enrolled in the hospice program, and offered appropriate, ongoing support. Veterans choosing to participate in **outreach activities will receive training in presenting information to Veterans'** groups about palliative care, hospice services and VA benefits. Finally, the

program will form a community/VA workgroup to improve coordination of services across venues of care, identify gaps in both patient care and business practices, and develop policies and procedures to address the issues.

Suggested objectives:

1. Establish a Vet-to-Vet volunteer training program for patient care and outreach activities
2. Implement a Veteran-specific support program for the Vet-to-Vet volunteers
3. Recruit and train Veteran volunteers in patient care and outreach activities
4. Inform and engage hospice staff about the special needs of Veterans, especially those who have experienced combat, dangerous duty assignments or traumatic events
5. Develop mechanisms to facilitate the transition of Veterans across community and VA settings
6. Address reimbursement of VA-paid community services

Target population: Veterans living in the service area with an emphasis on those who are homeless and living in rural areas

VA partners: VA staff from the Palliative Care Program and others working in a VA facility; Community-Based Outpatient Clinics; Vet Centers

Community partners: Veterans, government agencies; community hospices, community organizations and healthcare providers, doctors' office staff, clinic and emergency room staff, civic/social/church members, hospitals/emergency departments; County Veterans Service Officers; Veterans Service Organizations; State Veterans Homes

Potential outcomes/measure of success:

- Recruit and train Veterans to volunteer for patient care and outreach activities
- Provide Vet-to-Vet volunteer services for Veterans enrolled in hospice program
- Offer community outreach presentations to Veteran groups
- Quality improvement processes are in place to monitor and address patient and family satisfaction and hospice staff satisfaction
- A minimum of one staff member will be appointed as a Veteran liaison

Hospice-Veteran Partnership (HVP) Program

Description: The purpose of the Hospice-Veteran Partnership (HVP) Program is to increase Veterans' access to high-quality hospice and palliative care that spans multiple providers and health care systems. Essential to the success of this program is the existence of an established HVP with the active

participation of VA and community leaders at all levels. The HVP will conduct local, regional and statewide educational programs for community and VA health care providers using available Veteran-specific clinical curricula as well as materials developed by the HVP that address coordination of services and business practices such as health care and hospice referrals and admissions, transitions across care settings, enrolling eligible Veterans in VA, and reimbursement for VA-paid community services. The HVP will also develop and disseminate a Veteran-specific quality improvement program and facilitate communication and coordination between community and VA providers.

Suggested objectives:

1. Develop educational programs that include clinical and business content
2. Develop standard protocols that recognize regional differences for health care and hospice referrals and admissions, transitions across care settings, enrolling eligible Veterans in VA, and reimbursement for VA-paid community services
3. Implement a dissemination plan for conducting educational seminars across the state or region
4. Increase the number of hospice agencies using the Military History Checklist or equivalent
5. Develop a process to track and report, to the HVP, the number of Veterans being served by hospice agencies in the state
6. Disseminate contact information that facilitates access to VA hospice and palliative care services
7. Design a Veteran-specific quality improvement program that can be disseminated to community hospices

Target population: Veterans living in the region or state with an emphasis on those who are homeless and living in rural areas

VA partners: VA staff from the Palliative Care Program and others working in a VA facility; Community-Based Outpatient Clinics; Vet Centers

Community partners: Community health care providers and service organizations, government agencies, County Veteran Service Officers; Veterans Service Organizations; State Veterans Homes

Potential outcomes/measure of success:

- Standard agendas that include both clinical and business content developed
- Regional HVP educational programs in the state or region conducted
- Standard protocols that address VA/community clinical and business relationships and recognize regional differences developed
- Process to track and report number of Veterans served in the community
- Veteran-specific quality improvement program developed and disseminated to community hospices in the state

Reaching Out Model Creation Solicitation

Four of the organizations selected for this program will choose from the five existing models [above] of community partnership to enhance end-of-life care to rural Veterans. One organization will develop a new model that promotes partnership, communication and collaboration. The community will work in collaboration with the National Rural Health Resource Center to develop this model. The model must address the current reimbursement of VA-paid community services. Outcome measures will be developed by the community organization selected, with support from The Center, to describe how they intend to develop their model. Some outcome measures must also address reimbursement of services and plans to enhance communication between the organization and the VA. This model should address the unique challenges that the organization faces, but should be able to be replicated in other communities.

See Appendix A: Community Created Documents

III. Reaching Out Model 1: Vet-to-Vet

The purpose of the Vet-to-Vet Program is to recruit and train Veterans to be hospice volunteers for fellow Veterans as well as participate in community outreach activities targeting fellow Veterans; increase community awareness of hospice and home care palliative care services available to Veterans in the community and VA; and improve coordination of services between these settings.

Two organizations in VISN 23 developed and implemented a Vet-to-Vet Volunteer Program in collaboration with one another. Organization A was a nonprofit hospice organization that served Veterans in 14 counties, 12 of which were rural. They have an average daily census of 214 patients and have been in existence for 30 years. One of the identified partners for Organization A was the PACE (Program of All-inclusive Care for the Elderly) Program in their service area. Organization B was a nonprofit, free-standing hospice organization that was established in 2007. The organization has an average daily census of 25 and serves patients in nine counties in VISN 23. **Both organizations were participants in the "We Honor Veterans" campaign and both actively participated in their state Hospice Veteran Partnership.**

Objectives

Community A created four objectives for their project:

1. Inform and engage hospice and PACE staff about the special needs of Veterans, especially those who have experienced combat, dangerous duty assignments or traumatic events

2. Recruit and train Veteran volunteers for patient care and outreach activities
3. Provide Vet-to-Vet services for Veterans enrolled in hospice and palliative care programs
4. Create a community committee to improve coordination of services across venues of care along with training for Veteran volunteers

Community B identified and created five goals and supporting objectives for their project:

1. Establish a base of Veteran volunteers to serve Veteran patients
2. Build partnerships with community organizations
3. Create processes and procedures
4. Develop staff orientation and education, including presentation from Deborah Grassman, on the Wounded Warrior Project
5. Honor Veterans

Challenges

- Time was an issue for staff. Some of the outreach work would be difficult without outside funding to support staff time
- Implementing the Military History Checklist into electronic medical records was a challenge
- Frequently received positive response following our presentation, but did not have as much commitment to participating in the full training
- Reframing the idea of hospice and palliative care. Some potential volunteers exclusively equated hospice with death and dying
- Large percentage of Veterans not aware of their hospice benefits through the VA. Additionally, many Veterans are not accessing their VA-paid benefits due to enrollment challenges (real or perceived)

Successes

- Staff is engaged, educated and excited about serving Veterans in service areas
- **Veteran "champion" identified to organize** Veteran outreach activities
- Over 20 Veteran volunteers trained
- More than 40 community presentations given to educate people about unique end-of-life needs of rural Veterans
- Linkages created between Veteran volunteers and Veteran hospice patients
- Strengthened relationships with regional VA Medical Centers, Community Based Outpatient Clinics, Vet Centers and other VA organizations
- Military History Checklist embedded into electronic medical record and processes created to identify Veterans at intake
- Pinning ceremonies took place to honor patients who were Veterans
- Created relationships with Veterans service groups, such as American Legion, regional commanders, etc.
- Developed training manual and contract for Veteran volunteers

Unique Outcome Measures

The two Vet-to-Vet sites, in addition to reporting outcome measures that the other three sites were reporting, were also asked to report the following measures:

- Number of Veteran volunteers recruited
- Number of Veteran volunteers trained
- Number of Veterans receiving peer volunteer service
- Percent of Veterans receiving peer volunteer service

IV. Reaching Out Model 2: Community Partnership

The purpose of the Community Partnership Model is to increase community and hospice staff awareness and establish educational and outreach programs to address their specific end-of-life care needs. This model is designed to educate Veterans about the VA hospice benefits and community resources; advocate for local hospice to implement the Military History Checklist to identify their Veteran patients; assist first responders, home shelter staff, and medical providers in identifying Veterans in need of hospice and palliative care services; help health care and community groups identify at-risk Veterans and teach them how to connect to Veterans to needed services; and publicize community resources.

Community C implemented the Community Partnership Model to offer educational resources and training to all local agencies that potentially care or come in contact with Veterans who have a life limiting condition. Community C was a non-profit regional hospice organization representing three hospices affiliated with five Critical Access Hospitals. This facility serves an average of 300 patients per year with an average daily census of 40. The service area is very rural with the larger cities having approximately 2,000 people over a 10-county service area. This facility employs 55 staff and has 175 volunteers.

Objectives

Community C created five objectives for their project:

1. Develop and distribute a Reaching Out Toolkit
2. Form a collation of several Veteran Service Officers, hospice staff, staff from the VA Medical Center, and others
3. Offer community presentations to inform the general public of the unique hospice/palliative care needs of Veterans
4. Train/educate hospice staff and volunteers on unique care needs of Veterans
5. Train hospice staff on implementing the Military History Checklist

Challenges

- Connecting with the most appropriate person within the tribal population to discuss hospice services; received no response from all outreach attempts
- Limited time, funding, resources to train nursing home staff
- Limited time of grant funding
- Balancing time for the PCRI project amongst other staff duties
- Encouraging people to pay attention to the PCRI message and make time to learn about the Military History Checklist

Successes

- Distributed a Reaching Out Toolkit to 200 partner organizations within the service area
- Hosted a community presentation where 105 individuals attended, representing 25 organizations, including: County Veteran Service Officers, Tribal/Regional Coordinator with the Veterans Affairs, Emergency Medical Services, nursing homes, assisted living facilities, hospitals, etc.
- Established a positive working relationship with the County Veteran Service Officers (CVSO) and have been invited to attend regular CVSO meetings
- Developed a train-the-trainer curriculum for eight hospice staff to instruct 60 staff members/volunteers to reach out to partners within honoring Veteran preferences in end-of-life care
- Instructed staff on how to implement the Military History Checklist
- Strengthened working relationship with VA Hospice and Palliative Care Teams

Unique Outcome Measures

- Number of Native American Veterans who are also enrolled in Indian Health Services
- Number of Native American Veterans who are participating in Indian Health Services and the VA

V. Reaching Out Model 3: Community-Based Outpatient Clinic (CBOC)

The purpose of the Community-Based Outpatient Clinic (CBOC) Model is to **increase Veterans' access to hospice and palliative care services, by** collaborating with the local VA CBOC to develop protocols for referring, enrolling, transitioning, and providing services for eligible Veterans; and conduct outreach activities to inform the community about Veterans and the benefits to which Veterans may be entitled.

Community D implemented the Community Based Outpatient Clinic (CBOC) Partnership Model to build a collaborative partnership with the CBOC located

within their community and offer educational resources and training to all local agencies that potentially care or come in contact with Veterans who have a life limiting condition. Community D was a faith-based, non-profit hospice organization that is part of a medical system. This facility has a service area of 26 rural counties. There are 324 Veterans within the service area and 145, 237 within the entire state.

Objectives

Community D created five objectives for their project:

1. Collaborate with the local CBOC to develop protocols for referring, enrolling, transitioning, and providing services for eligible Veterans
2. Offer community presentations on hospice and palliative care services and Veterans unique end-of-life care needs
3. Offer educational sessions to various community organizations spotlighting Veterans and Medicare benefits related to palliative and hospice care services
4. Establish a Veterans liaison position responsible for working closely with Veterans issues
5. Train 75% of hospice staff on End-of-Life Nursing Education Consortium (ELNEC) for Veterans curriculum within the service area

Challenges

- Difficulties understanding the VA systems operations, chain of command and perspective
- Lack of awareness on how to effectively build and maintain community partnerships
- Lack of awareness and expertise on how to market services
- Lack of Veterans Service Office support and involvement
- Community avoidance of hospice and palliative care issues as a concern
- Resistance from Veterans to enroll/receive VA benefits

Successes

- Communication efforts between the hospice agency and the local CBOC is continuing post PCRI funding
- Provided community educational events in all 25 counties within the service area
- Recruited liaisons within present staff to answer questions regarding hospice and palliative care services, members/volunteers to reach out to partners within honoring Veteran preferences in end-of-life care
- 81% of hospice staff in the service area completed the End-Of-Life Nursing Education Consortium for Veterans curriculum
- Implemented the Military History Checklist into daily practice
- Initiated Veterans certificates and presentation ceremony within the first few days of hospice services

- Tracked the average daily census of Veteran patients

Unique Outcome Measures

- Number referred by a VA Community-Based Outpatient Clinic (CBOC)

VI. Reaching Out Model 4: Create Your Own

The purpose of the Community Partnership Model is to increase community and hospice staff awareness and establish educational and outreach programs to address their specific end-of-life care needs. This model is designed to educate Veterans about the VA hospice benefit and community resources; advocate for local hospice to implement the Military History Checklist to identify their Veteran patients; assist first responders, home shelter staff, and medical providers in identifying Veterans in need of hospice and palliative care services; help health care and community groups identify at-risk Veterans and teach them how to connect to needed services; and publicize community resources.

Community E implemented the Community Partnership Model to offer educational resources and training to all local agencies that potentially care for or come in contact with Veterans who have a life limiting condition. Community C was a non-profit, regional hospice organization representing three hospices affiliated with five Critical Access Hospitals. This facility serves an average of 300 patients per year with an average daily census of 40. The service area is very rural with the larger cities having approximately 2,000 people over a 10-county service area. This facility employs 55 staff and has 175 volunteers.

Objectives

Community E created five objectives for their project:

- Establish an education and outreach program for end-of-life issues
- Raise community awareness about Veterans living in the five-county region area, the end-of-life needs they have and the benefits to which they are entitled
- Disseminate educational materials that can be used by VA and community agencies to help Veterans access services and benefits
- Educate employees and volunteers on unique care needs of Veterans
- Address reimbursement of VA paid community services
- Coordinate with VA and VA partners to assist in seeking reimbursement for palliative care

Challenges

- Connecting with the most appropriate person within the tribal population to discuss hospice services; received no response from all outreach attempts
- Limited time, funding, resources to train nursing home staff

- Limited time of grant funding
- Balancing time for the PCRI project amongst other staff duties
- Encouraging people to pay attention to the PCRI message and make time to learn about the Military History Checklist

Successes

- Met with County Veteran Service Officers within the service area to collaborate about roles and network regarding opportunities to support Veterans end-of-life care needs
- Hosted educational sessions at local health fairs
- Presented at local and state-wide conferences educating peers on the end-of-life care needs of Veterans
- Trained social workers, medical home, and palliative care and hospice staff regarding Veterans services at end-of-life using the We Honor Veterans tools
- Informed area ministers of We Honor Veterans Program at Hospice Foundation of America videoconference on Ethics Issues at the End-of-Life
- Strengthened working relationship with VA Hospice and Palliative Care Teams through teleconferencing sessions

Unique Outcome Measures

- Number of Veteran patients referred out of the community to VA hospice
- Number of Veterans referred by VA to community palliative care
- Number of Veterans transferred from community palliative to community hospice care services

VII. Technical Assistance

The Center provided technical assistance to the VISN 23 PCRI organizations to enhance education of Veteran specific topics, assist in establishing collaborative relationships, and provide guidance on building a model of care **to best serve Veterans' hospice/palliative care needs** in rural communities.

The technical assistance was provided through:

- Conference calls: Initial kick-off calls with each organization and VISN 23 to review the work plan, goals and regional VA contacts and project calls between local VA hospice and palliative care staff, VISN 23, the PCRI community and The Center
- Cohort calls with NHPCO grantee model hospice organizations and the PCRI communities
- Email correspondence between The Center and PCRI organization
- Webinars: Quarterly
- Site Visits
- Workshop

See Appendix B: The Center Created Documents and Appendix C: Other Documents

VIII. Summary of Findings

The PCRI convened a workshop on August 7 – 8, 2012 in Bloomington, Minnesota to:

- Describe how hospice and palliative care could be tailored to suit the unique needs of rural Veterans
- Identify resources and points of contact in providing hospice and palliative care for Veterans
- Identify the lessons learned in working toward improved hospice and palliative care for Veterans
- Learn strategies and models for providing hospice and palliative care for Veterans
- Understand how to continue hospice and palliative care for Veterans beyond the VA-funded project year

Thirty participants attended the workshop and represented The Center staff, VISN 23 Hospice and Palliative Care staff, the VA Medical Director, Hospice and Palliative Care, VA Office of Geriatrics and Extended Care, the National Hospice and Palliative Care Organization, the Minnesota Hospice Veterans Partnership, Atlas Research and the five PCRI community hospice organizations.

Following presentations of the community model successes, challenges and next steps and four discussions were facilitated to gather input from all participants in the areas of reimbursement, community partnerships, VA partnerships and communities and sustainability.

Reimbursement

Challenges encountered by rural hospice communities implementing hospice and palliative care services for rural Veterans:

- Few [hospice] patients services paid by VA in PCRI
- Need authorization number from VA to invoice
- Few VA contract nursing homes approved and often are full
- If the Vet isn't on Medicare, catastrophic enrollment in VA is an option. Also, Veteran benefits may be used for the uninsured and patients under 65 years old
- Need clarification and process for VA-paid palliative care benefit

Resources either created or needed (technical, peer, financial national/regional) to impact the outcome of this issue to improve rural Veterans health:

- Home base nurse has to authorize for VA benefit
- Both VA and Medicare complement each other

- Need more VA-approved nursing home sites for emergency contracts - VA central office
- Better understanding of Home-based primary care (HBPC) contract for rural Veterans
- PACE might be an option
- We Honor Veterans
- No comprehensive list of potential partners
- More information about Veterans health care benefits and reimbursement for providers and health care organizations

Lessons Learned and successes from PCRI in VISN 23 and elsewhere:

- Rural resourceful, tend to be self-sufficient
- Build in time or money and staffing
- Sense of obligation in rural
- Ask the question
- Not a great list of organizations
- Lack of trust of outsiders
- More info about Vets in service care
- Being aware of community/service area (in health care)

Community Partnerships

Challenges encountered by rural hospice communities implementing hospice and palliative care services for rural Veterans:

- Credibility
- Time and prioritizing needs
- Encouraging commitments from partners
- Building trust and personal connection
- Message resistance; building awareness of hospice care
- Defining partners; identifying key players and change makers
- Working with competitors

Resources either created or needed (technical, peer, financial national/regional) to impact the outcome of this issue to improve rural Veterans health:

- VA coalition
- Cohort including multiple partners to present case
- Building a model of what it means to be in partnership with both VA and hospice definition (i.e. Road Map)
- Cross-walk partnership models with other models

Lessons Learned and successes from PCRI in VISN 23 and elsewhere:

- State Hospice Veterans Partnership
- NHPCO
- Contacting Commander at state level for County Veteran Service Organizations
- Sharing resources and successes among PCRI communities

VA Partnerships and Communication

Challenges encountered by rural hospice communities implementing hospice and palliative care services for rural Veterans:

- Knowing who to talk to at VA; understanding hierarchy; need a contact list, WHV website
- Understanding the VA benefits available and how to access them (VSO training)
- Need [tip sheets](#) locally within [Hospice Veterans Partnerships](#)
- Need trust and communication with CBOCs; more coordination
- Getting required approval
- Enrollment in a timely manner
- Switching between community and VA physicians and providers

Resources either created or needed (technical, peer, financial national/regional) to impact the outcome of this issue to improve rural Veterans health:

- VA acronym glossary
- [1010 EZ Form](#) – for enrollment, available online
- VA formulary for non- VA docs
- Locally created tip sheets
- Key Hospice and Palliative care structure and contact info
- Hospice and Palliative Care staff VISN 23
- Joint VA/Community electronic file storage place / information clearing house
- [National Hospice and Palliative Care Organization](#) website
- [We Honor Veterans e-group](#)

Lessons Learned and successes from PCRI in VISN 23 and elsewhere:

- Having a champion-like Caroline Schauer at VISN 23
- Honoring of Veterans, building Veteran-centric process into the system
- Raised awareness for hospice staff, VSO's, patients
- Starting point established and a "jumping off" for rural Veteran hospice and palliative care
- Better understanding of what VA can and can't do and how it works
- Bringing this group together for networking; PCRI contract

Sustainability of PCRI

Challenges encountered by rural hospice communities implementing hospice and palliative care services for rural Veterans:

- Money for travel and outreach; education; staff time
- Building a program to continue after champions of PCRI have left
- Maintaining momentum
- Integrating partners without more cost
- Continuous improvement
- Sharing outcome information across VA and non-VA

Resources either created or needed (technical, peer, financial national/regional) to impact the outcome of this issue to improve rural Veterans health:

- Palliative Care Toolkit (NHPCO)
- Coordinated technical assistance through web/e-forum (sharing resources and notes)
- Final report (executive summary) to share with community hospice leadership
- Funding
- Phase II PCRI

Lessons Learned and successes from PCRI in VISN 23 and elsewhere:

- Build Veterans care into the overall hospice strategic plan
- Identify leaders in each office/site
- Adjusted training and orientation into include Veteran specific care
- Use technology established
- Share information with leadership
- Continue to use volunteers (quilts, visits, pinning)

Final Workshop Comments:

- Demonstrate that it can be done – VISN 23
- Seeing success
- Work through road blocks together
- Learn about VA system
- Building trust – unique in PCRI
- Connect with real world and meet the needs
- Kind of care for rural
- PCRI built knowledge for hospice staff
- Education and resources/networking
- Validation of challenges
- Learn about Veterans and their needs

Recommendations for Rural Reaching Out Models

Successful implementation of the Reaching Out Models to serve rural Veterans requires collaboration. Rural health care providers are generally in a collaborative mode due to the limitations of workforce, transportation, technology and specialty services. Implementing the Reaching Out Models to expand hospice services to Veterans in their rural communities required building an awareness and relationships with new partners. The key factors for success from the PCRI included:

- Establishing relationships with collaborative partners from the initial relationship at the VISN (State HVP, NHPCO, State Hospice Association, State CVSO, VA Rural Health Resource Centers and Rural consultants)

- Developing communication and collaboration (VA Medical Center, Vet Center, CBOCs, community partners-hospital, nursing home, other hospices)
- Understanding the VA system structure and the reimbursement enrollment process

The PCRI communities submitted quarterly outcome measures for their models. The number of Veteran patients served through the project from February 15 through August 2012 was 302 with an average of 43.6 Veterans per community hospice. Twelve of the Veterans served by the community hospices received VA-paid hospice care across the five hospices. A majority of the Veterans were referred by non-VA organizations to the community hospice care. These included nursing homes, health care providers, and community hospitals. There was one referral from a County Veteran Service Officer. The referrals from the VA for community hospice care were all from the VA Medical Centers, except for one from a CBOC.

All five sites implemented plans to utilize the Military History Checklist upon admission. By the end the final reporting period all sites, except one, reported administering the checklist to 100% of patients upon admission. Analysis of Family Evaluation of Hospice Care for families of Veterans patients (FEHC-V) was not possible within such a short time period since very few surveys had been returned from patient families. Sites had some data on patients with military experience-related symptoms – 18 patients reported for the entire project.

A number of the measures reflected types of outreach and the collaborating organizations. A total of 615 community-based organizations were contacted about the PCRI project and included 119 Veteran Service Organizations. One hundred-seventy seven outreach events or activities were held over the five-month initiative reaching 2,398 participants. Thirty-one Veteran volunteers were recruited and trained in the Vet-to-Vet Models and 27 Veterans received peer hospice volunteer services. All five sites had staff complete We Honor Veterans training provided by NHPCO.

Exit Interview Summary

At the end of the one-year Palliative Care Rural Initiative (PCRI) Project, National Rural Health Resource Center (The Center) staff conducted exit interviews via phone with the lead staff person involved in the PCRI project at each of the five communities. They were asked the same nine questions that included ratings of 1-5 and follow-up comments if desired as well as three additional open-ended questions and the opportunity to provide any additional final comments. Anonymity and confidentiality were promised. The Community Participant Exit Interview Template is included in Appendix B.

Several themes emerged as a result of the exit interview analysis. All five communities gave high ratings to the service received from The Center. The service was described as **"absolutely phenomenal," "professional," "accommodating," and "responsive."** When asked for a rating of The Center representative assigned to them, all five communities gave enthusiastic **"5" ratings and described their representatives as "superb," "energetic," and "fabulous."**

Four of the five communities also gave the highest rating of 5 to the service they received from the Department of Veterans Affairs (VA) and to the **Contracting Officer's Technical Representative (COTR) who served as the primary point of contact representing the VA.** The COTR was referred to as **"fabulous," "wonderful," and "excellent."**

There were several comments about the constraints of working with the VA because of their structure and the requirements to get authorizations before proceeding with ideas and plans. The communities became frustrated when their ideas had to be put on hold while awaiting approval from the VA, causing a loss of momentum and enthusiasm. For some, it was their first experience working with the VA, and they had to learn about and adjust to their approval process, which can be viewed as complicated and time consuming.

There were some comments about the lack of information and understanding of the project, especially in the beginning. Some communities felt they **didn't** know what was expected of them. There were some growing pains while getting everyone from the various organizations working together in synchrony.

The usefulness of conference calls and webinars was rated a 4 by four of the communities and a 5 by the other. People commented on the lack of face-to-face contact in the beginning making it hard to understand what was happening with the project. Some communities commented a face-to-face meeting would have been helpful at the kickoff of the project, allowing them to get to know each other and learn about the project and expectations. There was a sense of wishing they had received information sooner while at **the same time appreciating that they didn't fully understand the information** they did receive and were too confused to know how to formulate questions.

The communities all rated the site visits a 5, and the face-to-face workshop for all the communities and partners held near the end of the project received the highest praise as well. One community staff member called it **"unbelievably helpful."** Another said, **"It was one of the best networking meetings I have been at where everyone actually had input and we learned from each other, and I have been to lots of them."**

The ease of invoicing was rated one 3, one 4, and three 5's. One person found it "cumbersome," and another described an instance where they

couldn't do an invoice because they had to wait for some information from the VA that was not communicated in a timely manner. The other three communities had no complaints.

The ease of outcomes reporting was rated two 3's, two 4's, and one 5. Some said they had very little information to report or didn't understand what they were supposed to report or felt what they were doing was not applicable to the reports. In addition, collecting data was not always easy.

When asked whether their hospice planned to continue the Veterans Hospice Care Model beyond the PCRI project, all communities gave an enthusiastic yes. Many demonstrated passion for providing these services to Veterans. Support from management was named as an important factor to ensure sustainability. There is desire to continue training of staff members, working with the VA, utilizing volunteers, creating recognition programs, and hosting educational conferences. The sense is that staff members at the hospices were enthusiastic about providing these services to Veterans moving forward.

When asked what advice they had for other rural hospices starting a similar project, the following suggestions were made:

- Hold a face-to-face meeting for rules and regulations at the beginning.
- Talk to as many people as you can to tell them about Veteran benefits.
- **Educate yourself first of all. Find out what you don't know, and raise awareness within your organization.**
- Find a volunteer Veteran champion, someone already committed to the hospice concept.
- Be prepared for the extra time it may take to build relationships, and remain open to dialogue and information sharing.
- Develop relationships with County Veterans Service Officers (CVSOs).
- Partner with other health care organizations in the community.

When asked how their organizations have been impacted by the **Palliative Care Rural Initiative (PCRI) project in their ability to serve rural Veterans' end-of-life care needs**, the five communities responded that implementing standard use of the Military History Checklist (found in the Tools & Resources section) helps them identify Veterans so they can provide better services to them. They have raised their level of awareness about the Veteran population in their area. Some have implemented ways of recognizing Veterans for their service to our country by awarding them certificates, books, and other types of tributes. One person commented that because of this project, their staff was able to take several hours to devote to training **about Veterans' hospice and palliative care needs that would have been unlikely to get approved by management otherwise.** Another person commented on the value of reaching out to rural Veterans and giving them the ability to put a face with the hospice concepts, making it less scary.

Final comments from the communities showed a genuine appreciation for the opportunity to participate in the PCRI project. They felt their staff awareness about Veterans and their unique needs was increased, and the workers showed compassion and respect for this special population and gave positive feedback about their training. There was some regret that the project only lasted a year, and just when things were getting going, it was over. However, the general belief is that the momentum created by this project will continue into the future.

IX. Opportunities to promote grantee outcomes and business models

Opportunities to promote grantee outcomes and business models include dissemination of the business models, tools, resources and educational materials created by PCRI to selected PCRI Test Sites in other VA regions. The Center has an extensive national network for information dissemination and with VA permission, can use that network to disseminate information and materials collected. This Dissemination Model and Implementation Guide, in whole or in part, can be made available via The Center website with VA authorization.

Potential methods and interested parties well-suited for the sharing of information about the PCRI project are as follows:

Potential Methods of Dissemination

- Organizations – hospice, palliative care, Veteran, rural
- Presentations at annual meetings and conferences
- Webinars
- Websites
- Newsletters - electronic and print
- Listservs
- Blogs
- Social Media: Facebook, Twitter, LinkedIn, etc.
- Individuals
- Journals accepting articles for submission
- Special mailings

Potential Interested Parties

- National Rural Health Resource Center
- State FLEX Programs (45)
- State Offices of Rural Health (SORH)
- State Hospital Associations
- State Hospice Associations
- State Hospice Veterans Partnerships
- Public Health Agencies
- Rural Health Networks
- Community Health Networks / Social Service Agencies

- Veterans Integrated Service Network (VISN) Offices
- County Veterans Service Officers (CVSO)
- VA Office of Rural Health
- Scholarly Journals
- National Rural Health Association (NRHA)
- National Hospice and Palliative Care Organization (NHPCO)
- Rural Assistance Center (RAC)
- National Organization of State Offices of Rural Health (NOSORH)

X. General Tools and Resources

The following are tools and resources that were useful to those involved in the PCRI project, but were not created specifically for this project or by the community grantees or the National Rural Health Resource Center:

National Nonprofit Organizations

National Association of County Veterans Service Officers

<http://www.nacvso.org>

Directory of County Veterans Service Officers

<http://www.nacvso.org/modules.php?name=Content&pa=showpage&pid=10>

National Association of State Veterans Homes

<http://www.nasvh.org>

National Hospice and Palliative Care (NHPCO)

<http://www.nhpc.org>

National Hospice Foundation

<http://www.nationalhospicefoundation.org>

Caring Connections

<http://www.caringinfo.org>

Consider the Conversation

<http://www.considertheconversation.org>

We Honor Veterans (WHV)

<http://www.wehonorveterans.org>

Veterans Military History Checklist

<http://www.wehonorveterans.org/i4a/pages/index.cfm?pageid=3337>

Hospice-Veteran Partnership Toolkit

http://www.wehonorveterans.org/files/public/HospiceVeteranPartnership_Toolkit.pdf

Partners: Hospice and VA Working Together

http://www.wehonorveterans.org/files/public/WHV_Hospice-VA_Partnering.pdf

Department of Veterans Affairs

Department of Veterans Affairs (VA)

<http://www.va.gov>

VA Benefits Administration (VBA)

<http://www.vba.va.gov/VBA/>

VA Forms

<http://www.va.gov/vaforms/>

VA Geriatrics and Extended Care

<http://www.va.gov/geriatrics/>

VA Health Administration (VHA)

<http://www.va.gov/health/>

VA National Cemetery Administration (NCA)

<http://www.cem.va.gov>

VA Facility and Service Organization Locator

By state

<http://www.va.gov/statedva.htm>

By zip code

<http://www2.va.gov/directory/guide/home.asp?isflash=1>

By map

http://www2.va.gov/directory/guide/division_flsh.asp?dnum=1

By organization name, type, and zip

<http://www.wehonorveterans.org/i4a/pages/index.cfm?pageid=3336>

State Hospice and Palliative Care Associations

Hospice and Palliative Care Association of Iowa

<http://www.hpcai.org>

Nebraska Hospice and Palliative Care Association

<http://www.nehospice.org>

Minnesota Network of Hospice & Palliative Care

<http://mnhpc.org>

Hospice Organization and Palliative Experts (HOPE) of Wisconsin

<http://www.hopeofwisconsin.org>

See Appendix C: Other Documents

XI. Appendix (Separate Attachments)

Appendix A: Community Created Documents

Appendix B: The Center Created Documents

Appendix C: Other Documents

NOTES:

- Some of the appendices have community identifying information in them, especially those created by the communities in Appendix A