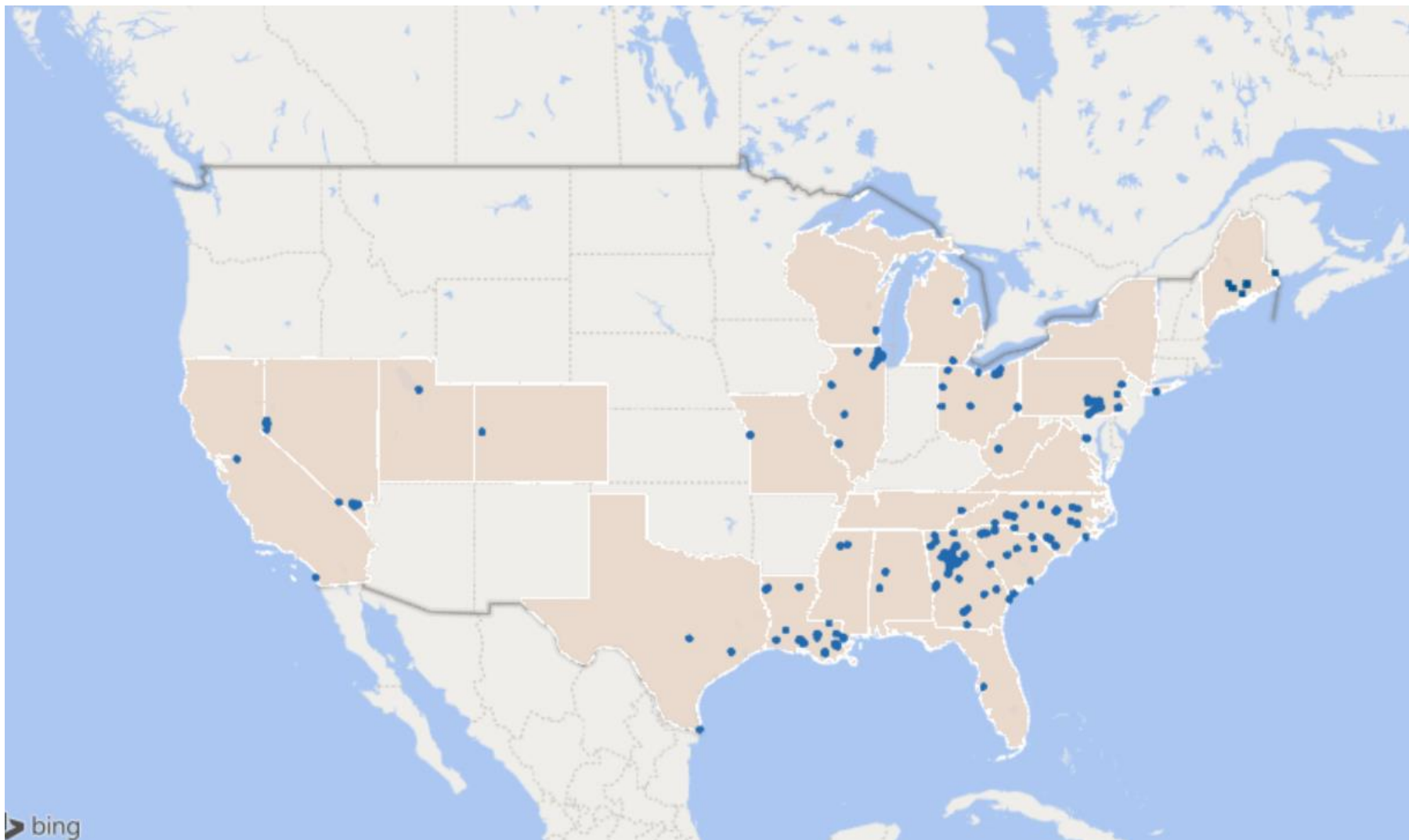
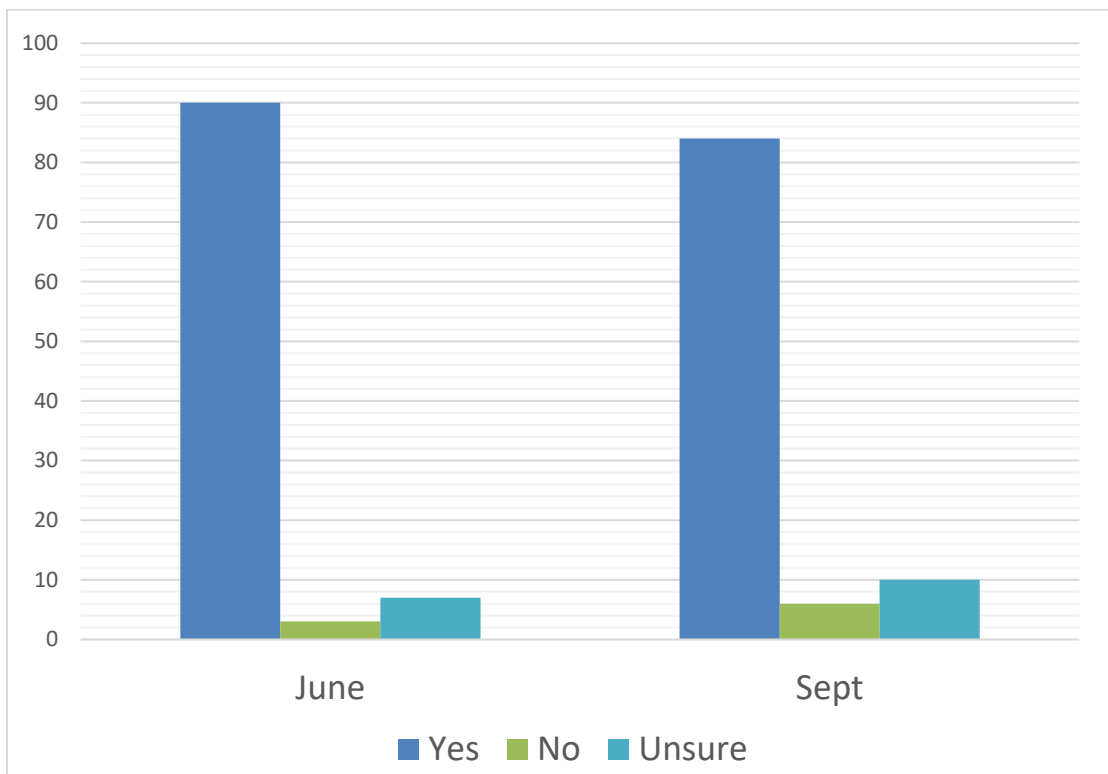

Trauma Informed Care Initiative for Veterans on Hospice

Final Survey September 2020

Please provide your organization's zip code:

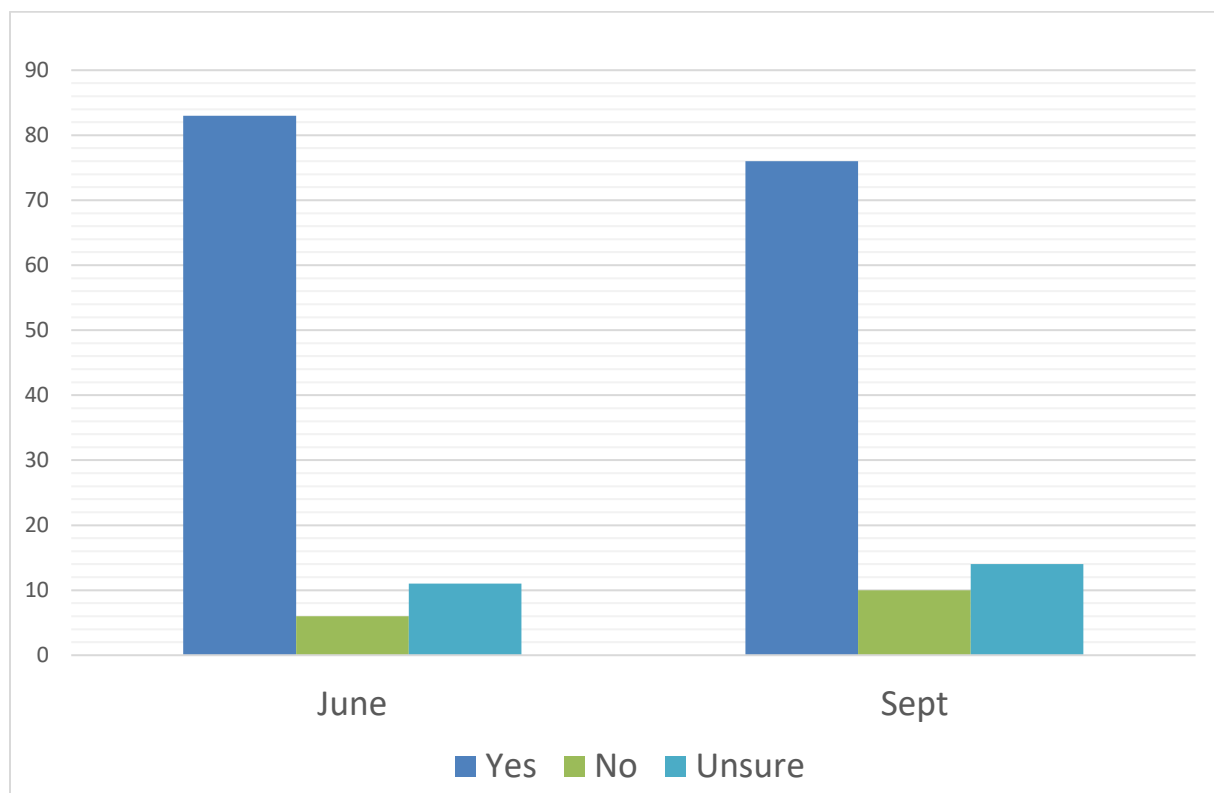


Is Veteran status obtained?



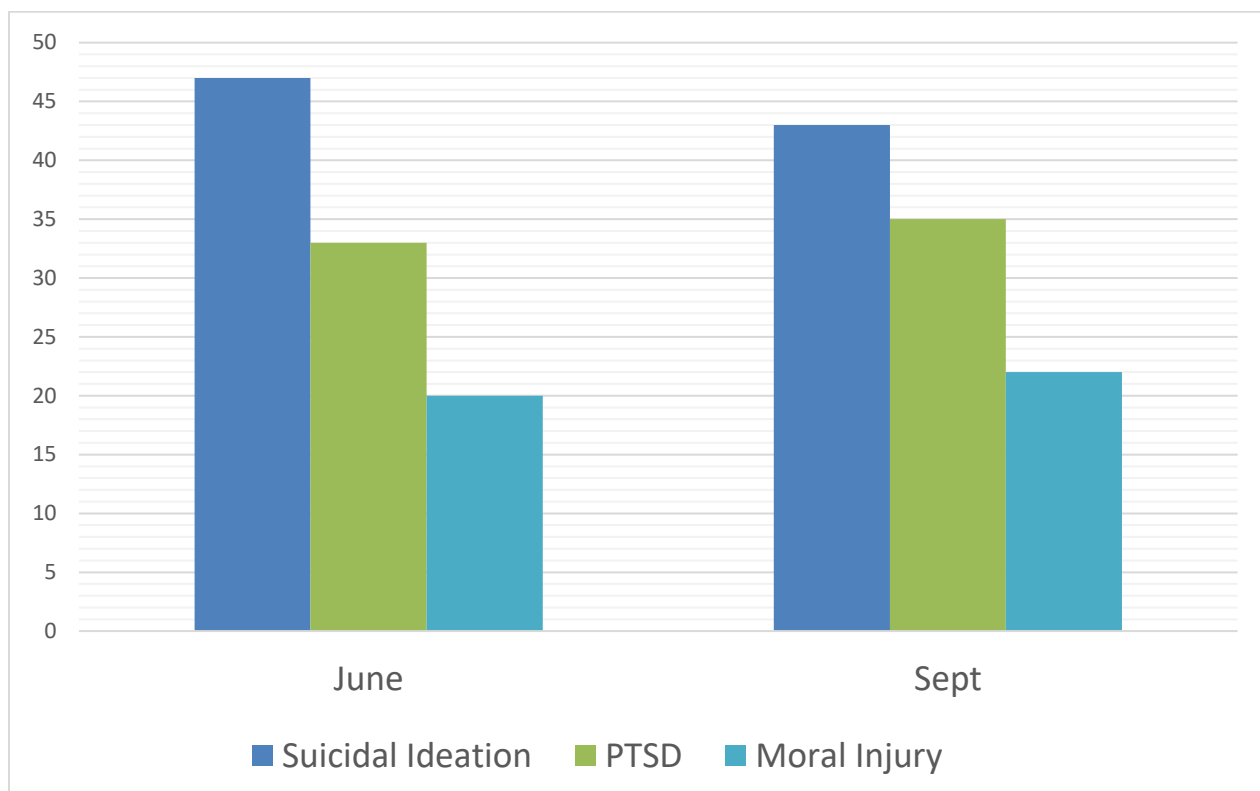
June			Sept		
	%			%	
Yes	90%	201		84%	200
No	3%	6		6%	15
Unsure	7%	16		10%	23
Total	100%	223		100%	238

Is war era defined and documented?



June		%		Sept		%
Yes	83%	170		76%	181	
No	6%	13		10%	24	
Unsure	11%	23		14%	33	
Total	100%	206		100%	238	

Are PTSD, Suicidal Ideation and Moral Injury routinely screened for?



	June	%		Sept	%	
Suicidal ideation		47%	108		43%	161
Post-traumatic stress disorder		33%	74		35%	132
Moral injury		20%	46		22%	85
Total		100%	228		100%	378

If so, what are your screening questions?

We will do a suicide assessment if patient appears to be risk of suicide after assessment of anxiety, depression and spiritual concerns by nurse. Our questions are, "do experience anxiety?" "Do you have any spiritual concerns?" MSW questions: does the patient report fear/anxiety? Does the patient report depression? Does the patient report grief Does the patient exhibit/report anger Does the patient report excessive crying/loneliness? Indicate patient's coping mechanisms

We currently require sw to discuss pt mood and feelings /degree of hopelessness that may be present. There is a section within the assessment which triggers more specific questions. Also at the admission the SW asks all home patients to complete the following (this is a small section that relates back to medication diversion) . We are committed to supporting your emotional needs. (Check all that apply) Personal History or currently experiencing: Past Suicide attempt/ current thoughts of ending my life Hospitalization for mental health reason Schizophrenia Depression Bipolar Disorder Obsessive Compulsive Disorder Attention Deficit Disorder Childhood/ Adult Trauma Adult/ childhood sexual Trauma Other When hands on care or personal assistance is needed is there anything that would help you to be more comfortable or you desire us to be aware of?

Do you have any thoughts of harming yourself or others?

Columbia Test

Questions are from the NHPCO Checklist

These are addressed within our Initial and Comprehensive Assessment/Military History check list. There are not specific questions per say but questions except for suicidal/homicidal ideation. Information provides insight to symptom burden and allows us to assess with consideration of goals of care on how best to approach. • Only if psychosocial assessment indicates need for further screening, such as for suicidal ideation which would result in suicide risk assessment being completed. There are currently no specific screening questions in place just for PTSD and Moral Injury. • These are the specific questions asked: o Have you had an experience in your past that is still affecting you today? o Do you have thoughts of harming yourself? (Or the Means) o In your Military life have you either witnessed or perpetrated something that you regret? • We use Suncoast as our EMR, we follow the section re; suicidal ideations. If a concern is triggered, then we proceed with our policy. (this is for all admissions) • Suicide: Suicidal behavior, current ideation, past attempts, plan, means, impulse control, able to contract. • PTSD: We do the typical psychosocial that addresses suicide and depression in addition to a mood cognition assessment. • Right now we just ask if they have suicidal ideation and if so whether or not they have a plan. If they have a plan, that triggers additional steps.

Align with weighted bereavement risk assessment

Military history checklist and Veterans Planning Guide

PHQ - 9

We use the PQ2 and 9 in our assessment and if needed move to CSSR and we recently build PTSD screening into our new EMR using the care plan guide found on NHPCO

“Are these thoughts disturbing to you?” “Have you had these thoughts before?” “How often have you had these thoughts?” “Do you have a plan?”

Did your service include combat, dangerous, or traumatic assignments? Overall how do you view your experience in the military Do you have a service connected condition?

History of Service Related Issues: Issue (PTSD, Anxiety, Depression, Psychosis, Suicidal Ideation, Substance Abuse, Military related Sexual Trauma, Frostbite/cold injury, Malignant Diseases, Traumatic injuries),, diagnosis Date(s), Medications when and how helpful, Mental Health Counseling: When and how helpful, Additional Symptoms: Flashbacks, Nightmare, Hallucinations, Panic Attacks, Sleepwalking, Physical aggression toward others, Social Isolation, Other.

Built into EMR

Was the patient ever involved in combat? Did they experience trauma as a result of combat? How does the patient view their experience within the military? Do you ever feel as if you would be better off dead? Are you currently having thoughts of hurting yourself? Have you had these thoughts within the last 6 months? Any prior attempts?

(PHQ-2) DOES THE PATIENT HAVE LITTLE INTEREST OR PLEASURE IN DOING THINGS (INSTRUCTIONS FOR THIS QUESTION: ASK THE PATIENT: "OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS"?) N/A PATIENT UNABLE TO RESPOND (PHQ-2) IS THE PATIENT FEELING DOWN, DEPRESSED, OR HOPELESS? (INSTRUCTIONS FOR THIS QUESTION: ASK THE PATIENT "OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWIN PROBLEMS"?) N/A PATIENT UNABLE TO RESPOND

We now utilize the screening tools that are provided by the VA. Our staff do not have a set of specific questions they ask - instead they have a conversation with the patient. This is usually our LCSW and our Chaplain. Our HVP is working on putting together some screening questions that would be helpful

A. Have you had an experience in your past that is still affecting you today? B. Do you have thoughts of harming yourself? (Or the Means) C. In your Military life have you either witnessed or perpetrated something that you regret?

Suicide: Suicidal behavior, current ideation, past attempts, plan, means, impulse control, able to contract. PTSD: We do the typical psychosocial that addresses suicide and depression in addition to a mood cognition assessment.

Have you ever been told that you have PTSD? Have you ever had to do something that you did not feel was moral? Have you ever had thoughts that you would be better off dead? Etc. We ask if the patient is having specific symptoms listed on the WHV Care Planning Guide for Veterans.

After being involved in the conversation about their enrollment How do you view you experience in the military? Based on their response the conversation continues to develop about how their experience has impacted their personal/family life. Then, the Social workers or chaplains continue to go deeper in the conversation about if they have seek any help for any symptom they have developed. If they are unclear about their symptoms, then the following questions are asked: Have you experience any flashbacks, nightmares, hallucinations, panic attacks, sleepwalking, physical aggression toward others, social isolation, other? Have you received any mental help for this symptom? Have you been diagnosed by a mental health professional? do you need to see a mental health professional? do you need a referral for a mental health professional?

Is the patient a Veteran? Did the patient serve on active duty? Did the patient's services include combat, dangerous or traumatic assignments? Does the Patient have a service connected condition? In which war era or period of service did the patient serve. Has the Department of veterans affairs (DVA) authorized and agreed to pay for care? Indicate how the patient viewed their overall experience in the military? What is the name and contact information of the patient's VA physician or primary care provider? What is the name of the VA hospital or clinic the patient utilize?

Are there any morally difficult issues you have stemming from your military service? Do you currently or in the past have struggled with suicidal ideations? What ways can our staff help you address any inequities or combat related issues that you still think about today?

Have you had repeated, disturbing memories, thoughts, or images of a stressful military experience? Feeling very upset when something reminded you of a stressful military experience? Feeling irritable or having angry outbursts?

PC-PTSD, PHQ-9 item #9, C-SSR, Moral Injury: Do you feel like a transgression occurred during your time served? Did you witness or fail to prevent an event that produced emotional guilt and shame, or a sense of betrayal or anger during your time served? Is there anything specific that happened during your military service that you would like share with your family at this time?

1. Have you been exposed or threatened death, serious injury, sexual violence, experienced trauma, witnessed domestic abuse, neglect, or violence? 2. RISK OF HARM TO SELF: Prior suicide attempts, stated/plan/intent recent loss, presence of behavioral cues, (isolation, giving away possession, rapid mood swings.) Family history of Suicide, Terminal illness, substance abuse, marked lack of support, Psychosis, Suicide of friend/acquaintance. 3. RISK OF HARM to OTHERS: Prior acts of violence; If yes, when was most recent violent act? Destruction of property; Arrests for violence; Access to means (weapons); Substance use; Physically abused as child; Was physically abusive as a child; Harms animals; Fire setting; Angry mood/agitation; Prior hospitalizations for danger to others; Psychosis/command hallucinations; If yes, is there a history of acting on any commands to harm others? 4. RISK of HARM to SELF or OTHERS RATING SCALE: (LOCUS Risk of HARM Evaluation PARAMETERS) 5. UNDERSTANDING MORAL INJURY HANDOUT IS UTILIZED

What training is provided to staff for addressing PTSD, Suicidal Ideation and Moral Injury? How many hours for each and is this part of the orientation process?

Yes, it is a part of the volunteer orientation and it takes about 4 hours

We have at least 1 hour of these subjects in orientation as well as inservices at various intervals during the year.

It is part of the check list for verbal discussion with the new hire. However, we can do better about standardizing this component and will be adding a required video etc.

Training is provided as an overview during orientation for all disciplines. Additional on-going training is provided for clinical disciplines.

Current training has just begun with this grant program. Staff have taken 3-4 hours for training but will continue to discuss issues and have the social workers obtain further education

We have hosted 1-hour training sessions from Cleveland VA to educate and inform our staff and volunteers on PTSD, Suicidal Ideation, and Moral Injury. We have also continued to offer these trainings as they have been made available to NHPCO members. Training on the unique needs of veterans (including PTSD, Suicidal Ideation and Moral Injury) is also included in new hire orientation. • Several Veteran-centric staff presentations have been offered as part of the We Honor Veterans program. The above concepts have also been introduced at team meetings for Admissions Team, Social Work and Chaplain Teams and all inpatient, home and long-term care teams in four geographic service areas. Though not addressed in the orientation process, brief training on these concepts is also included as part

of the overall Annual Mandatory Education for all staff. • Hospice requires all staff and volunteers to Psych Armor training and view the Soul Injury webinar. • We also require viewing “15 Things Veterans want you to Know”. This is part of our orientation and each requires 1 hour. • Hospice has had additional training in these topics. We partnered with the VA from Cleveland to be part of their pilot program. We did 3 Skype trainings with our current staff (etc. Social Workers, Chaplains, Bereavement, and Nurses). • We just recently rewrote our suicidal\homicidal policy and procedure for all admissions. We now complete education with all staff\volunteers upon hire and yearly. Education is approximately an hour. • Very minimal training for staff. We participated some with the Care of Vietnam Era Veterans Education in 2019. This is an area we will need to work on. We do have bereavement coordinators with grief counseling background and one with mental health. We do have the ability to contract with an outside mental health group when needed.

All staff received training on PTSD, SI and MI. This will be included in our training for all staff-- our education team has created modules that will be available through our on-line learning and required annually for all staff.

Each staff person watches the 3 webinars created by the VA dealing with PTSD, Suicidal Ideation and Moral Injury. It has not been made part of the orientation process.

Part of new employee orientation

Staff have been participating in IL-HPCO webinars on trauma-informed care. Addition internal training has been provided by other hospice clinicians.

At this time we utilize trainings from outside of our network when made available

Heck, I have no idea how many hours, as we receive at least an hour in orientation, than further hours throughout the year as educational presentations.

Annual video presentations and monthly updates

About 2.5 hours

Part of the orientation process. Prior to grant initiative, training involved one hour for all.

Yes, it is a part of our orientation. We offer a 3 hour collection of videos in our annual staff education.

Educational training from the We honor veterans website is given to employees to view each month. Maybe 30 minutes for each

15 Things Every Vet Wants You to Know, as well as multiple videos from WHV website

No but should be

All staff complete the VHA train modules related to all three topics- they are each `1 hour in length. They will also listen to the recorded version of all three webinars that we presented in the month of office- this will be a requirement for the year- each 90 minutes in length. Yes - VHA train modules are required in orientation.

The VA trainings that have been offered are our only resource. It is not part of the orientation process.

Our entire staff has completed the WHV training on PTSD, Moral Injury and Soul injury, Our SW team provides intervention for Suicidal screening

Staff members are required to complete 12 hours of continuing education yearly based on their job requirements. Suicidal Ideation and the protocol to follow is included in orientation, 1 hour,

We are working on developing education for staff. This series has been very helpful.

None, unfortunately

We provide education and we encourage attendance of webinars like these. They are invaluable!

We just had three part training on PTSD(1 hour) MORAL INJURY (1 hour) and SUICIDAL IDEATIONS (1 Hour) on VHA Train. Our HVP will be putting together training sessions to offer to community organizations training on on all three sessions. This will be a three-part series for about an hour long. During orientation each staff member is required to watch a series of videos including Moral Injury vs Soul Injury, Suicide Prevention and PTSD. Each training is about an hour long. We have implemented quarterly trainings and annual trainings.

Training modules from WHV website used to train current staff annually and is incorporated into our new employee orientation process.

We just recently rewrote out suicidal\homicidal policy and procedure for all admissions. We now complete education with all staff\volunteers upon hire and yearly. Education is approximately an hour. Hospice requires all staff and volunteers to Psych Armor training and view the Soul Injury webinar. We also require to view "15 Things Veterans want you to Know". This is part of our orientation and each requires 1 hour. Hospice has had additional training in these topics. We partnered with the VA from Cleveland to be part of their pilot program. We did 3 Skype trainings with our current staff (etc. Social Workers, Chaplains, Bereavement, and Nurses).

Very minimal training for staff. We participated some with the Care of Vietnam Era Veterans Education in 2019. This is an area we will need to work on. We do have bereavement coordinators with grief counseling background and one with mental health. We do have the ability to contract with an outside mental health group when needed. Staff participated in education from Cleveland VA in 2020 as part of this grant program.

We have done trainings on PTSD, Suicidal Ideation and Moral Injury, we do them monthly at our Transitions of Care meetings. Training hours vary, usually 30 minutes to 1 hour and 30 minutes. We have not yet had a formal orientation training or training schedule developed but that is our goal to do so.

No specific number of hours, educational sessions set up every other week for 30 minutes with all hospice staff. A different topic is discussed and presented each time.

We need to do more, but we handle this during annual training and orientation

There has been training for staff for PTSD and Moral Injury. 1 hour for each, yes this is part of the orientation process

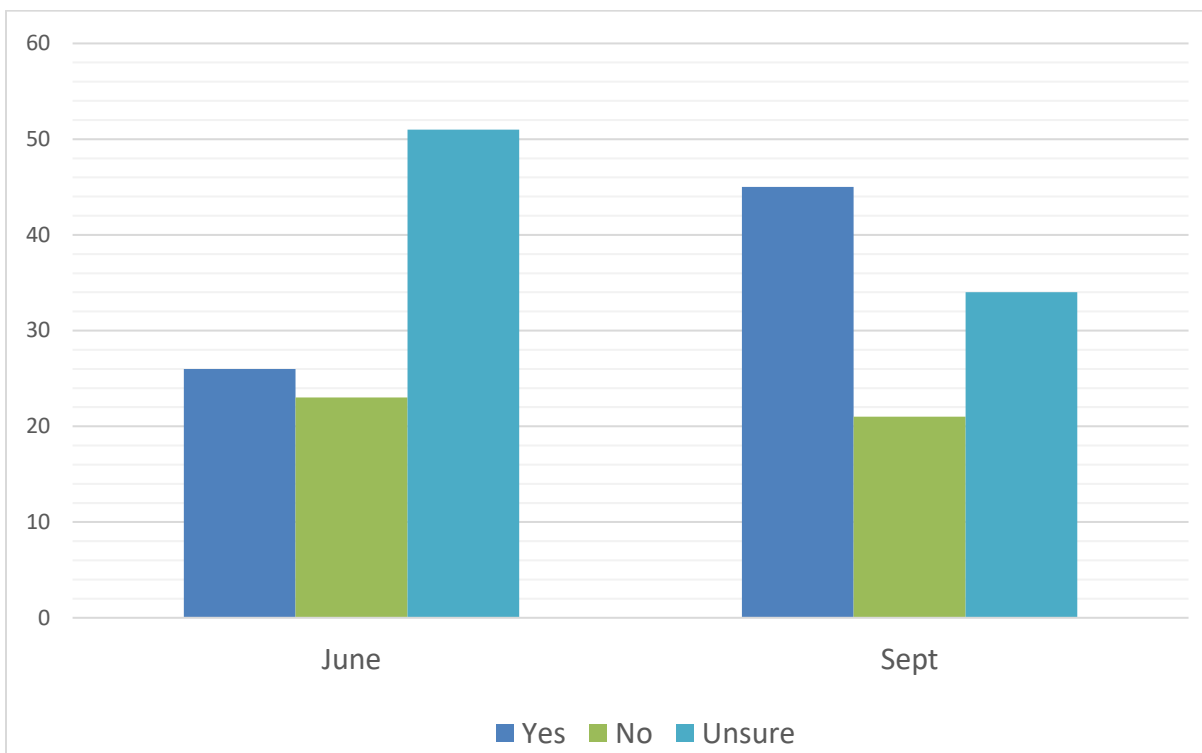
Annual training is required for each, 1 hour each.

Beginning the level one process for We Honor Veterans with a training each quarter focused on Veteran-centric education

There are several required trainings for Suicidal Ideations. There are several other trainings in the area of PTSD and Moral Injury that are available but not required.

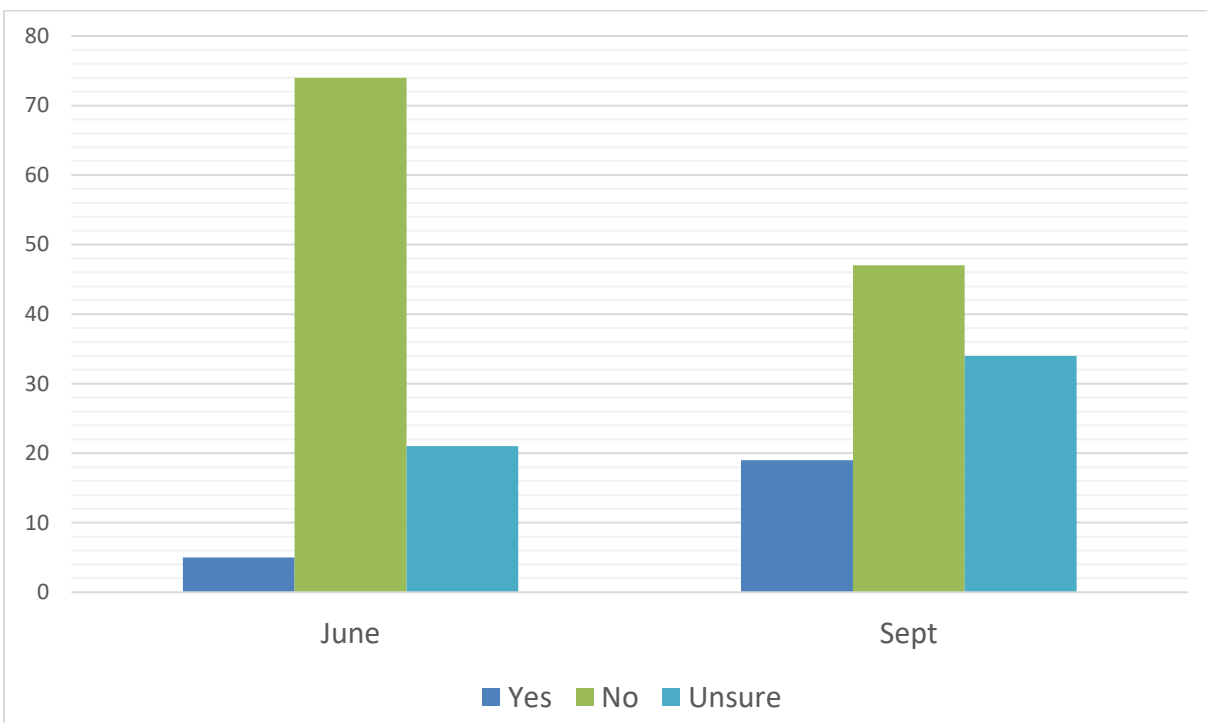
It is not currently part of the orientation process. All of our clinicians are required to be licensed. We are implementing the training from the recent TIC initiative into our training.

Is a Psychologist or other Mental Health Provider readily available to treat these common Veteran issues within 24-48 hours of diagnosis?



	June		Sept	
Yes	26%	58	45%	107
No	23%	51	21%	51
Unsure	51%	112	34%	80
Total	100%	221	100%	238

My hospice is currently collaborating virtually with a VA Mental Health Provider via Telehealth.



	June		Sept	
Yes	5%	11	19%	46
No	74%	162	47%	111
Unsure	21%	46	34%	81
Total	100%	219	100%	238

What is the most significant barrier/reason for not collaborating virtually with a VA Mental Health Provider via Telehealth? (check one):

Answer		
Difficulty identifying the appropriate contact person at VA to engage the Veteran in these services	21%	42
Difficulty getting the Veteran enrolled in order to receive services	11%	23
Veteran and/or family reluctant to receive or use VA services	10%	21
Our community hospice team is able to handle all issues related to end of life care	20%	41
VA Medical Center was unable to provide these services as requested	3%	5
Other (please describe):	35%	71
Total	100%	203

Other (please describe):

Child Welfare

Lack of awareness this was available, and Not having time to implement changes desired during COVID

When a veteran is admitted for hospice care, they are usually home bound and are too sick to receive treatment because they are dying. We don't get that many veterans, but the ones that we do are true Hospice patients.

The greatest challenge faced by our members was the short length of stay for the patients we felt may have been able to benefit from the services and in turn, introduce the concept of Telehealth and the technology associated with receiving Telemental Health support. Unfortunately, the short length of stay was a barrier to introduce the concept of Telemental Health Services and the technology was a potential barrier for those who were very late in their disease progression.

Short stay patients and families who have their own trauma from the PTSD/SI/MI of the veteran.

We have not come across a veteran to refer to date.

We only recently became aware of these services and are now beginning to use them.

We have had very few situations that our staff could not manage for the patient. However, we do have patients unwilling to use VA

More education needed about this service

Was not aware of the services. Look forward to learning more on 9/1 and educating our team. We will use them once we know how to access.

Not even aware it was available

Still navigating how to use the system.

We were not aware of the availability of this service.

Did not know it was available

VA so slow in getting back.

No issues

Takes VA so long to respond. Our hospice uses our webinar education and have MSW on call with nurse/chaplain 24/7.

Currently working to develop these relationships with VA Services.

Working to build this relationship.

Mental health issues in general are not addressed due to a lack of social worker availability, there are currently several open job postings.

The Medicare hospice organization connects hospice clients with outside support such as VA mental health support.

We haven't run into a need beyond what we provide.

In process of setting up.

We are working with our staff towards having a better collaborative approach with the VA.

Logistically, getting staff trained and developing processes to incorporate routine screenings was difficult to achieve in such a short time span. Another challenge was identifying appropriate screening questions. With regard to the trainings, there was consensus that the information/education was outstanding and very useful.

The greatest challenge faced by our members was the short length of stay for the patients we felt may have been able to benefit from the services and in turn, introduce the concept of Telehealth and the technology associated with receiving Telemental Health support. Unfortunately, the short length of stay was a barrier to introduce the concept of Telemental Health Services and the technology was a potential barrier for those who were very late in their disease progression.

No veteran patients.

Age of patients - not comfortable using technology because they have never done so.

This service has not been needed as of yet. If it does, I will be sure we reach out to the VA hotlines for assistance.

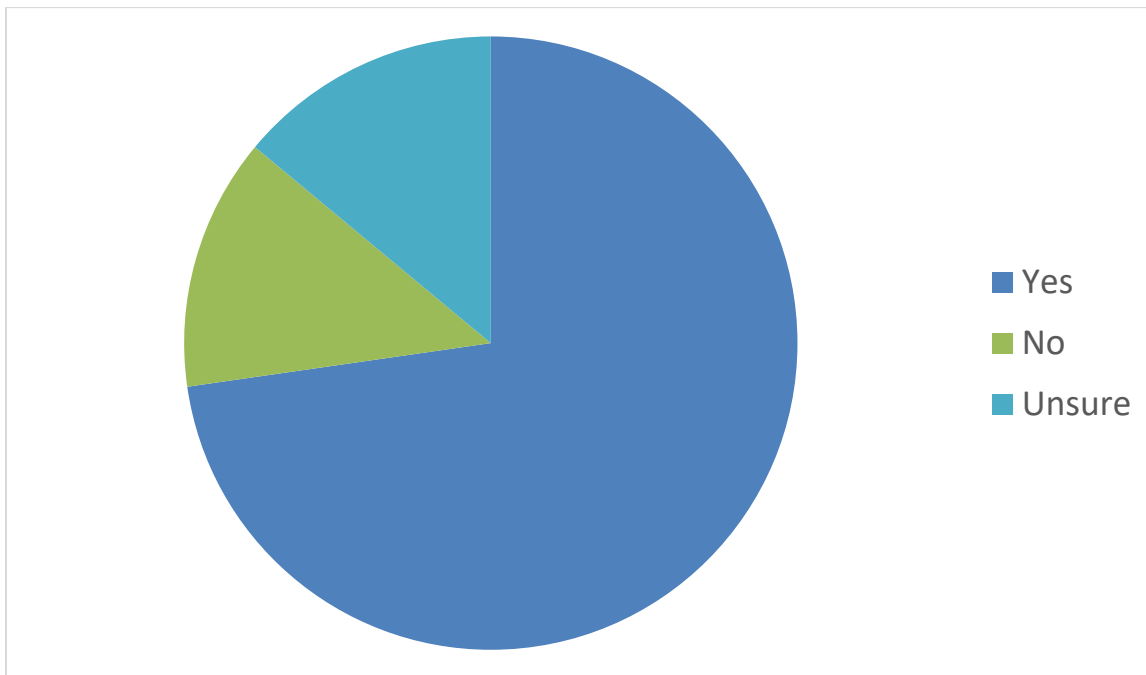
Have had these issues in the past and VA stated they were not able to do telehealth visits. We have not had any issues since the VA has been able to do telehealth visits for Hospice patients, but we have accessed it for Home Health patients that are not at end of life.

Veteran feels needs may not be met being LGBTQIA.

Unaware of difficulty communicating with the VA.

This is the first we have heard of this and would love to learn more!

My hospice is currently using protocols available (the Veteran's Care Planning Guide available on the WHV website - click [HERE](#)) to screen for PTSD, Suicidal Ideation, and Moral Injury.



Yes	224
No	41
Unsure	43
Total	308

Please enter the number of Veteran patients that have been screened using this protocol guide since the beginning of the initiative:

3,585

List the number of Veterans who screened positive in each of the domains (PTSD, Suicidal Ideation, and Moral Injury). If you do not have the breakout numbers, you may provide the total or any data that you have:

PTSD	187
Moral Injury	66
Suicidal Ideation	27
Uncategorized	225
Total	505

Please provide any comments, lessons learned, or feedback for NHPCO and the VA on this initiative. Is there anything you think is important to consider as we look to expand and improve the care of Veterans impacted by trauma?

I appreciate the information

Very informative

This webinar helped me to see things through the veteran's eye and to know the help is available for the patients and their families. I would like to know more, but as I stated our agency gets the patient when they are dying. Comfort care and encouragement and socialization from the SW Nd the Agency Chaplain is all we have been able to provide. I am the SW and I have connected veteran to the necessary resources for housing and sitters.

I am not sure that we had enough time to really see how the collaboration will work. The vets need to have the time to develop a trust with the nurses and SW. Would be good not only for hospice but for those needing home care in general to have the screenings completed and more time for the social worker to work with the Vet in their home setting.

We were able to find success in educating staff and promoting Telemental Health Services to veterans on hospice with a brief window of time and restrictions of COVID-19 on our community outreach opportunities. We also were able to improve relationships and increase contact between community-based hospices and the VA. We have increased clinical staff awareness of Telemental Health Services and the knowledge base of providers regarding PTSD, Moral Injury and Suicidal Ideation. Looking to the future, more access to Telemental Health Services by community-based Palliative Care Teams may be

the opportunity to provide upstream access to patients that would greatly benefit from the service. New, additional education furthering the knowledge base of the clinical staff would also be a great benefit. Physician focused education may also be an addition that would help to access Telemental Health Services and educate the clinical teams on a bedside level. There is also a place for community-focused education that may reach our veterans directly and help our veterans understand the availability or the services and technology associated with receiving Telemental Health Services. Participation in this effort has been a great honor and has greatly benefitted our clinical staff as well as benefitting the care of veterans, both now and in the future.

We found that many patients were not willing or able to process and address their particular trauma, however patients are not willing or able to specifically address or process. Family members and caregivers may benefit from a screening for their needs. Very often the trauma a veteran experiences is felt by the family and is experienced generationally. We see that surviving children and spouses could benefit from TIC in bereavement and to support as they provide care to their loved one.

The Veterans who come under care generally fit in one of 2 categories: proud of their service and appreciative of recognition and honor OR do not want to talk about their military experience. Makes it difficult to deal with them on moral injury or PTSD. The care of the veteran who has PTSD and moral injury needs to take place further "upstream" before they get into hospice care. We are willing and able to work with our veterans in their distress.

Great training, very knowledgeable presenters!

Loved the training webinars

We are very pleased to have VA PTSD consultation program available. Additional training from NHPCO/ILHPCO on screening for trauma would be appreciated.

We were unaware of the amount of educational resources available. Greatly appreciated.

This program is stellar in its efforts to reach such a vulnerable population as our veterans. I see many veterans frustrated that either they cannot find the right person to speak with, or they feel shut out of veterans services as they have no idea how to access offered services, or cannot figure out how to appropriately apply for services.

We were a secondary partner to a grantee so probably do not have all the background to make a complete assessment however this initiative seemed rushed. From our organizations standpoint it was a waste of funding, resources. It was confusing what the deliverables were. Unfortunately, we are left with very little to take away which is a complete shame. If anything I am more passionate about doing research on my own going forward, that is a positive.

Because we see so many veterans through our medical group, it is important to have more training from those who understand treating Palliative Care Veterans. I appreciate your continued webinars to help.

More collaborations needed by VA.

Continue to offer CeU training events, these are extremely helpful and impactful.

Better local access with va reps.

It has been very helpful. I would like more information on how to get a veteran enrolled in the VA system prior to him needing assistance when he come on hospice services. I thought I was assigned a mentor but I never received a phone call or anything from this individual.

Many staff members have mentioned how educational and helpful the videos were.

Great program! Thank you! Plan to educate staff and begin screening for PTSD and MI in next 3 months.

This is a great resource for training.

In the rural communities of South Georgia, the accessibility of the VA resources is an issue. Attempting to contact the appropriate staff is also a problem I personally have encountered.

I found the three I identified to have worse terminal restlessness than most. Very difficult to manage and causing great emotional distress to spouse.

Just grateful for the insights and tools offered. We are just beginning to realize how many resources there are!

More info available on local agency level.

We have only been consistently doing Level 1 with recognition of service and general mental health questions.

We are just getting started with screening,

Even in the VA, careful identification of Veterans impacted by trauma, so that appropriate referrals and treatment can be provided.

This was a great webinar.

As long as our Hospice maintains adequate staffing we will have the opportunity to offer quality time to listen to our patients and their families.

Hines VA has provided us with enormous support and ideas on how to best work with them and the Veteran community.

The NW corner of GA struggles to get in contact with VA reps without having to go into the Atlanta area. Any help with that would be appreciated!

I work with veterans as a social worker and I feel that we have more immediate services for suicidal patients, but not the ones who need access to Aid & Attendant benefit. My patients often die before they are often approved. This breaks my heart.

I was not aware of this tool but will be sending it out to our team.

This was a great initiative and the leader was amazing, well organized, provided great opportunities for our staff to learn.

We found that talking about moral injury was very helpful to families and some health care providers. It was a new concept which helped them understand some of the behaviors that patient might be exhibiting. We will be incorporating this material into our future volunteer trainings which will help raise awareness in the community of the issues that veterans face and support them in getting the compassionate care they deserve.

We do find that some veterans do not want to even register with the VA. Often their reasons are private and they are clear on not wanting to connect with the VA. On the other hand, veterans who have registered with the VA seem to be mostly happy with the services. All veterans who use the VA would like to have a center here in Washington County. No one enjoys that long trip to Augusta, especially when they are not feeling well or do not have a car that can make these long trips, especially in the winter months. It would be helpful if there was a representative from the VA who made home visits and the contact information for all VA services were posted EVERYWHERE for people to see and easily take home with them.

Veterans need all the help they need and many times they will not ask.

I really found this presentation helpful and look forward to beginning to utilize some of these tools.

We as Healthcare Workers need to strive to find a way to identify our Suicidal, PTSD, Veterans Patients in a timely Manner to help Combat so many deaths etc.

Our Hospice is adding to our Admission Booklets: Veteran Resources: Listing all the County Veteran Service Offices, with contact information. Such as address, phone numbers, and email. How to Enrollment for Veterans: Phone: 1-877-222-VETS (8387). Online: <https://www.va.gov/health-care/how-to-apply/> Veteran Information you need to have to Enroll: List Information: such as Discharge Papers etc. Frequently Asked Questions: 1. Does the VA pay for cremation and Burial Expenses? 2. What are my Burial benefits? 3. What can I do now to prepare for the burial in a National Cemetery? 4. How do I get a copy of my Military discharge papers? 5. Am I eligible for a burial flag? We provide the answers to these questions.

We learned that the process will take time to fully integrate. A basic routine screening or assessment is performed with the initial visits by the social workers and chaplains but we find that more in depth, accurate assessing of these issues is dependent on time and the building of trust with the Veteran, something not always available with a percentage of patients dying within a short time of admission to the program. Participating in this Initiative, however, has had a significant impact on increasing our awareness and understanding of these issues, has fostered a growing interest in developing skills and processes to assess and address trauma related needs, and has strengthened our relationship with our local VA, all of which, we believe, will benefit the care we provide to our Veterans at end of life. We are so grateful for having had this opportunity and are excited about expanding on these experiences to better serve this population. Thank you.

We were able to find success in educating staff and promoting Telemental Health Services to veterans on hospice with a brief window of time and restrictions of COVID-19 on our community outreach opportunities. We also were able to improve relationships and increase contact between community-based hospices and the VA. We have increased clinical staff awareness of Telemental Health Services and the knowledge base of providers regarding PTSD, Moral Injury and Suicidal Ideation. Looking to the future, more access to Telemental Health Services by community-based Palliative Care Teams may be the opportunity to provide upstream access to patients that would greatly benefit from the service. New, additional education furthering the knowledge base of the clinical staff would also be a great benefit. Physician focused education may also be an addition that would help to access Telemental Health Services and educate the clinical teams on a bedside level. There is also a place for community-focused education that may reach our veterans directly and help our veterans understand the availability or the services and technology associated with receiving Telemental Health Services.

It provided an opportunity to assess our Veterans in a different light thereby providing further resources for them if needed.

Our Electric Medical Records doesn't automatically track veteran status therefore maintaining a log for surveys like this need to be manual. Most veterans that have recently been admitted have been unable to verbalize or make the trip to the va to initiate services.

It was a challenge for some Social Workers to assess and go beyond the simple questions covering their branch, military experience, exposures, and their enrollment in VA benefits. It looks like I will have to have more training on how to address the questions to assess the "history of Service Related Issues" and also we need more education about how to formulate care plans addressing the unique needs of veteran patients and their families. Gathering information without proper Care plans with interventions will be useless data. Chaplains also will need more education and skills, which I am

already planning to provide, about assessing issues related to “Moral injury,” creating individualized and meaningful care plans with appropriate interventions. This 3-month-initiative (collecting data) gave us the opportunity to learn that to serve our veterans the what they deserve, we need to have more training in order to develop the required skills and work as a “TEAM” addressing their concerns and providing the emotional and spiritual support both, veteran patients and families need and deserve. I am putting together a binder with local resources available to address any symptom reported by patient or family. i have been in the Bereavement Manager position for 5 months and I am still learning my new role and the resources available for veteran patients and families

Thank you for providing an invaluable resource to our hospice, patients, families, staff - particularly new orients to end-of-life care.

Difficulty identifying and working with the appropriate VA person to engage/advocate for patient's mental health needs. After referral is completed, there is no follow-up to ensure the referral went through and issue was addressed.

Thank you.

We will be working harder to implement the things I have learned so far in this initiative and moving forward.

There needs to be more care for mental health for homebound home health patients as well as hospice because almost all of our patients transition to hospice within 1 to 2 years of becoming homebound.

The Veterans don't want to talk about their service injuries or bring up poor memories.

We look forward to utilizing all resources to assist our vets. Please continue to include us as new programs are released. Thank you.

Great program to utilize and use for our veterans.

Extremely informative information and valuable insight to understand the business and population health demands needed to address veterans.

Thanks for the valuable insight into Veteran issues.

Very informative series, increased my respect for veterans and willingness to help, please continue to educate the community.

I have learned so much from this training and need to integrate into program.

Very informative series.

How do we get pamphlets to be able to handout to our vets?

This program has created so many opportunities to connect with our veterans regarding their service and experiences. Thank you for involving our agency.

During the pandemic it is difficult to do community outreach and connect to community based Veterans groups.

I think this is a wonderful resource that is really needed.

I appreciated the virtual training being silent, giving time to review slides. Thank you.

I thought these trainings were very timely and greatly needed at this time.

We just truly appreciate receiving this kind of training and hope that this continues.

Grantee (State Hospice Orgs/HVPs) Final Submitted Reports:

Total Initiative Training Attendees – 3,594

Objective Outcomes:

- Created Trauma Informed Care Resource Page on CHAPCA website. Our webpage has received 2,585 hits/visits since May 19 and was used during webinar trainings.
- GHPCO has a wonderful relationship with the Atlanta VA Palliative Care team. We were thrilled to coordinate with them to provide 7 provider members the opportunity to collaborate directly with the Atlanta VA Palliative Care mental health provider resources and PTSD consultation program offering direct interaction with Atlanta VA clinicians to enhance the tele-mental health initiative.
- HHAU has encouraged its members to adopt the NHPCO VA TIC protocols that were shared with the participating states. Additionally, we have assembled a list of recommended screening protocols for moral injury, PTSD and suicidal risk and spoken with the VA about narrowing the list to a select standardized test for home use.
- 85% of the registered hospice agencies in Utah (i.e. 64/75) now have an established Trauma Informed Care Specialist designated as the Point of Contact for VA/NHPCO/HHAU TIC information.
- HHAU contacted the Salt Lake VA Telemental Health Director to notify them of our participation in the VA TIC initiative, and to begin a relationship of support of their services. We were also provided with contact numbers for the other Telemental Health geographic coverage areas in Utah. This information has been shared with the hospice agencies in the State through their TIC Specialists and we will continue and develop an awareness campaign with the VA Medical Center for their telemental health services and PTSD Consultation Program.
- As part of this initiative IL-HPCO established an IL-HPCO Veterans Workgroup, consisting of members from Illinois Provider organizations. This Workgroup will report directly to the Board and has a Project Manager as paid staff. In the past IL-HPCO has not had a focus on Veterans. Now, this workgroup, which will be a standing committee going forward, is committed to sustaining and supporting the work IL-HPCO has initiated with the TIC project.
- IL-HPCO hosted weekly conference calls with our workgroup, representing Veteran representatives in IL-HPCO Provider Agencies, and now a Phd Clinical Psychologist from Hines VA in Illinois. Our (now named) Veterans Workgroup hosted Zoom calls to respond and plan training, QUIRC surveying and suggestions to further expand information on the VA's palliative telemental health services and PTSD Consultation program. Our Officers, and Board, have approved this Workgroup to continue into 2021 and forward. We found Illinois VAs were focused on education and more than happy to provide experts.
- Our Hospice Veteran Partnership (HVP) is currently offering monthly training opportunities. One opportunity will be with a subject matter expert and the other is from the VA. We have created a Review Council that includes – Nikkie Ellis - Chair, LCSW from two other hospices, LCSW and RN from the VA Palliative Department. This group reviews case studies, protocols, PTSD Tools from

the VA, reviews all education materials to ensure that the teachings would benefit the partners, Flow Charts on when to use the Trauma Informed Care Telehealth Clinic Consultation. Nikkie was able to promote the proper use of the Plan of Care Guide/protocol to all of the hospices. The response from the VA and the Community Hospices when they saw the Plan of Care Guide was a positive and as stated “very helpful.” We were able to add a Licensed Clinical Social Worker who focused on trauma informed care at the end of life to our Review Committee.

- Weekly communication and updates about the grant and related activities with Teague Morris in Senator King’s Augusta office. Senator King continues to advocate for comprehensive broadband coverage. Maine HC was invited to join a roundtable discussion with Senator King to discuss the relevance expanding broadband coverage would have on health care. It gave me an opportunity to focus specifically on Veterans, as well as other individuals in our more rural areas, including coastal and island communities.
- NHPCO resources have been invaluable. In addition, there are many additional resources available through the VA and other internet sites. The care planning guide has been distributed to all as well as available on our website. As mentioned previously, the quarterly education meeting in October, as well as subsequent trainings, discussions and conferences provide valuable assistance to attendees as they use the guide for patient assessments. Literature has been emailed to 200 partners, conference attendees and interested parties. Resource information will also be posted on the MHC website. MHC has been and will continue to work with Senator King’s office to advocate for expanding broadband coverage in Maine. MHC Executive Director has a meeting scheduled with the VA Center Director to discuss the Hospice/VA Partnership, including strategies going forward. Until staff have more experience, I think it is difficult to differentiate these domains, especially “moral injury”. However, one agency that has a large mental health division, reported 204 primary diagnoses of PTSD in their case load. Not all of these patients are Veterans, but that data will be forthcoming. Delayed due to family medical emergency.
- OCHCH did interviews with staff from 4 VA Centers which included: Dayton VA—Patrick Cook; Cleveland VA—Jill Dunmire Siddiq; Cincinnati—Kathleen Francis; Columbus—Cara Reynolds. Additional interviews were done with Denise Kresevic and Dr. Muralidhar Pallaki from Cleveland VA Medical Center. The interviews were helpful to hear about the VA Medical Center/Hospice partnerships and how those partnerships can be strengthened. VA staff also shared challenges in working with local hospice agencies. In one interview the VA representative said “The local hospice is the expert in end of life care and the VA is the expert in Mental Health issues”. This statement hit home for this writer. The OCHCH TIC education goal was to ‘marry’ the two expert perspectives in order to improve Veteran care in the local community.
- CSNO members have and are implementing an ongoing effort to leverage our Trauma Informed Care experts and champions to utilize the trainings offered by Cleveland VA to implement more uniform and routine veteran care planning that addresses trauma informed care elements. This includes a Veteran Plan of Care and elements of the PTSD, Suicidal Ideation and Moral Injury training provided by Cleveland VA. This continues to be an ongoing effort to be continued well beyond the end of the grant period.

Barriers to Completing Objectives Originally Outlined (ex: Timing, External Parties):

- We are confident this direct access to the Atlanta VA tele-mental health resources specifically will continue for those providers initially introduced as well as expanding to additional providers over time. Unfortunately, the timing of the grant period was just too tight to allow for necessary evaluation of our efforts and those of the providers participating. We would love to have more time to continue the process and interaction with the Atlanta VA along with the participating providers so we could ensure effectiveness of the program.
- The tight turn-around timing left no time to properly follow up with those providers and participants to ensure effective use of the tool kit. A longer length of time would allow for much better follow up and enhance the experience for both the veteran patient and the provider offering care.
- The timing of the grant is the biggest barrier to providing valuable education as there is not enough time to implement follow up actions and guidance to help support the information shared and learned.
- Getting ahold of the right people and “advancing the ball” has been a bit difficult. It may have been helpful for National VA leaders to reach out to local leadership once the States participating in the initiative were announced, help establish contact, make introductions, and suggest or direct ways that we could work together on promotion.
- We were unable to find the Mental Health Professional to assist us with the task of promoting the proper use of the Care Planning Guide. The Review Committee is committed to finding a mental health professional willing to join to assist us with barriers our HVP members may have.
- In May and June I contacted the North Texas VA Medical center and San Antonio VA Medical center to connect about the tele-mental health program. North Texas Palliative VA team did not know how to collaborate/help me find the right person who could connect me with information about tele-mental health. I could not get SA to return calls/emails, but after expressing my concern on one of our check-in calls, Ryan Weller reached out and Katherine sent me a message forwarded from the SA VA with an emergency number a veteran could call to get that team to help. No one knows about this program at the VA Medical Centers in Texas. No one is willing to collaborate or help find information that I could share with the hospices.
- Community based hospices have difficulty contacting the primary care offices at VA Maine. “All calls to the VA are funneled through a central call center. The caller leaves a message, but it may take hours to days before they hear back from a provider or provider representative. This delays skilled homecare for Veterans. It’s not a problem for accessing hospice homecare, but can be if hospice staff are calling to obtain orders for unrelated interventions. All unrelated issues need to go through the VA PCP, so the same issue as above occurs. All related hospice issues go to the Hospice Medical Director. However, if the Hospice staff are having challenges obtaining needed orders, they often will call the Hospice and Palliative Care coordinator for needed assistance. Skilled homecare does not have a central contact person.” Internet connectivity remains the

challenge. If a Veteran lives in a rural community with limited internet access, the VA has to convert to a telephone visit. As one social worker said, “The care planning guide is wonderful. However, if it isn’t in the dropdown menu, it won’t be used.”

- The nature of care planning for Veterans is a sensitive area that agencies and staff would have to feel they were truly ready and feel comfortable and capable of doing prior to implementing. Some may feel there are areas within the guide may be out of their scope. The guide can feel overwhelming at times. It could have a different layout that focuses on those items that are easier to accomplish such as military rituals first, followed by the more in-depth care planning topics. The guide can be overwhelming, so potentially having the document broken down into sections with those more capable of being accomplished in a shorter amount of time would be listed first. Hospices expressed concerns over short length of stays and whether some things are reasonable to be accomplished in the hospice setting. Hospices would appreciate having something such as a national panel discussion among hospices who have used and had success with the care planning guide for Veterans. Other educational opportunities could be developed such as educational care planning for Veterans on hospice modules on specific topics.
- The Salisbury VA was wonderful to work with and I appreciate their support to our Association during this grant process. One area that I would still need to continue to work on is knowledge of how the telemental health hub works statewide if referrals occur across all parts of the state and how those would be processed and how they interconnect with Veterans who are enrolled in other VA Medical Centers across the state. Since this process was new to me, I believe this could improve as I continue to gain more knowledgeability about telemental health services.
- Our course does not actually create a certification or another credential for agencies to promote to the public/veterans community. As such, our “train the trainer” approach—where we ask several people from one agency to get the training and then take back info to their agency to train others—relies on the individuals who get the training to facilitate inter-agency training for which we are not participating in at this point. This may create inconsistencies between agencies where some agencies might be better, or focus more, at TIC than other agencies. This is something we hope to evaluate moving forward. We found there was limited staff availability due to the COVID-19 pandemic and the demands of providing care in the midst of the pandemic.
- A small window of time and local VSOs (specifically VFW, American Legion and VVA posts) being closed due to COVID-19 prevented us from a great deal of community outreach at this time. There is the possibility of future presentations once the VSO posts have reopened.
- The greatest challenge faced by our members was the short length of stay for the patients we felt may have been able to benefit from the services and in turn, introduce the concept of Telehealth and the technology associated with receiving Telemental Health support. Unfortunately, the short length of stay was a barrier to introduce the concept of Telemental Health Services and the technology was a potential barrier for those who were very late in their disease progression.
- I am still unsure if the VA in South Carolina is able to provide mental health support via telehealth or not. Probably the biggest barrier was identifying if there was enough staff to support this type of service within the SC VA Medical Centers. Not knowing meant being

unsure in how to adequately communicate what was truly available to the community hospices in SC.

- This occurred in the summer months, there were staffing shortages and vacation times as a result of COVID and summer which prevented some people from participating.

Were there any other unforeseen outcomes, barriers or experiences? How was this initiative received among community hospice partners?

- The biggest unforeseen barrier was participating in this initiative during COVID-19. Most hospice agencies were clearly focused on operations and handling patients during COVID. The feedback from the hospice providers that we spoke to was that they were very grateful that we were participating in this initiative and appreciative of the information and resources.
- Our community partners were thrilled to have the opportunity to participate in these training initiatives and seem very eager to be exposed to education focused on these three domains. While we had tremendous participation in the education events we offered, we found that there is a need for on-going education to reinforce the trainings as providers and community partners are so involved with so many aspects of care. To have the opportunity to continue offering focused education around PTSD, Moral Injury and Suicide prevention would be so valuable to both the providers and the patients they serve.
- The initiative was received very well among community hospice partners, regardless of their membership status with our association or NHPCO. We were pleasantly surprised that we were able to establish a Trauma Informed Care Specialist in so many agencies, and excited to see success recruiting them as We Honor Veterans Partners (at least 14 new Partners!). One of the barriers that we confronted, was being able to determine how well received the initiative was among front-line clinicians, because we did not assess how many employees of each agency completed VA Train sessions, nor what percentage of each agency's Veterans on service were screened. We encouraged agencies to screen new admits and those Veterans already on service, but we do not know how many Veterans were on service to begin with. Even having established TIC Specialists with so many agencies, it required a lot of follow-through to get the survey responses that we did and our team was concerned that there was data lost simply because some of the TIC Specialists didn't take the time to gather or report it.
- Our community hospice partners were very receptive to this, we were surprised at the cooperation. Now that IL-HPCO has become intentional about Veterans and TIC we will see more energy and reception. We thank NHPCO for initiating this project and bringing IL-HPCO into it.
- As far as the initiative directly, we saw no real unforeseen outcomes or barriers. The experience showed that we have very solid VA partners in these areas through Louisiana and Mississippi, that it becomes imperative to further relationships within those organizations to the VAs. Our goal in continuing further education with this subject would include honing in the skills presented in this project and helping further develop those relationships directly.

- Some of the unforeseen experiences we had were not knowing if the hospices were actually adapting the protocols. Of course, time is always the barrier. Not having enough time to really implement all we have planned, however we are going to continue on with this intuitive as planned. Some of the hospices were not willing to share scenarios (without violating HIPAA) that will help the HVP Review Committee present a “what to do in this situation” training. The community hospices and the VA were excited to have these trainings and want to learn how they can take the best care of their patients. Since beginning this initiative, our Hospice Veteran Partners has grown by over 30% which included other community hospices and other Veteran Service Organizations. Our HVP is heading in a great direction to better serve our veteran community.
- Based on feedback from participants of webinar evaluations, hospice partners strongly agreed the initiative provided both knowledge and educational tools that they found useful and relevant. Hospice partners indicated they will implement the knowledge and/or utilize tools into their practice either immediately or within six months. Via conference call feedback, hospice partners strongly agreed the initiative provided both knowledge and educational tools that they will implement into their practice. All feedback indicated the initiative promoted awareness of the available educational resources via NHPCO and the Veterans Administration. Prior to the initiative many were unaware of the valuable education accessible online. The most significant barrier/reason for not collaborating virtually with a VA Mental Health Provider via Telehealth was that Many VA’s in VISN4 do not have palliative tele mental health programs.
- I didn’t expect so many hospices to sign up. At first they were a bit worried about screening veterans and then they ran with it. I had about 30 hospices sign up and only 17 reported back numbers. The ones that reported back were very excited and positive about the training and the experience and will continue to screen and collect data.
- Many comments from family members and hospice staff about frustration and stress trying to reach the “correct” staff person at the VA when looking for information about healthcare benefits for specific diagnoses.
- During this 3-month period, many community hospice staff said they didn’t have time to think of anything else other than the pandemic and its impact on staffing and finances. Several VA staff were detailed to other areas and not available for webinars, conferences, trainings, or the like. Two community hospice programs said their board of directors did not think allocating staff time to TIC was a priority for their organization. The majority have been participating in WHV and/or think it a good idea to explore TIC further. As life would have it, emergency health issues surfaced with three staff involved with the grant. This had a bearing on their ability to invest their time.
- The initiative was appreciated by so many community hospices in our state. I received nothing but positive feedback from others on the appreciation for the education and outreach from our Association through this initiative as well as through our partnership as a Hospice Veteran Partnership (HVP) in the We Honor Veterans program. The announcement about the initiative caused many hospices to reach out one on one to discuss questions they had about the We Honor Veterans program or ways that their agency could grow their specific

efforts related to Veterans outreach and serving Veterans in their communities. From the beginning I explained to hospices that while the grant was short-term, our commitment to Veterans and helping hospices to better serve Veterans was long term. I am so excited and appreciative for being selected to be an initiative leader and look forward to all we will do together collaboratively in the future. It was also very rewarding to spend time on webinars/calls with other initiative leaders. I learned so much and hope for there to be more opportunities for initiative leaders to convene together via webinar/call in the future.

- The OCHCH Trauma Informed Care initiative was well received by Ohio providers. Participants were engaged and anxious to learn during the program. The only somewhat surprising aspect of working with community-based veteran groups is the general lack of knowledge of trauma informed care, which speaks to the need of this project. This isn't something that the general veteran community necessarily knew about or ask for, so we needed to explain what it was before we could explain this specific TIC program. The veteran groups have been very receptive to the project once they knew what it was and how veterans could benefit.
- The initiative was received very well by our CSNO members. Hospice of North Central Ohio echoed a recurring comment from our CSNO members. Many would like to see increased outreach to the palliative programs regarding the telemental health initiative within the VA. The hospice patient population is built upon the assumption that the patient population has six months or less to live. The average length of stay nationally within the hospice industry is about 60 days, so this leaves a short time frame to identify the trauma a veteran at end of life might face and make referral to services offered through the VA and allow the veteran to receive meaningful therapeutic responses to their needs. Patients within palliative programs often have at least a year of life expectancy depending on the program and this time frame could be longer depending on the palliative care program. By partnering with palliative programs in the telemental health initiative it increases the likelihood the veteran population can receive further meaningful therapeutic interventions because the likelihood of life expectancy is increased.

Stein Hospice has added the following to the Admission Booklet as a result of this program:

- Veteran Resources: Listing all the County Veteran Service Offices, with contact information. Such as address, phone numbers, and email.
- How to Enrollment for Veterans:
- Phone: 1-877-222-VETS (8387).
- Online: <https://www.va.gov/health-care/how-to-apply/>

Veteran Information needed to enroll:

- List Information: such as Discharge Papers etc.

As well as a Frequently Asked Questions:

- Does the VA pay for cremation and Burial Expenses?
- What are my Burial benefits?
- What can I do now to prepare for the burial in a National Cemetery?
- How do I get a copy of my Military discharge papers?
- Am I eligible for a burial flag?

Hospice of Cincinnati utilized trainings on Trauma Informed Care offered through VA Northeast Ohio Healthcare System and participated in ongoing telephone conferences to discuss how to access and facilitate use of telemental health services for our Veteran patients. This group was instrumental in helping to better navigate these resources through our local Cincinnati VAMC, strengthening the relationship with the Hospice and Palliative Care Coordinator at Cincinnati VAMC for assistance in connecting Veteran patients/family members to these services for Hospice of Cincinnati. The social workers will identify a need, refer it to the Veteran's Service Liaison for follow up, who immediately contacts the VA Hospice and Palliative Care Coordinator to understand whether a patient is already connected to mental health services at the VA, whether telemental health is needed and assist in accessing services for the Veteran. We learned that the process will take time to fully integrate. A basic routine screening or assessment is performed with the initial visits by the social workers and chaplains but we find that more in depth, accurate assessing of these issues is dependent on time and the building of trust with the Veteran, something not always available with a percentage of patients dying within a short time of admission to the program. Participating in this Initiative, however, has had a significant impact on increasing our awareness and understanding of these issues, has fostered a growing interest in developing skills and processes to assess and address trauma related needs, and has strengthened our relationship with our local VA, all of which, we believe, will benefit the care we provide to our Veterans at end of life. We are so grateful for having had this opportunity and are excited about expanding on these experiences to better serve this population. Hospice of the Western Reserve is adding information on Telemental Health Services and PTSD Supports to the EMR so that it continues to be a routine part of the screening and dialog with veterans we serve. This will allow the clinical staff to have a more direct access to making referrals to the resources provided by the VA and allow the veterans to be screened and referred throughout their time on service, currently the majority of screening takes place at admission, over the course of time with the veteran we may be able to find more information that would allow for an appropriate referral.

- We have gotten great feedback from the hospices on the 4 sessions. One reached out and said that 'this was the best education we have ever had... and it was free to us!'. Several participants discussed it on a VA Hospice Partnership call after the 4th session providing positive feedback, especially at the expertise of the speakers, that many were veterans themselves, and how helpful the tools would be to work with trauma informed care. One barrier in the series is that all VA Health Systems are not actively involved with their hospices, nor do they all have the same depth of experience and staff in their palliative care divisions. That provides us both a barrier as well as a nudge to still reach out to them and try to reinitiate the VA Hospice Partnerships

Please provide any comments, lessons learned, and feedback for NHPCO and the VA on this initiative. Is there anything you think is important to consider as we look to expand and improve the care of Veterans impacted by trauma?

- CA: CHAPCA was very honored to be granted the opportunity to participate in the Trauma Informed Care initiative. I appreciate the webinar check-ins, resources and ideas. The only suggestion I would make is to have a longer time period to reach providers in CA. Three months is a short amount of time. Most webinars need at least two months to promote in order to get the attendance up. In addition, the VA groups that meet monthly or quarterly need time to schedule us in their presentation, etc.
- GA: While GHPCO has a wonderful working relationship with the Atlanta VA and was therefore able to offer support and access to providers serving patient in the metro-Atlanta area, there is still a major disconnect with the two other VA Medical Centers in Dublin and Augusta. We were unable to engage community partners from those two areas in this grant period. Having more time would certainly enhance the effectiveness of that issue. We feel very grateful to have worked with the Atlanta VA in 2019 on the TIC train-the-trainer initiative and made every effort to maximize 2019 provider participation in this grant period to build on the work started. However, we feel the time between both initiatives was too long and the 2020 grant period was far too short. We would be thrilled to continue to participate in any funded efforts to further this initiative as we found certain providers to be very engaged and invested and GHPCO would love the opportunity to continue the relationship with both provider members and the VA partners in an effort to further educate the communities served.
- UT: We are very appreciative to the VA and to NHPCO for the opportunity of participating in this initiative and hope that the results of the study will result in other projects that will improve the identification and care of our Country's Veterans in need. Through the distribution of educational materials and our scheduled events, our members learned a lot about identification of concerns, particularly of elusive, and often misunderstood, moral injury. Our participation in the initiative also revealed or reinforced our awareness of the gaps in the system. We discovered a need to make TIC telehealth services more known and more available to community providers and Veterans. We also determined that standardized screening tests/protocols are needed to assist clinicians. Finally, the initiative has stimulated thought about how we can better engage front-line workers in hospice/palliative care, home health and personal care, to become better informed about TIC, and to then transform their compassion into compassionate action. We look forward to continuing support of the mission, and to working further with NHPCO and the VA in the future.
- IL: We have learned that often the VA representative in an agency is a volunteer, this makes it more difficult to establish contact and receive information. We are grateful to Katherine Kemp and her team for the information and guidance they provided every step along the way. We realize that NHPCO and this initiative encompasses a diverse group, and being new, we were impressed with the learnings and the tools provided by NHPCO. THANK YOU!

- LA/MS: I think the majority of the questions we had surrounded enrollment or expediting enrollment into VA services since we are working with those in end-of-life care. Though we had some wonderful interactions on the majority of the subject matter, this seemed to be the biggest concern. I really think it is very important to continue developing this initiative to further the relationships with our community partners and the VA to help figure out systems or work through other opportunities to ensure care can be provided to these Veterans in need.
- NV: Our community hospices loved the trainings and have requested more. Here is some of their feedback/take a ways from the trainings that we offered:
 - *What is the ONE THING you will take away from today's training to INFORM THE CARE (PTSD) you provide?* Knowledge of the contraindication of some medications; New resources; The vast number of services to provide patients and their families as resources to better meet their needs; Great information provided that I will share with our team; Respect; Resources the individual with PTSD can contact for help; That PTSD patients need consistency in the care team assigned to them, that trust is very important. Also that medications typically used for patients may not be appropriate for at patient with PTSD; Be more aware of PTSD; The medications to avoid while treating PTSD; The recommended vs non recommended medications in Veterans with PTSD; That whomever I come across under my care that they acknowledge that I am there for them and that I understand that it is very difficult for them after experiencing any life damaging events. Also so they understand I am not a threat but be that person they can trust if and when they have no one else.
 - *What is the ONE THING you will take away from today's training to INFORM THE CARE (Moral Injury) you provide?* How important it is in managing veterans mental health and understanding triggers and what we can do to manage their care; The steps approach; Let them lead the conversation; ask open ended questions, and accept if they don't answer; Be aware and it is ok to listen. Do no try and compare it to your experiences; Listen; Listen to my parents to help me understand what that went through and are going through; I loved how Nikkie gave examples of how to address certain situations and how to verbalize how important it is to make the Veterans feel at ease; To understand why a veteran feels depressed or stressed at end of life unlike others who embrace death; How to properly draw out information without making the person uncomfortable; I learned ways of appreciation for our service members; The concept of Moral injury; It's ok not to be the person who manages the need as long as you are the one who can connect the patient/family with the person who can manage it; A better knowledge of what Moral Injury is and how it may manifest; More compassion; The importance for us to be a bridge for family connection and the outside resources available; Compassion; Listen to the vet even if it doesn't make sense. Validate them; Listen; Information; It's okay to talk to patients about those subjects; Help give resources to the community; Understand the hidden trauma of a Veteran; How to use open ended questions to further engage patient's in discussions regarding; Instill confidence in the Veteran; Verbal processing and deepening exploration during life closure. A deeper understanding of the trauma and feelings a

Veteran has had to go through in the adjustment from military service. A better understanding of "unfinished business" the Veteran may still be having during EOL care; More Active Listening; Good Information.

- *Here is a list of a few trainings that community hospices would like to see in the future:*
Appropriate ways to start the conversation with veterans who don't like to talk about their experience; As a volunteer, I would welcome any other webinars that provide insight into how to assist veterans with moral injury; Assessment, more techniques (although the ones provided were very helpful); Conferences are nice when we are able to do them again; Dealing with a veteran in the middle of a PTSD episode; Guides with examples of scenarios/symptoms would be a wonderful help; Guides, conferences and consultations with supervisors, social workers; How best volunteers can support assessment of Moral Injury; How to manage terminal agitation of the combat veteran; I think training on how to communicate with veterans that feel regret for their service and would be useful; I would love more training on depression; Key words to avoid!; Managing existential pain; Mental health assessment; Mental Health interventions for PTSD, Suicide Prevention, Domestic Violence, etc.; More education on the history of the wars and our communities' response to them; Telehealth hints to help with assessment due to COVID; The dying veterans needs; Understanding them; Ways of detecting, signs to look for; Ways we can help in that moment, guides; Trainings specifically on actively listening to a veteran explain their experiences in their our way; Videos and visual examples of patient care with PTSD; Videos of dramatizations based on applicable principles that include assessment, specific symptoms & interventions with reality based outcomes.
- PA: The We Honor Veterans website, Veterans Administration website and the va.train.org are all a wealth of information. We highly encourage expanding the awareness of these resources. We plan to do so via our website(s), newsletters and through educational offerings. There is a high volume of information to navigate. Increasing the ease to navigate the most applicable and update resources available for veterans facing trauma would be an effective and efficient way to gain knowledge and deliver better care.
- TX/NM: I thought it went well considering the COVID environment. I would hope that next time all the VA medical center locations were informed and on-board instead of just a few areas of the country. That being said, it was a wonderful experience and I would do it again in a heartbeat.
- ME: Unless individuals have an appreciation of what it means to be a homeless Veteran, before being able to assess needs accurately, in order to give a care plan any chance of success. This is also the case for Veterans who are incarcerated and/or living in other care settings or ethnic communities. Mentorship programs would be helpful. There needs to be more comprehensive data collected on numbers of Veterans in prisons in the United States, as well as research on the correlation between PTSD, Moral Injury and crime. Continuing education on TIC should be required for all health care professionals because a history of trauma may have a significant impact on the care plan. Classes on TIC should be part of the core curricula for all undergraduate students in health care. MHC works closely with several academic institutions, as a placement site for

interns. We shall continue offering guest lectures on TIC as schedules permit. Developing trust with a Veteran is probably one of the most important factors necessary for successful care planning. Veterans listen to and trust Veterans before anyone else. Over the years, MHC has encouraged hospice programs to hire or engage an appropriate Veteran volunteer to be part of the team. In many cases, this has proven to be immeasurably helpful. We also need to engage Veterans to facilitate Veteran -centric education classes for the health care community. Communication pathways and collaboration between and among community organizations and the VA need to be seamless in order to care for our Veterans and their families. It takes all of us listening, learning and working together to convey that we really do care.

- NC & SC: I feel the area I need to do more work on of all the grant objectives within the state is on the care planning guide for Veterans. I only had brief discussions and would need more time to further develop dialogue and discussion and subsequent educational offerings around this topic and truly see us make more of an impact in Veteran Care Planning. Other thoughts:
 - Continue to look for ways to make educational opportunities available, especially an educational panel discussion for Veteran Care Planning, possibly a dedicated workshop around Veteran Care Planning. There could be specific educational modules developed to expand on the content and help agencies to develop or improve care planning for Veterans.
 - Continue the role of “Initiative Leader” for those Associations and Organizations who were chosen for this grant so that the momentum can continue in our work together collaboratively. Work as an initiative leader task force to continue to strengthen community hospices ability to care for Veterans nationally as well as build stronger VA/Community Hospice partnerships.
 - Offer initiative leaders continued opportunities to engage with national VA leadership representation to continue to learn and work collaboratively together.
 - I would like to close by saying Thank You! Thank you for this opportunity and I am so appreciative that our Association and community hospices statewide were able to be a part of this initiative.
- OH: I appreciated the responsiveness and assistance provided by the VA Medical Center staff. They were supportive of local hospice programs and offered good insights of how the partnership between the VA Medical Center and local hospices could improve. OCHCH began the TIC program with the intention to train the first group of participants. However, OCHCH sees this as an ongoing process and will continue the training with the next group of participants in November 2020.
- OH: We were able to find success in educating staff and promoting Telemental Health Services to veterans on hospice with a brief window of time and restrictions of COVID-19 on our community outreach opportunities. We also were able to improve relationships and increase contact between community-based hospices and the VA. We have increased clinical staff awareness of Telemental Health Services and the knowledge base of providers regarding PTSD, Moral Injury and Suicidal Ideation. Looking to the future, more access to Telemental Health Services by community-based Palliative Care Teams may be the opportunity to provide upstream access to patients that would greatly benefit from the service. New, additional education furthering the knowledge base of the



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clinical staff would also be a great benefit. Physician focused education may also be an addition that would help to access Telemental Health Services and educate the clinical teams on a bedside level. There is also a place for community-focused education that may reach our veterans directly and help our veterans understand the availability or the services and technology associated with receiving Telemental Health Services. Participation in this effort has been a great honor and has greatly benefitted our clinical staff as well as benefitting the care of veterans, both now and in the future.

- NY: We really appreciate this opportunity. The care of our veterans is very important to us at HPCANYS, and to the hospices. We focused on the WWII veterans and had lots of energy around making their care the best care possible when 1,000 were dying a day. This initiative now has brought the other veterans and their needs to the forefront for our hospice providers and given them tools to give these veterans the best care possible. Thank you so much for presenting in the last session, and for all of your support and encouragement.