Fall 2020

Rural Veterans of Texas and Their Accessibility to Mental Health Care Services

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Rural Veterans of Texas and Their Accessibility to Mental Health Care Services

A Dissertation

Presented to the Faculty of the

Department of Public Policy and Administration

West Chester University

West Chester, Pennsylvania

In Partial Fulfillment of the Requirements for

the Degree of

Doctor of Public Administration

By

Jeremy Buchanan

December 2020

Dedication

To my son, Jordan, as reminder that there is always more to learn and that you need to always check your sources and to Erika for dealing with me as I continue to keep learning more.

Acknowledgements

Thank you to Dr. Amanda Olejarski, my advisor, for all your guidance, assistance, and input as I worked through this dissertation.

Thank you to Dr. Angela Kline who pointed me in a more focused direction and narrow down how I can pursue a more clear and succinct paper and Dr. Jenna Gress-Smith for your breadth of knowledge on this topic and opening my eyes to some very important information, legislation, and policies regarding the mental health of veterans.

Lastly, thank you to Tim Keesling, Director, Veterans Mental Health Coordination and Programs/TX HHS for taking the time to speak to me and provide a great wealth of information for what the State of Texas is doing to address the mental health care needs of veterans.

Abstract

After their service commitment has concluded, United States servicemembers are evaluated to what medical ailments and afflictions, both mental and physical, are attributed to their military service. The Department of Veterans Affairs is the government agency that is specifically tasked with the treatment and care of that exam and continuously works on this overwhelming endeavor as military members transfer out from their respective branch of service. One area that is outside of the VA's control is where veterans will reside upon their separation from the military. When it comes to rural areas, the access to resources, primarily for this study, mental health resources, are very limited. This study examines the mental health care resources available within the rural areas of Texas and gives a quantitative analysis in how the VA and in Texas Health and Human Services are addressing the mental health issues afflicting veterans. Through a community needs assessment, this study evaluates what approaches would work best in Texas and assist in the identification of mental health treatment methods that can be utilized in rural areas, while also taking into consideration the different types of technological mediums that veterans in rural areas can use to gain access to more mental health care resources and how programs are being implemented. Through review of the MISSION Act and discussion of the manner in which this piece of legislation directs the VA to implement policies that directly affects veterans, to include the discussion of the moves towards privatizing the VA, a public administration policy literature review is conducted inclusively of this study. It is determined that there are significantly no differences between rural and urban mental health providers, and that mental health care providers are willing to provide treatment as long as the VA is providing funding and training to these providers.

Keywords: Rural, Veterans, Mental Health, and Needs Assessment

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Chapter 1 – Introduction

The Department of Veterans Affairs (VA) Veterans Health Administration (VHA) has the responsibility and duty to provide health services to United States military personnel after their obligation of service ends with the Department of Defense. When separating from the military, after an honorable discharge, servicemembers go through the process to submit claims to the VHA to identify ailments and afflictions that may be connected to their military service and will now be covered under the VHA system of care. Yet, the consideration must be made to those veterans who may be suffering from mental health illnesses that have been undiagnosed by the VA or were not discharged honorably from the military, but who have a mental illness connected to their military service. An underlying challenge that exists is where veterans reside and their distance to the VHA facilities to receive their treatments; the VA uses the distinguishing factors determined by the U.S. Census Bureau and the definition schemes of the Rural-Urban Commuting Areas (RUCA) that is discussed further in this research. VHA hospital and outpatient facilities are strategically placed around the country in mostly urban areas to provide access to veterans in concentrated populations and for those in rural areas to commute to these facilities, which are supplemented by Community-Based Outpatient Clinics (CBOC) to assist the VHA with the veteran populations in the VHA facilities and clinics servicing areas to provide further reach for their treatment services . However, the large population of veterans that reside in areas that are considered rural still have difficulties gaining access to VHA clinics, many of which are considered as *underserved*. Rural residing veterans who are in need of health care treatments face additional difficulties depending on the severity of their issues and the frequency in which they need treatment, yet another aspect of this is the need for mental health treatment. Mental health treatment resources are scarcer in rural areas, especially in regard to available

resources commensurate with the VHA's mental health treatment requirements, especially for those in need of treatment outside of a regular schedule (i.e. emergencies), meaning that these mental health resources need to be in their local/rural community, or at least easily accessible in some manner.

The efforts of research in regard to this topic are emerging and the needs for adequate VHA provided care to veterans residing in rural areas is garnering attention from many areas of research, from states and commonwealths across the United States, and within the Department of Veterans Affairs, including the MISSION ACT of 2018. According to the VA, "The Veterans Health Administration (VHA) is the largest integrated health care system in the United States, providing care at 1,255 health care facilities, including 170 VA Medical Centers and 1,074 outpatient sites of care of varying complexity (VHA outpatient clinics) to over 9 million Veterans enrolled in the VA health care program" (Veterans Health Administration, 2019). With this large amount of people to serve and the number of VHA facilities, centers, and clinics located throughout the United States, their inability to reach all of them is inevitable. Due to this fact, the VHA has been proactive in its efforts to address this gap between services needed by rural veterans and the VHA's inability to serve them through its Office of Rural Health (ORH) Programs that solicits research, innovative ideas, and new programs from academia, state and local governments, private industry, and non-profit organizations (Veterans Health Administration, 2019).

Created in 2006, the Office of Rural Health Programs is the focal point of VHA's efforts to provide health related services to veterans who reside in rural areas. Its mission is based on the three principles for determining the best practices in reaching rural veterans: research, innovation, and dissemination (Veterans Health Administration, 2019). Through review of the

publicly provided information from ORH, it appears that the office is transparent in its objectives and supports and advocates for research efforts to bring about change and identify needs to serve veterans who reside in rural locations. The challenges of meeting the mental health care needs of veterans who reside in rural areas is gaining attention in research and is paving ways for the VHA's Office of Rural Health Programs to expand its reach and better serve the needs of this subset of America's veterans.

The purpose of this study is to provide public policy research using a positivist approach, a study based upon scientific evidence and statistics, that will give information and insight into the mental health treatment resources available to veterans in rural Texas areas through community resources that are supported by the VHA through its Office of Rural Health, legislation, and other offices. Additionally, the findings of this study are relevant to show comparisons of the studies in other states concerning this very issue to that of the State of Texas discussed within the scope of this research. It highlights the manner in which communities are providing mental health resources to veterans and gives insight to the ORH and VHA on its methods to address the gaps in treatment that rural residing veterans are unable to obtain, as well as other methods that may be used to assist in providing these treatments; i.e. tele-health (mobile applications) and other new technologies.

Through a needs assessment administered to private practices, government clinics (public health offices), and non-profit organizations, quantitative data is gathered to test a variety of analyses to determine their capabilities, processes, treatment methods, and willingness to treat veterans, to include their inclination to treat veterans, as well as, determining their current participation in veteran mental health treatment programs in which they'd be involved. Based upon the data collected, along with other studies that have taken place in other states and

commonwealths, interviews were requested with officials at Texas Health and Human Services and the Department of Veterans Affairs Office of Rural Health and other representative from the VHA's mental health programs in Texas to determine their implementation of treatment programs in rural areas of Texas and other states, to include the success, barriers, and failures they have met in rolling out these types of programs. Ultimately, a mixed methods approach, was used to compare the data collected to other state programs and research regarding veterans, and provide governmental offices, at both the state and federal levels, to give additional insight into the issues in their implementation and rollout processes for mental health care treatments to rural veterans.

Based upon the foundation of the data collected and in regard to the VA MISSION Act, three main points of interest will be reviewed and analyzed that the legislation addresses: accessibility of care for mental health care, training for non-VHA mental health practitioners, and funding to non-VHA mental health care practitioners.

Research Questions and Hypothesis

This study examines the following research questions and hypotheses:

RQ(1) – Are there significant differences between the mental health care providers in rural, urban, and unknown [to the provider] areas to their designation as mental health care providers with regard to their willingness to provide treatment to veteran patients with support from the VHA or their designee?

H(1)o1– There are statistically significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their willingness to provide treatment to veteran patients with support from the VHA or their designee.

H(1)a1– There are statistically significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their willingness to provide treatment to veteran patients with support from the VHA or their designee.

RQ(2) - Are there significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their screening of patients for military service?

H(2)o1 – There are statistically significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their screening of patients for military service.

H(2)a1 – There are statistically significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their screening of patients for military service.

RQ(3) – Are there significant differences between mental health care providers respondents location and their clinic's sector (private, public, or non-profit) with regard to the methods of treatment they provide?

H(3)o1 – There are statistically significant differences between mental health care providers respondents location and their clinic's sector (private, public, or non-profit) with regard to the methods of treatment they provide.

H(3)a1 – There are statistically significant differences between mental health care providers respondents location and their clinic's sector (private, public, or non-profit) with regard to the methods of treatment they provide.

RQ(4) – Are there significant differences between rural, urban, and unknown located mental health care providers who are willing to treat veteran mental health care patients with training or

funding support with regard to sector (public, private, and non-profit) of mental health care they provide?

H(4)o1 – There are significant differences between rural, urban, and unknown located mental health care providers who are willing to treat veteran mental health care patients with training or funding support with regard to sector (public, private, and non-profit) of mental health care they provide.

H(4)a1 – There are significant differences between rural, urban, and unknown located mental health care providers who are willing to treat veteran mental health care patients with training or funding support with regard to sector (public, private, and non-profit) of mental health care they provide.

RQ(5) – What has the Department of Veterans Affairs and the State of Texas Health and Human Services done so far to implement technologies, policies, and procedures into action for rural veterans in the State of Texas?

Testing of the research questions and their hypothesis through a mixed methods approach provides a public administration study with the purpose of the identifying policies and programs that are in place or should be implemented to the close the capability gaps that exist between veterans and their accessibility to mental health resources.

Chapter 2 – Literature Review

Introduction

As of June 2015, the Department of Veterans Affairs released a report that 62 percent of all Operation Enduring Freedom and Operation Iraqi Freedom veterans have used VA health care since October 2001; between July 1, 2014 and June 30, 2015, 738,212 of these veterans accessed the VA health care (Office of Public Health, 2015). "The frequency and percent of the three most common diagnoses were: musculoskeletal ailments (759,850 or 62.3 percent); symptoms, signs, and ill-defined conditions (715,263 or 58.7 percent); and mental disorders (708,062 or 58.1 percent)" (Office of Public Health, 2015). It needs to be noted that veterans can have more than one diagnosis. In addition to the VA's publishing of their national reports, they also report their findings per state, in Texas, as of September 30, 2017, there were 1,584,844 veterans, 747,221 who were enrolled in the VA health care system (National Center for Veterans Analysis and Statistics, 2017). According to the following figures provided by the Department of Veterans Affairs (Figure 1) and Department of Agriculture (Figure 2) the amount of rural counties within the State of Texas is categorized as almost all counties, with the state recognizing 172 of its 254, almost 68%, counties as rural, and the amount of VA mental health treatment facilities considerably overwhelmed in comparison (Texas Department of State Health Services, 2015).

Definition of Rural

To understand why a need exists for the VHA to deliver health care to veterans who reside in rural areas due to the limited access to mental health resources in their community, the definition of *rural* needs to be established as a foundation to reference throughout the scope of this research. In order to determine a working definition of rural, existing rural veteran research

is utilized and compared to the definition set forth by the VHA. The definition of "rural" provided through the VHA, although lacking substance, is set by the Departments of Agriculture and Health and Human Services. Bumgarner et al. explain in their literature review regarding mental health care for rural veterans, "[l]ess than half of the articles reviewed were found to report adherence to a specific definition of rurality…described…as a significant confound to rural research" (Hart, Larson, & Lishner, 2005; West et al., 2010, as cited in Bumgarner et al., 2017, p. 227). West et al. (2010, as cited in Bumgarner et al., 2017, p. 227) suggested that VHA rural designations should be supplemented with more detailed breakdowns, like those of the Rural–Urban Commuting Areas (RUCA) designation schemes (Bumgarner et al., 2017, p. 227).

Presumably, the ORH will always base its actions and policies on the VHA's approved definition of rural; therefore, a determination must be made if their definition does align with the what research outside of VHA has established as a definition, as well. In conjunction with the development of the Rural-Urban Commuting Areas (RUCA) system, which is used by U.S. Census Bureau in their counting methods and used by the VHA in their Urban/Rural/Highly Rural designations, the following category schemes will be used throughout this study (Veterans Health Administration, 2019):

- Urban Area - Census tracts with at least 30 percent of the population residing in an urbanized area as defined by the Census Bureau.
- Rural Area - Land areas not defined as urban or highly rural.
- Highly Rural Area - Sparsely populated areas – less than 10 percent of the working population commutes to any community larger than an urbanized cluster, which is typically a town of no more than 2,500 people.

These three categories that further expand the definition of rural under the RUCA system are what provides additional reference points as the term rural is explored further.

In 2010, an article published in the Journal of Rural Health, *Defining "Rural" for Veterans' Health Care Planning*, explored more in depth what constitutes the definition of rural based upon the definition that the VA bases their policies upon. Within this article, a more thorough explanation is given to the set of parameters that the VA has established as which health services should be provided within the veterans' residence and how it relates to the Urban/Rural/Highly Rural categorical designations. According to research within this article, the VHA has broken down the schemes as follows to meet the VHAs "access standards" (West et al., 2010, p. 306):

(1) 70% of veterans should have to travel no more than 30 minutes to VHA primary care if they are Urban or Rural residents, or no more the 1 hour if they are Highly Rural
(2) 65% should travel no more than 1 hour to access a VHA acute care hospital if they are Urban, 90 minutes if Rural, and 2 hours if Highly Rural; and
(3) 65% should travel no more than 2 hours to VHA tertiary care if they Urban or Rural residents, or beyond VISN (Veterans Integrated Service Network) boundaries if they are Highly Rural.

Furthermore, the VA has established access stands, which needs to be considered in regard to this and similar studies. Access standards, per the Department of Veterans Affairs Office of Public and Intergovernmental Affairs, are as follows (2019):

- Based on average drive time and appointment wait times.
- For primary care, mental health, and non-institutional extended care services, VA is proposing a 30-minute average drive time standard.
- For specialty care, VA is proposing a 60-minute average drive time standard.

- VA is proposing appointment wait-time standards of 20 days for primary care, mental health care, and non-institutional extended care services, and 28 days for specialty care from the date of request with certain exceptions.
- Eligible veterans who cannot access care within those standards would be able to choose between eligible community providers and care at a VA medical facility.

By taking these parameters into considerations and the VHA approved definition based upon the determinations of the Departments of Agriculture and Health and Human Services, a working definition is established with a framework to the boundaries put in place. However, limitations to the definition must be identified; time is only one aspect of the equation when it comes to distance, another area that needs to be explored more in depth is the true measure of distance, i.e. miles from the facilities. Another fault in the classification designations that are put in place is that they are contradictory, depending on the viewpoint of the organization, i.e., RUCA and U.S. Census Bureau versus U.S. Departments of Agriculture and Health and Humans Services, versus that of the State of Texas, as well.

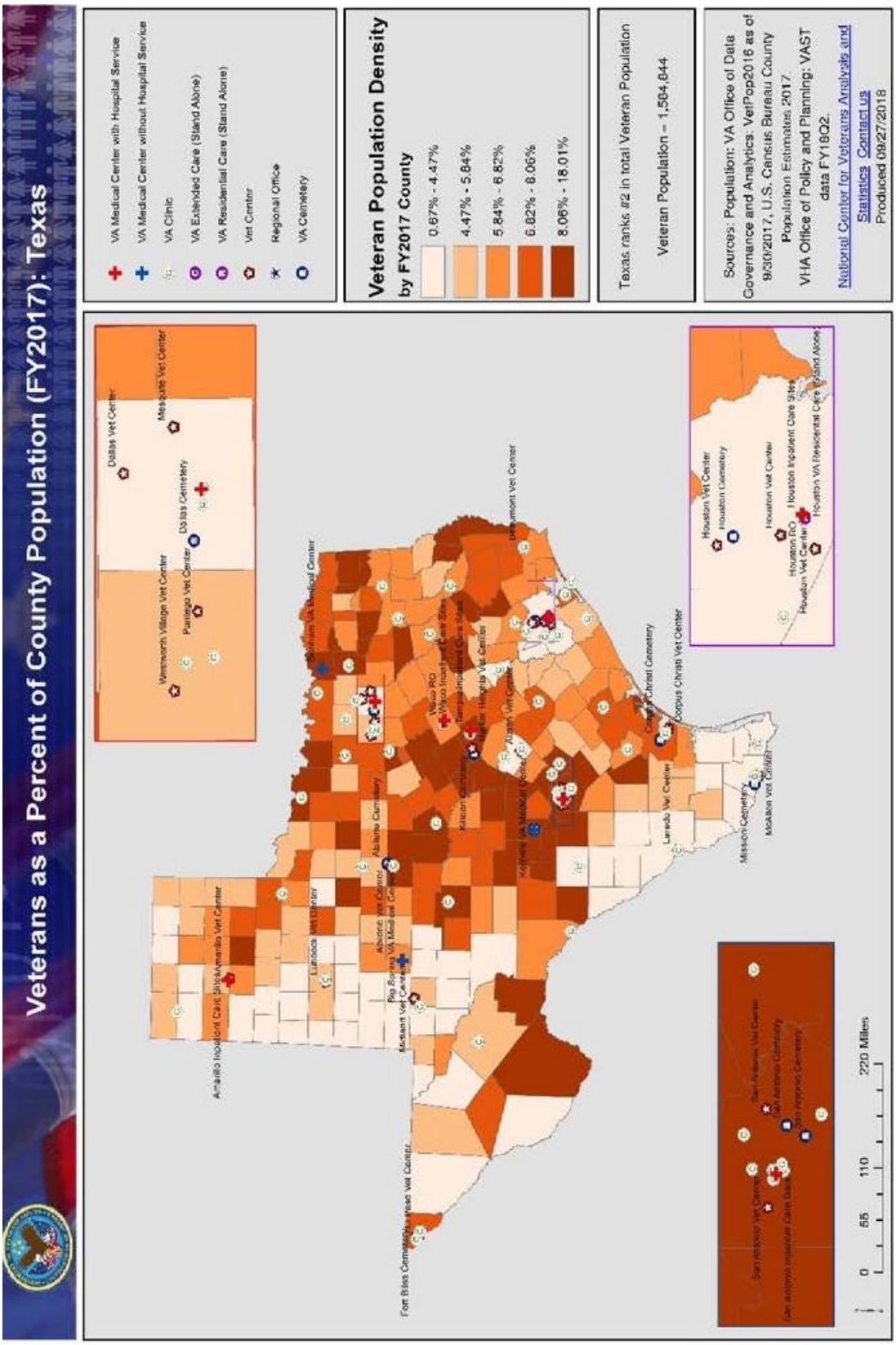

Figure 1: National Center for Veterans Analysis and Statistics, 2017

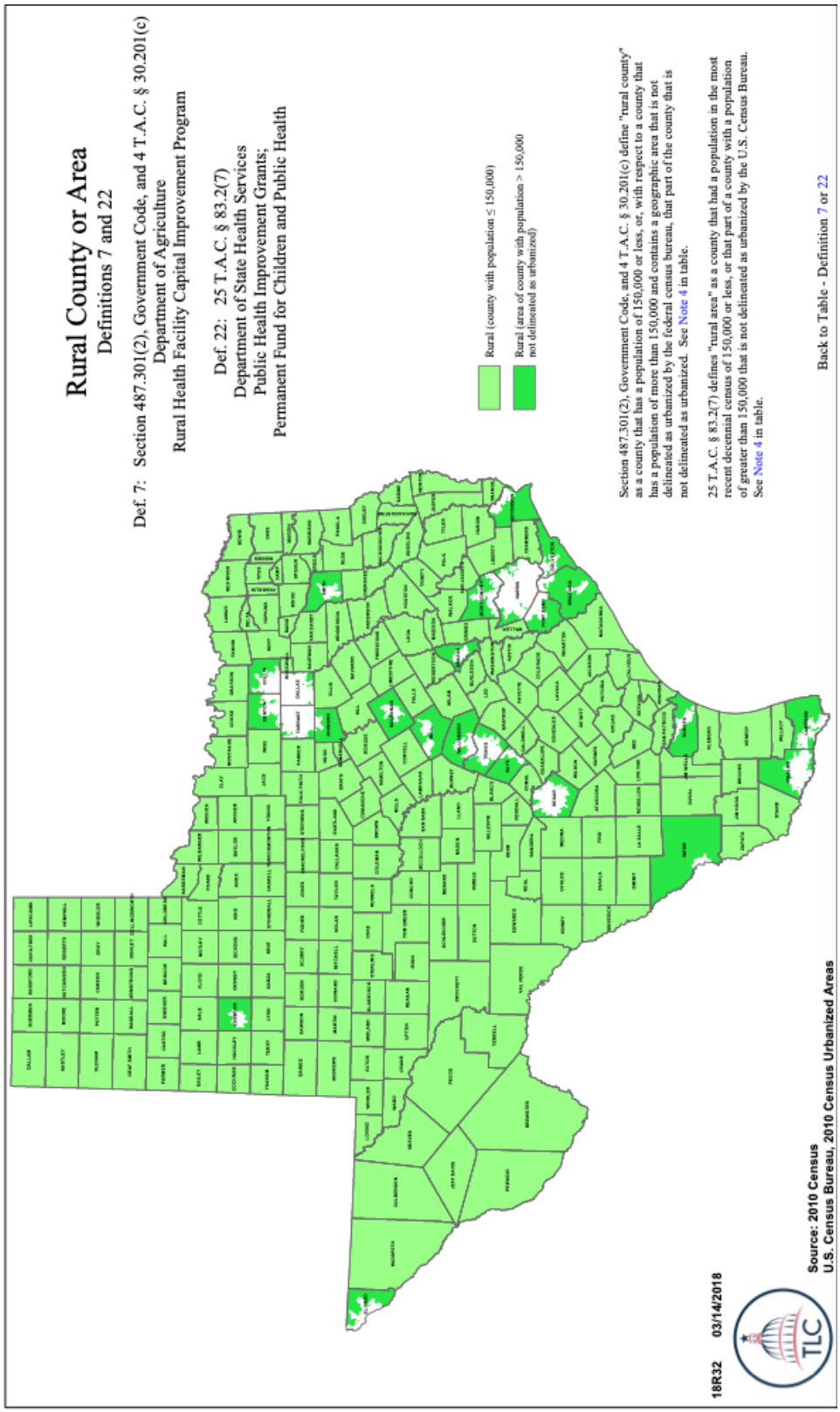

Figure 2: *Texas Legislative Council, 2018*

Previous Studies as a Framework

Studies focusing on the health treatment of veterans in rural areas are continuing to grow in scope and content per the purpose of the ORH and the increasing awareness in gaps of services. Due to the large geographic area that the VHA has to cover to address the health concerns with veterans in rural areas, the need to break down the research and needs of veterans should be addressed at the state, regional, county, and local community levels. These efforts to identify any phenomena that may be occurring in one area compared to another. In 2011, a comprehensive study took place in Alabama to evaluate what health care needs rural Alabama veterans were having unmet by the VHA, *Alabama Veterans Rural Health Initiative: A Preliminary Evaluation of Unmet Health Care Needs.* This study focused on three primary research questions to determine the amount of rural Alabama veterans who use VA health care services; the unmet needs for these veterans by the VHA; and the barriers that are preventing them from obtaining the care they need (Davis et al., 2011, p. 16). The foundations of this study and the methods utilized provides data that is comparable to data from different studies that have been conducted from other areas of the country, provide causal information to determine reforms to VHA health care provisions, and devise new programs to assist in more accessible health care for rural veterans.

The amount and types of health professionals in the vicinity of rural residing veterans can be a contributing factor to provide effective treatment. Additionally, changes in technology can also provide health care to veterans throughout the nation through telecommunication applications. Yet, in order to determine the possibility of such endeavors, understanding the needs of mental health practitioners across many communities must be made so the demand of such applications can drive their need in the industry. Through the use of needs assessments as a method of

gathering data to determine if services are available or if they have the potential to be available to veterans in rural areas; ultimately, determining if health professionals are capable of providing these services. In 2009 through 2010, a study was conducted in Pennsylvania that utilized a *Needs Assessment Survey* with the Geisinger Health Systems, which is spread across 43 counties in Pennsylvania (Boscarino, 2010, p. 162). Research conducted within this study is commensurate with research conducted by Boscarino et al. (2010) with a focus on the mental health of rural residing veterans in Texas. Through this study, it was determined that a significant amount of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans were seen for mental health problems and that a majority (65.4%) of the facilities reported to have a mental health professional on staff to assist in these matters (Boscarino et al., 2010, p. 169). It was determined through their needs assessment that providers in this study lacked knowledge of dealing with veterans with PTSD and other combat related mental disorders, to include the overall VHA resources available (Boscarino et al., 2010, p. 169). Through findings and methods exhibited in this research, it will continue to be a source of reference in the manner which this study is conducted can be compared and provide data to determine if the same problems described in rural areas of Texas is similar to the 43 counties of Pennsylvania, therefore providing information to the large scope of issues within the VA in their treatment of rural veterans nationally.

A focus on similar studies to provide an analysis on the trends taking place related to treatment of veterans and the unique needs required to address their mental health problems is a primary focal point of this research. There is a discrepancy in the availability of resources to those who reside in *Urban, Rural,* and *Highly Rural* areas. Another study that addresses the use of a needs assessment for mental health problems and the access available for veterans took

place in the State of Maryland, *Treating Behavioral Health Conditions of OEF/OIF Veterans and Their Families: A State Needs Assessment of Civilian Providers.* By taking a similar approach framed within the methods of Koblinsky et al.'s (2014) research, another comparative reference point is used to develop the data collected within this study and replicate a contrasting viewpoint to allow for the emerging trends to show more development or to address the outliers that may be prevalent in providing VHA supported mental health care to rural veterans.

As shown within the Koblinsky et al. (2014) study, a look at the ability of non-VHA health care providers to give treatment to veterans is assessed and evaluated through a needs assessment to draw conclusions if their involvement in veterans' treatment is a sustainable solution to the problem. It is important to note that the Koblinsky et al. study captures preliminary data on the use of the DOD's uniformed servicemembers, retirees, and their dependents TRICARE system, which shows, "[a]mong respondents, 31% participated in TRICARE; about half (49%) did not participate; and 20% were unsure about whether their agency participated in the health program" (p. 165). The reason it is important to highlight these statistics, is that this gives insight into the probability of providers outside of the VHA having any current involvement or knowledge into the VHA's health care needs and requirements. Furthermore, this study provides responses from private health care providers, most notably in the fields of mental health, and through their research, highlights low numbers in results in regard to the confidence of the professionals. The study shows "between three and four out of 10 respondents reported feeling very confident in their ability to treat veterans who were experiencing depression (37%), anxiety (35%), and suicide/suicide ideation (30%). One-third of providers felt very confident in treating family stress and relationship problems (34%) and caregiver stress (33%) in veteran families. Notably, only 28% of providers felt very confident in treating PTSD in veteran clients" (Koblinsky et al. 2014,

p. 166). Results in the 50% range for interest of these professionals in treating these mental health issues and with an 89% interest for them to be involved in face-to-face training (Koblinsky et al., 2014, p. 166). These percentages highlight the concerns this study raises, but also provides the need for the inquiry of a needs assessment for local health professionals to be involved in the treatment of veterans residing in areas where VHA facilities are difficult to visit.

Explanation of Needs of Services

Although the need for mental health service delivery to rural veterans continues to grow and awareness is being brought to the issue, implementation across the country is not uniform. As noted previously with the three different studies taking place in Pennsylvania, Alabama, and Maryland, the rollout of health care programs and the methods of providing different results in the manner in which they have been implemented. The need for these services must be addressed, to include the specificity in mental health related issues that have been afflicting veterans of the wars in Iraq (OIF) and Afghanistan (OEF); this subset of veterans is identified specifically, as they are those who are involved in the most recent military conflicts, however, they are not exclusive in their needs compared to all veterans and their needs for mental health treatment. Many veterans who have served in Iraq and Afghanistan have been able to return without physical injuries. However, injuries do not have to be physical in nature, as many do return with PTSD or depression; recent studies show that 18.5% of returning troops (approximately 300,000 OIF/OEF servicemembers) meet the probability criteria of having either PTSD or depression (Tanielian & Jaycox, 2008 as cited in Burnam et al., 2009, p. 771). It has also been noted that many OIF/OEF veterans who have PTSD, depression, and other combat-related mental health disorders are not receiving mental health care. About half of those identified to meet the criteria for PTSD or depression have sought a provider and of that half,

almost half of them received what can be considered minimally adequate treatment (frequency of treatment and level of experience and knowledge of service providers) – these findings show the substantial gaps in treatment that is occurring with OEF/OIF veterans (Burnam et al., 2009, p. 772). Another outlier are those veterans with traumatic brain injuries (TBI), as their treatment needs extends into both the physical and mental health, which is a major undertaking for those treating these veterans.

The area of residence chosen by veterans after their obligation of service should not be a limitation in their access to VHA provided treatment. In multivariable quantitative analyses, "no significant differences between rural and urban areas were found in the odds of depression screening or diagnosis. Among those diagnosed as having depression, veterans in urban areas had significantly lower odds than those in small or isolated rural towns of receiving an antidepressant in the 90 days after diagnosis (odds ratio [OR]=.56, $p<.05$) and of receiving psychotherapy (OR=.61, $p<.05$)" (Hudson et al., 2014, p. 1422). As noted by Hudson et al. (2014), the residential location of veterans is giving a limitation to their access in rural areas to the mental health care resources that are needed in comparison to those veterans in urban areas. Further explaining, "[v]eterans in urban areas were less likely than those in small or isolated rural towns to be diagnosed as having PTSD (OR=.79, $p<.05$). Among veterans diagnosed as having PTSD, those in urban areas had significantly lower odds than those living in small or isolated rural towns of receiving psychotropic medication (OR=.52, $p<.01$) or of having a psychotherapy visit (OR=.61, $p<.05$)" (Hudson et al., 2014, p. 1422).

A study published in 2009 by Mohamed et al. that compared the VHA's mental health intensive care management (MHICM) program's data between FY 2000 and FY 2005 and provided the comparative analysis detailing:

> 5,221 veterans enrolled in the MHICM… with 81,818 veterans treated for schizophrenia in other VA programs in FY 2006 showed that MHICM clients were less likely to come from large urban areas, slightly more likely to come from moderate-size cities, but less likely to come from small rural towns or isolated rural areas. MHICM veterans residing in isolated rural areas were significantly more likely to be unemployed, to receive VA disability compensation, and to have a payee or fiduciary. Although they appeared to have more severe disabilities than those from other areas, these differences were modest in magnitude. Greater proportions of MHICM clients in rural areas were diagnosed as having schizophrenia or organic brain syndrome, and they had spent more time in psychiatric hospitals than clients in urban areas. (p. 918)

Significant differences between the severities of mental health ailments and afflictions between urban and rural veterans highlights the needs to address the growing issues and the gap between the availability of services between the two groups.

Research is being sought to answer the question if private health care professionals are a part of the solution to provide rural veterans with accessible health care to lessen the limitations their geographic residence is not providing them. Research has shown that veterans who reside in rural areas are more likely to be unemployed, which often equates to no private insurance, as well as, a higher reported amount of other health care concerns; "[t]he VHA Office of Rural Health (2014) estimates that only 9% of physicians practice in rural areas, despite the fact that 20% of Americans reside in such locations (see also Weeks et al., 2004, as cited in Ahlin & Douds, 2018, p. 3171). Rural veterans also are less apt to have private insurance and more likely to have more complicated health care needs, which can make providing comprehensive care

especially challenging" (Weeks et al., 2006; Weeks et al., 2008; West & Weeks, 2009, as cited in Ahlin & Douds, 2018, p. 3171).

Contributing research to the health care issues facing rural veterans highlights that they have a lower quality of life compared to that of urban veterans. It is often argued that the limitations to care may be the contributing factor; conversely, the counterpoint to this argument is that the poor quality of life of rural veterans congregating together and the rural area itself is contributing to their poor quality of life (Weeks et al., 2004, p. 1766). Weeks et al.'s (2004) research makes the implications in regard to rural veterans' quality of life in their study, *Difference in Health-Related Quality of Life in Rural and Urban Veterans,* stating in relation to resources and needs of veterans in rural areas:

> …lower health-related quality-of-life scores are associated with greater health care service needs in the general population. The differences… found suggest that rural veterans will generate health care costs higher than their urban counterparts based on MCS [mental health component] scores and 2% higher based on PCS [physical health component] scores. The combination of lower scores, higher morbidity, higher anticipated greater service needs, and higher anticipated costs suggest that policymakers should be cautious when comparing costs and utilization of care in rural and urban settings. (p. 1766)

In Congressional testimony by Graham L. Adams, Ph.D., South Carolina Office of Rural Health, and State Office Council Chair, National Rural Health Association at the hearing for *Closing the Health Gap of Veterans in Rural Areas, Discussion of Funding and Resource Coordination,* concluded that "rural health facilities are the cornerstone of primary and preventive quality health care in rural America. Each is required to meet federal requirements for

quality, provider credentialing, and the use of health information technology. Current collaborations with the VHA in Wisconsin, Missouri, and Utah are strong examples of success. Expanding the levels of collaboration will vastly increase access to care in a cost-effective manner" (United States Congress, 2009, p. 32). Conclusions by Dr. Adams highlights that the VA has found success in states treating rural veterans and the previously noted studies that took place in Alabama, Maryland, and Pennsylvania continue to provide a gap between the implementation of health care services in the different states and a lack of uniformity in the rollout of any programs. This contributes to the need for more research conducted at local, regional, and state levels to determine the needs for areas throughout the United States to provide needed health care service to rural veterans.

Barriers in Place

The need for health care services for veterans regardless of their residential locations, urban or rural, is only one aspect of the overall necessity of addressing these issues. Another aspect of the equation is the barriers in place that prohibits veterans from seeking care. Initial thoughts when barriers are mentioned concern physical barriers; i.e. transportation, work schedules, and costs. Other barriers must also be discussed to portray that they are not only physical, but also psychological and if anything, can lend even further credence as to the need for mental health care for veterans, especially those in rural areas where resources are limited. In order to address the needs of rural veterans, the correlation has been made as to what barriers in place to treatment exists to non-veterans, "rural people have been identified to have three main factors that can act to prevent them from accessing care: sociodemographic factors (e.g. gender, age, and marital status), illness-related factors (e.g. comorbidity, psychological distress), and attitudinal factors (e.g. stigma, stoicism, self-efficacy) (Jackson et al., 2007, as cited in Stotzer et al., 2012,

p. 2). As research further shows, the issues that are apparent in the non-veteran population of rural areas is compounded by the unique situations that veterans experience in regard to their mental health. According to Stotzer et al. (2012), research suggests that within rural areas and their perceptions towards mental health, inclusive of the subculture of veterans, they socially may have a significant challenge in obtaining mental health services in their community; furthermore, veteran and rural cultural values tend to be negative towards the seeking of professional mental health services and lend to the stigmas that are ingrained within the perceptions that veterans feel they receive in seeking such treatments (p. 2).

Perceived barriers must be addressed when identifying a solution to the problems at hand with mental health issues among rural veterans. Time, cost, and schedule flexibility are barriers that anyone can associate with a reason for increased difficulty to seek treatment; "OEF/ OIF veterans were more likely than Vietnam veterans to agree that work conflicts interfere with treatment and their lives are too busy for treatment, but across eras of service there were no other differences observed for such logistical barriers" (Garcia et al., 2014, p. 275). These logistical barriers are accessibility to transportation, the costs of treatment, and the lack and costs of childcare to attend appointments (Garcia et al., 2014, p. 275). Although the logistical barriers are legitimate, research further suggests, "negative treatment attitudes may be more prominent than logistical barriers in predicting treatment engagement among OEF/OIF veterans, particularly those already enrolled in VA care" (Garcia et al., 2014, p. 275). Furthermore, research suggests that the focus on these issues need to highlight the significant differences that exist between OEF/OIF veterans compared to the veterans of other eras. Garcia et al. (2014) found that with OEF/OIF veterans, there is an underlying belief within the veteran community that treatment means they are weak and should be able to handle their issues on their own, also finding they

have more of an aversion to talking in groups; these finding appear more prevalent with OEF/OIF veterans that those of Vietnam veterans (p. 275).

Stotzer, Whealin, and Darden's research further details these stigmas and non-logistic barriers in their study; they suggest that the traditional norms of veterans have a continuation of their military service in their identity towards masculine roles (Stotzer et al., 2012, p. 3). These identity roles also include their independence, self-reliance, competition, power, strength, and emotional control; and although the VA is pushing efforts to change this culture, the culture itself "conforms with masculinity norms [that are] associated with less use of health care services" (Reivich, Seligman, & McBride, 2011, as cited in Stotzer et al., 2012, p. 3). Which means, the efforts by the VA may not be reaching the veterans who need them most. The continued stigma of seeking treatment for mental health is a barrier that cannot be ignored and highlights the need for changes in the manner in which services are delivered and offered to veterans, to also include the logistic barriers that are also in place. "[R]esearch with OEF/OIF military populations (e.g., Wright, Cabrera, Bliese, Adler, Hoge, & Castro, 2009, as cited in Stotzer et al., 2012, p. 4) suggests that [the] military community attitudes and internalized stigma are two interacting factors that influence service members' willingness to get help." Within the context of this research in seeking methods of mental health treatment to rural veterans, Stotzer et al. (2012) did find that logistic barriers can exacerbate the non-logistic stigmas; for example, those who reside in rural areas are shown to know each other more intimately than those in urban areas, and gossip amongst the community is contributing fear among these veterans (p. 5). Additionally, the findings by Weeks et al. (2004, as cited in Stotzer et al., 2012, p. 7), the lower quality of life that is shown to be more apparent in rural veterans has a contributing effect onto the barriers and stigmas that are emerging as leading causes for veterans not seeking treatment. The need for a

solution and changes into the delivery methods of providing treatment must be researched more and the determination made as to how the VHA will ultimately provide them to veterans.

Solutions to the Problems

Barriers play a major role in the mental health treatment process for all veterans, rural or otherwise, however, research dictates that veterans in rural areas are prone to more health issues and their barriers, although not different from urban veterans, play a greater role in their deterrent to seek treatment. One area that is highlighted to require more data for research, is that outside of the VA there is little known reporting to capture the data for veterans using non-VA assistance (Maiocco & Davidov, 2016, p .91). Maiocco and Davidov (2016) explain in their research article, *Rural Veterans' Utilization of Non-Veterans Administration Community Health Care Services*:

> A state sponsored legislative survey exploring the mental and physical impact of military experiences of rural veterans noted 43% had a community health care provider, whereas 30% used the VA. Approximately 25% never accessed the VA and 18% had no medical evaluation in over 2 years. When the VA was used, it was primarily for mental health reasons. According to this survey, older veterans had a community provider, a mental health provider, and multiple physical health problems. Younger veterans had higher exposure to stressors related to the wars in Iraq/Afghanistan, poorer quality of life, higher rates of physical pain, and experienced mental health issues frequently. The survey did not address utilization of acute care services by veterans, which, when assessed, may give NPs [nurse practitioners] a more comprehensive picture of veterans' health-seeking activities. (p. 91)

Based on the findings of Maiocco and Davidov, the need and ability to reach younger veterans continues to highlight the areas of focus on rural OEF/OIF veterans; but does not mean that other eras of veterans should be ignored. As they continue to be a demographic that is in need and the appearance of a major gap in those requiring treatment and those actually receiving treatment, research and applications focusing on this subset of veterans needs to carryon. It must be noted that such research does not exclude all veterans, if anything, it will open the discussion that crosses over to the treatment needs of all veterans.

The VHA ORH has sought solutions in order to provide rural veterans with the health care they need, most notably mental health (MH) care, "[VHA] has worked diligently over the last decade to open-community based outpatient clinics (CBOC) in rural areas and ensure they include MH expertise" (Jonk et al., 2005, as cited in Kirchner et al., 2011, p. 417). "Yet, many rural veterans are still not utilizing many of the VHA supported community clinics" (Kirchner et al., 2011, p. 417). Research suggests with the limited number of rural veterans who need mental health care services, but are not seeking it themselves, highlights a point in which the community should work together to establish a network in assisting rural veterans with treatment. A program in Arkansas was developed to include three areas that had a high amount of involvement in the lives of OEF/OIF veterans: post-secondary education, as many veterans joined the military for education benefits; clergy, as they or their families were able to turn to religious resources to seek assistance; and the criminal justice system, as many veterans who are in need of mental health services often have some sort of interaction with law enforcement (Kirchner et al., 2011, p. 419). Success in the pilot program was noted and it has been suggested that southern states may want to adopt this program or a variation of it due to the networks that exist more prevalently in the South; i.e. religious (Kirchner et al. 2011, p. 421). Yet, as other

research dictates there is a stigma that still exists in veterans seeking treatment, therefore, other avenues must be explored to determine multiple methods of treatments available.

As discussed in other literature, the expansion of innovative delivery methods is being explored with a focus on rural veterans, these include "mobile clinics, clinical consultation via videoconference, and text message support" (Teich et al., 2016, p. 303). While recognizing the barriers and stigmas that are shown to be a prevalent deterrent for treatment among veterans, methods, like the pilot program in Arkansas, that has professionals identifying veterans and providing them with a mechanism to seek treatment as opposed to the veterans seeking treatment themselves. Studies have shown, there are a number of evolving types of treatments models that have been or are being developed, like tele-health, which includes collaborative care and consultation, and also leveraging the scarce mental health resources that are intrinsic to rural area patients (Fortney, Payne, Turner, & et al., 2015, as cited in Teich et al., 2016, p. 303). Additionally, noted in Teich et al.'s research, "[t]he VA's mental health intensive case management (MHICM)…resources for nurses to travel to various areas to provide services to veterans, as advanced practice psychiatric nurses (APPNs) are more likely than other mental health providers to reside in rural areas and may be better able to access and leverage available community resources" (Wynn & Sherrod, 2012, as cited in Teich et al., 2016, p. 303). It has also been found that the use of tele-health is comparable to face-to-face (in-person) and cost-effective in it use (Ziemba et al., 2014, p. 448; Fortney et al., 2015, as cited in Bumgarner, 2017, p. 227). These findings can be correlated to the types of telecommunication technologies that allow for personal interactions just like face-to-face and the availability of such technology and its delivery cost, it can lessen the overhead price, assumingly.

One of the emerging trends that is taking shape to deliver mental health treatment to veterans because of those barriers discussed is the use of mobile application platforms. Advocacy on part of the VHA to condone these practices has been growing and within the Office of Rural Health the need for research in the use of these technologies is growing, "VA research teams found that small rural clinics without on-site mental health treatment providers could successfully adapt a team model of depression care [management]—shown effective in larger VA settings—by using tele-health technologies such as the telephone and videoconferencing" (Veterans Health Administration, n.d., p. 4). Adams et al.'s (2018) study, *Utilization of Interactive Clinical Video Telemedicine by Rural and Urban Veterans in the Veterans Health Administration Health Care System,* suggests that the use of this technology among veterans had drastically increased in their use with their findings highlighting that Clinical Video Telemedicine (CVT) had a 421% increase from FY2009 to FY2015, with all areas of the study's findings each year out pacing the previous year in regards to the use of CVT (p. 311), giving insight into how technology can be used to overcome these barriers. These findings do not include the use of *VA Video Connect* (VVC) where the veteran is treated through tele-health applications while at home due to the timeframe of the Adams et al. study.

In April 2018, a policy paper was published discussing the *Best Practices in Videoconferencing-Based Telemental Health,* that gives insight into many of the areas that private industry must undertake to enable it to provide these types of health care systems to its patients and in decision-making efforts to bring forth this service, a needs assessment should be conducted to determine which types of services to provide. As Shore et al. (2018) suggests, the needs assessment should, at a minimum, include an overview statement, services that should be delivered, proposed patient population (OIF/OEF veterans in this case), provider resources

technology needs, staffing needs, quality and safety protocols, business and regulatory processes, space requirements, training needs, evaluation plan, and sustainability (p. 828). Their findings cover a wide array of what health care providers should be considering when delivering these services, as far as identifying veterans, "[p]roviders shall be familiar with the federal and specific organizational structures and guidelines for patients related to the location of care. Providers should familiarize themselves with the culture of the patients (e.g., military cultural competency) and the organizational systems in which they practice" (Shore et al. 2018, p. 831). It is being argued that the VHA can supplement their resources with private industry and different technological applications to further their reach and services to provide the needed mental health care to OEF/OIF veterans; research like that of Shore et al. gives a good foundation that paves the way for such solutions to address this issue.

A major piece of legislation was introduced and enacted in 2018, known as the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 or the VA MISSION Act of 2018 (Public Law 115-182), which will be referenced as MISSION Act within this study. This act is extremely comprehensive and brings to light many problems that are issues for veterans; many of which are encompassed within this study. The purpose of the legislation is to provide hospital care, medical services, and extended care to covered veterans; additionally, the Secretary shall coordinate these services, at a minimum:

> (A) Ensuring the scheduling of medical appointments in a timely manner and the establishment of a mechanism to receive medical records from non-Department providers.
>
> (B) Ensuring continuity of care and services.

> (C) Ensuring coordination among regional networks if the covered veteran accesses care and services in a different network than the regional network in which the covered veteran resides.
>
> (D) Ensuring that covered veterans do not experience a lapse in care resulting from errors or delays by the Department or its contractors or an unusual or excessive burden in accessing hospital care, medical services, or extended care services. (Public Law 115-182, 2018)

The implementation of the MISSION Act of 2018 is to provide an expanded network or increase the accessibility of the variety of cares to veterans, especially to those veterans in rural areas. Title III allows for means to recruit dentists and physicians in underserved areas by providing a means of two scholarships and a specialty education loan repayment program (Albanese et al., 2020). "Title IV of the VA MISSION Act requires the development of criteria to designate VA Medical Centers as underserved facilities and a plan to address their needs" (Albanese, 2020 et al., p. 134). Additionally, the Act establishes a pilot program to furnish mobile deployment teams of needed medical personnel to the facilitates that have been designated as underserved; in addition, "Title IV, section 403 creates a pilot program with [two] new authorities to increase physician training in underserved areas" (Albanese et al., 2020, p. 134).

The VA MISSION Act is a piece of legislation that expands on and supersedes the 2014 legislation, "Choice Program", which was to expand the use of Community Health Centers (CHC) to veterans with outsourced health care providers (Rieselbach et al., 2018). Studies suggest that the expansion of the program under the MISSION Act is a move in the right direction, however the funding dedication to this legislation is lacking severely. The Choice Program legislation had an estimated $5.2 billion dedicated to it and the MISSION Act is shown

to need over $55 billion dollars to fund the areas outlined in the Act, but no money was dedicated to fund it and the Executive Branch under the Trump Administration was urging Congress to seek funding from other funded programs and not earmark new funds for the program (Rieselbach et al., 2018).

As previously stated, the use of CHCs have been expanded with the Choice Program; CHCs have been used for over 50 years and grown to almost 1400 health centers and serves more than 26 million patients in over 9000 sites (Rieselbach et al., 2018). From 2008 to 2016, "the number of veterans served by CHCs increased 54% from 213,841 to 330,271. The number of veterans served by CHCs across the states range from 500 to over 30,000" (Reiselbach et al., 2018, p.152) (see Figure 3).

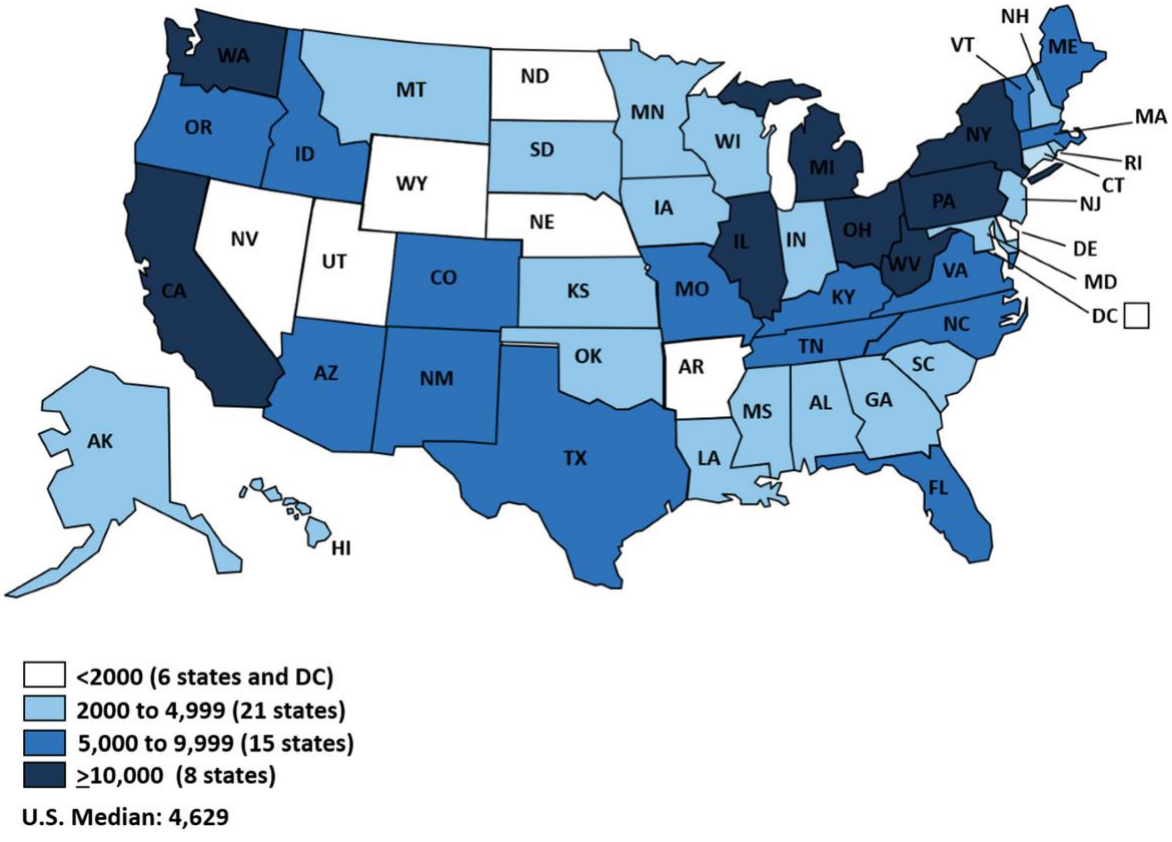

Figure 3: Number of U.S. Veterans Served by Health Centers, 2016 (Reiselbach et al., 2018, p.152*)*

Reiselbach et al. (2018) propose "greater utilization of CHCs for VHA outsourced care would generate considerable bipartisan support and provide a high-quality, cost-effective alternative" (p. 152). It is suggested that CHCs are able to control costs while meeting the needs of veterans, yet the unfunded MISSION Act requires more attention; Reiselbach et al. (2018) suggest that a study be conducted by the Congressional Budget Office to compare the costs of accessible CHCs and private practice outsourced care (p. 152). "The BVA Mission Act involves a $55 billion 5-year commitment to addressing shortcomings in the country's largest health system, with the potential to continue the frustrating bureaucratic and legal burdens associated with payments to private providers, as experienced with the Choice Act" (Reiselbach et al., 2018, p. 152). The gaps being identified and legislation being passed are major hurdles in addressing the needs in providing mental health care to rural veterans who may otherwise not have accessible VHA resources near them is one step in the right direction. However, not funding such a major piece of legislation brings to bear a major hurdle and issue. Research shows that budgeting of the MISSION Act and its costs are still under question and scrutiny from governmental officials, both elected and appointed.

With the creation and enactment of Congressional legislation over multiple administrations from President Obama's signed Veterans Access, Choice, and Accountability Act and then the transition to the MISSION Act signed by President Trump in 2018, many aspects of public administration and public policy in implementing these Acts have opened paths of treatment for veterans, yet the changes implemented have brought into question the privatization aspect of the VA (Yen 2019, as cited in Dulaney, 2020). With the Veterans Health Administration being the largest health care system in the United States and with regard to the notion that the MISSION Act is largely unfunded in its $50 billion projection and the suggestion being made that other

programs funding be moved to fund the MISSION Act, the question is raised, what direction the VHA will be headed with such a large piece of legislation and the amount of funding behind it?

The notion of the VHA being privatized brings forth a concern in the treatment that veterans receive and is the basis for this public policy and public administration issue under a large scope of responsibility for the Department of Veterans Affairs. "Veterans willingness to engage the VHA system is due to historical, societal, cultural, and psychological factors…veteran's perception of socialization, command leadership influences, and service mentality significantly influenced their post-military health care experiences" (Abraham, Cheney, & Curran, 2017, as cited in Dulaney, 2020, p. 30). The experiences of the veterans are one major area that can address how this issue will move forward, however, as studies regarding their care suggest, the VHA is in need of collaborative governance with the states and the mechanisms in place between these public entities and the community providers that can allow for a collaborative approach to this public administration issue that has shown to be an important concern as the multiple pieces of legislation suggest.

Summary of Literature

Research and literature dictate that the needs of providing health care to veterans is an issue across the board, especially in regard to those OEF/OIF veterans due to the stigmas and barriers in place. Furthermore, the stigmas and barriers only compound the issue in rural veterans. The VHA has taken steps to push for programs and research to help them address this concern through legislation that is helping support this issue. As the ORH has been the main advocacy arm of the VHA for rural veterans, they have shown that their office is in need of additional research on the subject of treating rural veterans. Through the research that has taken place, a needs assessment for the State of Texas is constructed within this study and gives a means to

gather new data for this region that will allow for research to provide analytical data that gives a comparative view to the other studies, as well as, provide a metric for the resources that are available to rural veterans that is inclusive of the types of delivery methods. Research further dictates that the use of newer technologies, i.e. mobile device platforms, can be a suitable means to lessen stigmas and provide veterans with anonymity as they seek treatment. The literature and research covering this study's framework provides a substantial foundation for new research to build upon and expand.

Chapter 3 – Data and Methods

Introduction

The Department of Agriculture, Department of Health and Human Services, the State of Texas, and the United States Census of 2010, consider 172 of the 254 counties in Texas be rural (Texas Health and Human Services, 2015). Within this research, health professionals in all counties were contacted to participate in a community-needs assessment survey with respondents comprised of private practices, governmental officers, and non-profit organizations. The goal of this research is to examine what mental health resources are available to veterans who reside in rural areas of Texas and whether mental health professionals across all sectors of care are willing to receive training and funding support from the Department of Veterans Affairs in their efforts to treat veterans. Furthermore, research will examine how the State of Texas and the Department of Veterans Affairs have implemented programs to assist rural residing veterans and document their success and barriers in providing these services to veterans.

The data collected from this study builds upon the literature review and takes into consideration the studies that have taken place in other states and commonwealths and compares them to implementation of programs in Texas. Determination through a community needs assessment survey as to what services are available or have the potential of being available to veterans who seek mental health treatment. The results of this study will give the State of Texas, the VHA, and other states health services administrators data that can contribute to the gaps, needs, and successes that are taking place in Texas, a state with one of the largest populations of veterans.

Research questions and hypothesis sought for this study are as follows:

RQ(1) – Are there significant differences between the mental health care providers in rural, urban, and unknown [to the provider] areas to their designation as mental health care providers with regard to their willingness to provide treatment to veteran patients with support from the VHA or their designee?

H(1)o1– There are statistically significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their willingness to provide treatment to veteran patients with support from the VHA or their designee.

H(1)a1– There are statistically significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their willingness to provide treatment to veteran patients with support from the VHA or their designee.

RQ(2) - Are there significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their screening of patients for military service?

H(2)o1 – There are statistically significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their screening of patients for military service.

H(2)a1 – There are statistically significant differences between the rural, urban, and unknown to their designation as mental health care providers with regard to their screening of patients for military service.

RQ(3) – Are there significant differences between mental health care providers respondents location and their clinic's sector (private, public, or non-profit) with regard to the methods of treatment they provide?

H(3)o1 – There are statistically significant differences between mental health care providers respondents location and their clinic's sector (private, public, or non-profit) with regard to the methods of treatment they provide.

H(3)a1 – There are statistically significant differences between mental health care providers respondents location and their clinic's sector (private, public, or non-profit) with regard to the methods of treatment they provide.

RQ(4) – Are there significant differences between rural, urban, and unknown located mental health care providers who are willing to treat veteran mental health care patients with training or funding support with regard to sector (public, private, and non-profit) of mental health care they provide?

H(4)o1 – There are significant differences between rural, urban, and unknown located mental health care providers who are willing to treat veteran mental health care patients with training or funding support with regard to sector (public, private, and non-profit) of mental health care they provide.

H(4)a1 – There are significant differences between rural, urban, and unknown located mental health care providers who are willing to treat veteran mental health care patients with training or funding support with regard to sector (public, private, and non-profit) of mental health care they provide.

RQ(5) – What has the Department of Veterans Affairs and the State of Texas Health and Human Services done so far to implement technologies, policies, and procedures into action for rural veterans in the State of Texas?

Concepts and Measurements

Through a quantitative analysis, this study determines if there are significant differences between clinics located in rural and urban areas and those clinics unaware of their location designation and their probability and likelihood in treating veterans who reside in rural areas away from VHA clinics. To achieve this measure, a series of quantitative studies examines data obtained through an online survey community needs assessment with mental health practitioners throughout the State of Texas. By utilizing the data collected from the multiple clinics/practices across the state, a series of analyses test dependent and independent variables identified in the survey. Mental health care clinics and practices throughout the state of Texas were emailed a link to the survey/needs assessment. They were identified by the repository of available services that the Texas Department of Health and Human Services provides on their website, which includes services already focusing on Texas veterans. Within this repository, mental health care providers from all three sectors are available, not strictly the public health care providers. Additionally, mental health care providers throughout the State of Texas were identified through online searches through professional registries and websites. Texas Department of Health and Human Services was contacted and their Mental Health Programs for Veterans identified themselves as the primary contact for the structured interview within this mixed methods study. Based upon the data of this study and the other similar studies that have taken place, the Veterans Health Administration Office of Rural Health or another VHA mental health representative was contacted directly for a structured interview to garner more data as to how the gaps between mental health resources and veterans can be addressed; however, the VHA declined the request and refused to respond to any other correspondence regarding interview requests.

The two primary sets of variables for this study are the sectors in which the health professionals work (private, public, and non-profit practices) and the location of clinics (rural,

urban, and unknown). These variables were tested against several variables identified in the community needs assessment: probability of the respondents in each respective sector to treat rural veterans; likelihood of the sectors to receive training and support from the Department of Veterans Affairs to provide treatment; and likelihood of these sectors to screen patients about veteran status; and current referral patterns to veterans health resources. Tests will determine what methods of treatments are being used by these sectors in regard to in person, over the phone, or other technology or application.

This study focuses on the following concepts throughout the research conducted: veterans are those who have served and are discharged from U.S. Armed Forces, to include the U.S. Coast Guard. Those servicemembers who are still serving on active duty, in the national guard, or reserves are not inclusive of this study, as they fall under the treatment for their service through the respective departments (branch of service) they serve (Tricare, 2020). Mental health issues as they relate to veterans will include the following primarily, but are not limited to, anxiety disorders, depression, interrelationship of mental health issues (multiple diagnosis), post-traumatic stress disorder, schizophrenia and bipolar disorder, and stress. Private, governmental (public health), and non-profit organizational sectors were requested to respond to the community needs assessment survey for this study in all counties throughout the State of Texas; based upon their response, data was compared to determine the location of clinics and practices who participated as either rural, urban, or unknown.

Treatments in mental health was kept at a minimum; in person or face-to-face, means that the veteran or patient attended treatment physically with a mental health professional. Telephone treatments, or tele-health, mean that the veteran and professional spoke using voice only, while video/mobile application means the use of a smartphone, tablet, or computer that provided

treatment in any way other than telephone (voice) only. For this study, concepts of specific types of treatment was not captured, but did identify if clinics do treat veterans and determined if the treatment exceeds their professional capabilities, resulting in referrals to the nearest VHA clinic. Furthermore, combination of the treatments that clinics provide was taken into consideration, to allow for all treatment methods to be considered for each respondent (i.e. clinics who provide face-to-face, telephone, and video telecommunication application).

After the collection and examination of the data, a structured interview was conducted with a representative from the State of Texas Health and Human Services and requests for an interview with VA mental health facilities in Texas and VA's Office of Rural Health were made to no avail. The VA's Office of Rural Health was contacted via email and declined to participate in the study; the VA mental health clinics we emailed with the public affairs/media relations office in different clinics throughout Texas with no responses, follow-up phone calls were made with no answer. The purpose of these interviews is to examine the actions that have occurred in their respective offices to treat rural veterans with mental illnesses. The State of Texas has already implemented pilot programs in six areas of the state regarding treating veterans, but inquiries will be made to determine if rural veterans were identified specifically (Texas Health and Human Services, 2019). Additionally, to determine what the current status of their programs are within Texas and nationally, the information sought in the interviews will provide research with the following: issues encountered in their implementation of rural health programs for veterans; plans in place to expand on the program; and the mechanisms in place for practices and clinics of all sectors to receive training, support, funding, and other resources to enable them to provide treatment to veterans that is commensurate or exceeds the standards of the VHA's treatment practices.

Taking into consideration the approach to research by Boscarino (2010) in Pennsylvania and the use of descriptive statistics, this study provides a snapshot of the data collected from the respective sectors of clinics and the breakdown of the needs assessment survey. Inspired by the research framework of Koblinsky et al.'s (2014) study, which processes data collection and examines test results, this study differs by removing veterans' spouses and family members (often referred to as dependents), and that it was conducted by sponsorship and involvement from the State of Maryland (Koblinsky et al., 2014). However, based upon Koblinsky et al.'s (2014) research, similarities do emerge in this research in regard to the use of the civilian providers and their capabilities and potential of providing treatment to veterans through the use of descriptive statistics and analysis of covariances. Due to specifics and data being sought for analysis in this study, a deeper look is made that is veteran centric, as opposed to the inclusion of a veteran's dependents.

The statistical analyses for this study include one-way and two-way ANOVAs, while also reporting all findings that were gathered in the needs assessment through descriptive statistics. An interview was conducted to gather qualitative data from Texas Health and Human Services and the VA MISSION Act legislation in lieu of an interview with VHA's Office of Rural Health which is analyzed in comparison with the findings of this study and the findings in similar studies that have taken place in Alabama, Arkansas, Maryland, and Pennsylvania (Davis et al., 2011; Kirchner et al., 2011; Koblinsky et al., 2014; & Boscarino et al., 2010). These methods of research are to provide predictive measures of non-Departmental providers in providing treatment to veterans with training and funding support from the VA and to show the existence of any statistically significant differences in the researched variables. All in efforts to provide an understanding of the current status for veterans residing in rural areas of Texas to receive

mental health treatment that is commensurate or greater than the VHA's mental health treatment methods.

Data and Validity

Dependent Variables. This research seeks respondents from private, public, and non-profit sectors of mental health providers in all counties (includes rural and urban designations in accordance with governmental identification schemes previously mentioned) in the State of Texas through an online surveying system, Qualtrics.com, sponsored through West Chester University. Ideally, each county would have a respondent from each sector of health providers (n = 254 for each sector, with a total n = 762). Due to the unforeseen participation of respondents, multiple providers of each sector in each county will be surveyed. The needs assessment survey consists of 32 questions and provides information that gives specificity of the respective clinics current status, ability, and capability to treat veterans; reference Appendix A – Veterans Mental Health Needs Assessment. The data collected provides little in subjective information and relies on objectivity in the responses from the clinics. All data collected from the surveyed assessment is compiled and coded for testing in the IBM SPSS statistics modeling program.

Independent variables. Conversely, those clinics in rural and urban locations, to include those who are not sure of their rural/urban designation, are also independent variables in testing to ascertain if significant difference exist in a two-way ANOVA test in regard to training and funding support from the VHA. Additionally, the following research tests variables in regard to clinic's willingness to receive VA (or their designee) supported training, screening of their patients for prior military service, and methods of treatment provided.

Through the use of SPSS, descriptive statistics are captured and allows for all independent and dependent variables to provide one-way and two-way ANOVA analyses. For this research, alpha will be set at .05 (α = .05), that is the results will be significant if only $p \leq .05$. The questions within the assessment are not an exact replicant of other studies' needs assessment, yet there are similar measurements and descriptors that can provide reliability of this study. The processes followed through SPSS in the tests and analyses used for this research increases the reliability of the information provided in this research. Utilizing the measures, data, and results of similar studies, the validity of this research emerges. Due to the types of data and tests utilized in this study, criterion validity as the construct measure is in direct correlation to the variables being tested.

The data collected and tested provides through statistical analysis an understanding of the current status of the sectors of health providers throughout the State of Texas. By identifying the descriptive statistics and the predictability of the different sectors of mental health care providers' probability in treating veteran patients, the results of these tests are used in the structured interview with representatives from Texas Health and Human Services. By using results of studies that were conducted in other states, the data supports the questions to the TX HHS representative and allows for objectivity and unbiased inquiries that are presented in support or rebuttal of their answers. With responses being sought through email, the ease and simplicity of responses should increase; questions posed are non-intrusive to personal information, therefore, an anticipated response rate to the surveys is ideally 70%, with an anticipated 30% nonresponsive bias. However, as respondents have no obligation in participation, the ideal response rate must be considered overexaggerated and therefore, the need

for interviews with responsible agencies in providing mental health care treatment to veterans must be completed to provide further information and validity for this study.

As research shows, the State of Texas has multiple programs to assist veterans in seeking treatment related to various ailments and afflictions in their health status. An interview with a representative of Texas Health and Human Services Mental Health Programs provides this study the current status of the veterans' programs that have been implemented by the State of Texas; reference Appendix B – Structured Interview with Texas Health and Human Services. The interview lasted approximately 45 minutes and was scheduled through email correspondence, the interview was conducted over the phone and recorded on a digital audio recorder with the dialogue saved on encrypted media device. The interview was conducted over the phone due to the concerns of COVID-19; the interview questions were given to the representative beforehand with the caveat that his answers may spur other questions This interview provides insight on future programs that will be implemented and what actions are being undertaken by the State of Texas to support the various sectors mental health care providers to treat rural-residing veterans. Furthermore, inquiries will address what relationships and other mechanisms are in place for the state and clinics under their purview to receive assistance from the Department of Veterans Affairs.

To obtain information from the Veterans Health Administration, interviews were requested with a representative from the Office of Rural Health and Texas Regional Mental Health Clinics to obtain the most up to date information in regard to their programs and the future of treating rural residing veterans. As these personnel represent the office and organization heavily involved in veterans mental health issues in Texas, a structured interview would provide this research with what is taking place within their offices in the State of Texas and nationally. This

would include the implementation of programs to reach veterans, what technologies are supported or sponsored through their office to assist mental health professionals to provide treatment to rural veterans, and what training, support, and funding is available to mental health professionals to treat veterans. The purpose of the interview was to provide research validity from the findings of tests conducted from the quantitative data collected and to make a comparative view and inquiry based upon the findings of this study. However, the requests were ignored and declined. Using findings from other studies to determine what mental health resources are available to rural veterans and the rurally located mental health care providers, capability gaps were identified between the needs for mental health services to rural veterans and the issues and barriers in providing mental health treatment to rural veterans in a variety of methods.

Method of Analysis

For this study, two tests were used to analyze the quantitative data collected: one-way ANOVA and two-way ANOVA testing of the independent and dependent variables. After the data was run through the quantitative statistical analysis program, the results were compiled and utilized in the secondary portion of this study, a structured interview with a representative from the Texas Department of Health and Human Services and in comparing the results of both the data and interview to the legislation of the VA MISSION Act. The purpose for these tests is to determine results based upon testing of the proposed research questions and their corresponding hypotheses. The interview was structured and focused on a positivist approach to provide a deeper analysis of the data from the community needs assessment survey that was conducted. The interview gives insight into the programs that have already been employed in Texas and the expansions of these programs and the roll out of new programs to support rural veterans.

Descriptive statistics. Upon completion of obtaining all responses to those surveyed in the assessment, all data will be coded appropriately into the quantitative data analysis software, IBM SPSS. Overall responses from those surveyed were coded as the three sectors of mental health practitioners: rural, urban, and unknown. Additionally, these three sectors act as the dependent variables when testing all other variables within the data collected, for the majority of all tests. Among these sectors of mental health practitioners, independent variables were coded to give data that pertains to the following descriptive statistics of the respondents: types of treatment provided by the clinic; professionals employed at their practice, the acceptance of veteran health insurance coverage plans; methods of treatment provided in regards to in-person, over the phone, or other technical applications; if referral for veterans is made to veteran-supported clinics; screening of patients for prior military service; a self-rated assessment of interactions with Texas Health and Human Services and Veterans Health Administration; and if the clinics have had any involvement with the State of Texas or VHA to receive support or funding to support veterans with their mental health needs that is commensurate with the mental health stands of the VHA. In addition to the independent and dependent variables tested, responses will reflect the rate of responses from clinics that from different sectors of mental health care providers: public, private, and non-profit.

Another descriptive statistic highlighted is if mental health care clinics that respond to the assessment survey accept VHA health care plans. Due to the different types of health insurance coverage that veterans can carry, either through their employer, VA-supported related to their service connected disabilities (that includes mental health), and as retired military members carry health coverage through Tricare (similar to active duty, reserve, and national guard), descriptions

of this variable is made as an independent variables to determine the sample that accepts these types of insurance coverage (Tricare, 2020).

One-way ANOVA. In furtherance of providing *t*-tests regarding the effects between the variables tested within this research, one-way ANOVA tests are done to determine if any significant differences exist between variables within the data gathered among the 102 mental health care providers throughout the State of Texas. Additionally, parametric testing among the variables analyzed to provide Chi-square results. Based upon the findings of the one-way ANOVA tests, the results were utilized to develop questions towards the State of Texas Health and Human Services representative interview.

Two-way ANOVA. The variables gathered were tested in two-way ANOVA tests to evaluate the means of the categorical dependent variables when tested to those independent variables; the hypotheses outlined in this research were used within the two-way ANOVA tests. For testing purposes, rural and urban located mental health providers were coded to provide a comparative view to how the location of a mental health care provider can affect the dependent variables tested. The State of Texas and Department of Veterans Affairs are the governmental entities that are actively involved in providing mental health care to veterans in Texas and their ability to provide mandates, funding, and training to all sectors of mental health care providers in rural and urban were addressed within the survey and determined through two-way ANOVA testing to identify significant differences between these independent and dependent variables, to include the interaction effect.

Structural interview. Through the collection and analysis of the data of those surveyed in the assessment, the data is presented to the representative from Texas HHS Mental Health Programs to provide a current status of the different sectors of mental health care providers

throughout the State of Texas and through the structured interview, provide this data to them and question where they see the data in relation to what is shown. Furthermore, the current status of veterans mental health programs in Texas can be addressed and allow the representative to provide information on upcoming programs initiatives sought. Overall, this gives details that will provide solutions to the identified gaps between mental health treatments and the veterans who need greater accessibility to treatments.

A mixed methods approach is utilized for this research to provide an overview as to the status of mental health care providers who represent the professionals who can be a part of the solution to the gaps identified between veterans and their access to mental health care with the understanding that the legislation created by the State of Texas and the United States Congress will be the mechanism that increases their involvement in veterans mental health treatment. In furtherance of the quantitative statistics, the qualitative interview provides validity and a deeper understanding to the descriptive statistics gathered in the community needs assessment. Therefore, the mixed methods approach provides the framework to the research design that answers the research questions and hypotheses outlined within this study.

Chapter 4 – Research Results

Descriptive Statistics

Responses of the community needs assessment yielded 102 respondents who all identified their practice or clinic to be providers of mental health services. In regard to the response rate of this assessment, an 8% yield occurred; the assessment was provided to 1313 mental health clinics throughout the State of Texas. For reference, see Appendix A – Community Needs Assessment Survey for additional context to the descriptive statistics to the responses.

Sector of Service	Private	Public	Non-profit
n	93	1	8
Total	102		

Table 1: Respondents over the three sectors of care providers

Responses of this assessment survey were provided more heavily by those in the private sector with a vast minority of responses being provided by those in the non-profit and public sectors of mental health providers. As the responses were kept anonymous, only assumptions as to why the lack of responses from these sectors can be made, yet through research it does appear more likely that the majority of mental health care providers throughout the state are in the private sector versus public and non-profit mental health providers. Of those who did respond, the distribution between urban and rurally located mental health providers were not too far apart with 43.1% self-identifying their location as rural and 51% self-identifying their location as urban, while the remaining 5.9% were unsure of their urban/rural classification.

Those clinics surveyed provided responses that reflect the professionals that are employed or operate in within their clinics. Those professions are identified as social workers, counselors, psychologists, marriage and family therapists, psychiatrists, and others. These professions are identified to work primarily in the mental health field and whose careers would be involved in

mental health issues relative to those affecting veterans. Additionally, other professions that were identified by respondents include case managers, recreational therapists, technology consultants, neuropsychologists, nurse practitioners, medical doctors, licensed chemical dependency counselors, and advanced practice registered nurses.

Profession of Respondent	Social Worker	Counselor	Psychologist	Marriage and Family Therapist	Psychiatrists	Other
Frequency	24	70	24	28	7	13
Percentage	23.5%	68.6%	23.5%	27.5%	6.9%	12.7%

Table 2: Percentage of professions at clinics

Inclusive of those professions surveyed, a determining factor in treating veterans, especially those whose medical insurance may be unique to retirees or those who have coverage through a VHA related plan is if these clinics accept such insurance plans at their practices/clinics. Of the 102 respondents, 33.3% accept VHA related insurance plans with 2% unsure if they do or do not. Therefore, a follow up to this inquiry is to determine the screening of veterans or those with military service as a part of their intake process at their clinics/practice, which also includes a mechanism in place for referring patients if their afflictions, ailments, or other medical/mental health issues exceeds their capabilities to treat such patients. Results of this assessment yield a result of 63.7% respondents who screen their patients for prior military service and 80.4% who have a mechanism in place for making referrals for veterans whose conditions exceed their professional capabilities. Based upon the findings in this assessment, Table 3 refers to the frequency in which respondents made referrals for veteran patients.

Frequency of referrals clinics make in regard to veteran mental health patients

	Frequency	Percent
Often	8	7.8%
Sometimes	70	68.6%
Never	9	8.8%
Unsure	15	14.7%
Total	102	100.0%

Table 3: Frequency of referrals clinics make in regard to veteran mental health patients

As research suggests, the need for additional and specialized training and support from the Department of Veterans Affairs or in the case of Texas, the Texas Department of Health and Humas Services, the assessment determined that of those respondents to the survey only 5.9% has annotated they have received support from TX HHS to assist in the treatment of veteran patients and 18.6% have stated they have received training or other support for the VHA to treat veterans. Based upon the respondents of the survey, those who did receive training from the VHA or TX HHS, took place in the last two years of this survey, July and August 2020. Furthermore, 8.8% have annotated that they have received follow-up or reoccurring training from the VHA or TX HHS. Of those who have received training, the mean of their rating is 3.07, which equates to an "Average" experience in their interactions with these agencies based upon the ratings of evaluation of this assessment survey (see Table 5). Yet, based upon all responses the asserted conclusion can be made that the involvement of the public agencies like the VHA and TX HHS appears to be minimal in their involvement with mental healthcare providers in the State of Texas. Additionally, 14.7% have responded that either the VHA or TX HHS has solicited their clinic to provide mental health treatment to veterans; 12.7% solicited from the Department of Veterans Affairs, 1% from the State of Texas, 2% from both departments.

How long ago did your personnel in clinic receive training from VA or VA-supported entity?

	Frequency	Percent
Less than one year	9	8.8%
1 to 2 years	6	5.9%
2 to 3 years	2	2.0%
3 to 4 years	1	1.0%
5 years or more	1	1.0%
Not applicable	83	81.4%
Total	102	100.0%

Table 4: Timeline clinics have received training to support veteran patients

If your clinic/practice does receive support from the Dept. of Veterans Affairs or Texas Health and Human Services, how would you rate your interactions with them?

	Frequency	Percent
Excellent	2	2.0%
Above Average	4	3.9%
Average	2	2.0%
Below Average	5	4.9%
Unsatisfied	2	2.0%
Not Applicable	87	85.3%
Total	102	100.0%

Table 5: Rating of respondents regarding support from government

If your clinic/practice would not be willing to receive training from the VA or a VA supported entity, what reasoning supports your clinic's/practice's decision?

	Frequency	Percent
Time	12	11.8%
Cost	10	9.8%
No Interest	1	1.0%
Not enough personnel	9	8.8%
Other	34	33.3%
None of the above	36	35.3%
Total	102	100.0%

Table 6: Reasoning by respondents in unwillingness to support VA

In furtherance of these findings, the assessment polled respondents with the notion if funding and/or training was provided by a government entity in the efforts to treat veteran mental health patients with findings yielding the following the results: 70.6% stating that they would

treat veteran mental health patients if funding was provided to them (9.8% respondents are already participating with fund) and 66.7% annotating that they would be involved in the treatment of veteran mental health patients if training was provided to the professionals in their clinics (13.7% already participating treatment with training). In furtherance of these findings, 8 respondents (7.8%, N=102) annotate they are receiving funding from a government source to provide mental health treatment to veteran patients.

Of those who responded to the survey, the question was posed as to what reasons would prevent them from their involvement in such training programs to treat veterans with their responses shown in Table 6. Furthermore, the responses of the 102 Texas mental health care providers from all sectors across the entire state, the following was ascertained from the community needs assessment survey: 72.5% were willing to provide mental health treatment to veterans in support of the Department of Veterans Affairs with 8.8% identifying that they are already supporting the VHA in these efforts. Respondents also annotated that they would be willing to provide mental health treatment to veterans if they received training from the VA or a VA designee; 74.5% stated they would be willing to receive training in support of this effort, 10% stating no, and 16% unsure if they would or not participate.

In the survey, the questions were posed to identify if mental health care clinics provide emergency mental health care to veterans and if they would be willing to provide emergency care, 24.5% stated that they do provide emergency mental health care to veterans and 68.6% said they would be willing to provide such treatment. Lastly, one other descriptive statistic was ascertained among the respondents of the community needs assessment survey that addresses their awareness of the MISSION Act of 2018 (Public Law 115-182) with 21.6% responding with the affirmative. Responses collected and gathered from these descriptive statistics were tested

through quantitative analysis software to ascertain their significance and to be used within the interview with the representative from Texas Health and Human Services and in the analysis of the VA MISSION Act legislation.

Clinic's specialization of care (*N=102*)

Specialization of care	Frequency	Percentage
Primary Care	2	2.0%
Specialty Care	3	2.9%
Mental Health Care	100	98.0%
Addiction Care	15	14.7%
Prescription Care	3	2.9%
Other Care	11	10.8%

Table 7: Specialization of respondents

Methods of Treatment provided by respondents (N=102)

Treatment method(s)	Frequency	Percent
Face-to-Face (F2F)	3	2.9%
Video	2	2.0%
Other	2	2.0%
F2F & Phone	2	2.0%
F2F & Video	24	23.5%
Phone & Video	1	1.0%
F2F, Phone, & Video	66	64.7%
F2F, Phone, Video, & Other	2	2.0%
Total	102	100.0%

Table 8: Treatment methods provided by respondents

Factors preventing clinics from making referral for veteran mental health patients.

Factor	Frequency	Percent
Knowledge of eligibility	26	25.5%
Knowledge of how to refer	18	17.6%
Concerns for wait times for veterans to be seen	41	40.2%
Concerns for quality of care veterans will receive	41	40.2%
Patients are not eligible for VA mental health services	20	19.6%
Concerns about the distance for the veteran to travel to VA mental health care services	28	27.5%
Patient is concerned about the impact of receive VA mental health care services	43	42.2%
Other factors	13	12.7%
None of the above	23	22.5%

Table 9: Factors that prevent respondents from making referrals for veterans

Results of One-Way Analysis of Variance (ANOVA). A one-way ANOVA was utilized to examine the effects clinic location (urban, rural, and unknown) by willingness to treat veterans when the clinic receives support from the VHA.

The results of the one-way ANOVA show no overall significant difference in the mental healthcare clinic's willingness to treat mental health veteran patients based on their clinic's location (rural, urban, and unknown) ($F = 2.82$; $df = 2, 101$, $p > .05$; see Table 11, $p = Sig.$).

The results of the post hoc Bonferroni test show no significant difference between urban and rurally located mental health care providers ($p = .64$, $p > .001$; see Table 12), The results also show no significant difference with rural located clinics and those clinics who are unsure of the location of their clinics ($p = .318$, $p > .05$; see Table 12). Rural clinics reporting higher levels of willingness (mean = 1.48; see Table 10) than urban clinics (mean = 1.29; see Table 10). However, even those who were unsure (unknown mean = 2; see Table 10) if their clinic was in a rural or urban designation, the distribution between means does not dictate a significant difference.

The results of the Kruskal-Wallis *H* nonparametric test show significant willingness to treat veteran mental health patients based upon the location of the clinics ($\chi^2 = 78.35$, $df = 2$, $p < .05$).

The results of the post hoc Tamhane's T2 test show no significant willingness to treat veteran mental healthcare patients difference between the rural and urban located clinics ($p = .522$, $p > .05$; see Table 12). Also, no significance was found between unknown location and urban or rurally located mental health care clinics.

Would your clinic/practice be willing to receive training from the VA or a VA supported entity to provide mental health treatment to veterans? (Descriptives)

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	
					Lower Bound	Upper Bound
Rural	44	1.4773	0.82091	0.12376	1.2277	1.7269
Urban	52	1.2885	0.63667	0.08829	1.1112	1.4657
Unknown	6	2	0.89443	0.36515	1.0614	2.9386
Total	102	1.4118	0.7493	0.07419	1.2646	1.5589

Table 10: Respondents willingness to receive training from VA or VA-supported agency.

ANOVA

Would your clinic/practice be willing to receive training from the VA or a VA supported entity to provide mental health treatment to veterans?

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	3.056	2	1.528	2.819	0.064
Within Groups	53.65	99	0.542		
Total	56.706	101			

Table 11: One-way ANOVA regarding willingness to receive training by respondents

Multiple Comparisons

Dependent Variable: Would your clinic/practice be willing to receive training from the VA or a VA supported entity to provide mental health treatment to veterans?

	(I) Respondent's location of clinic (rural, urban, unknown)	(J) Respondent's location of clinic (rural, urban, unknown)	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Bonferroni	Rural	Urban	0.18881	0.1508	0.64	-0.1784	0.556
		Unknown	-0.52273	0.3204	0.318	-1.3029	0.2575
	Urban	Rural	-0.18881	0.1508	0.64	-0.556	0.1784
		Unknown	-0.71154	0.3174	0.082	-1.4845	0.0614
	Unknown	Rural	0.52273	0.3204	0.318	-0.2575	1.3029
		Urban	0.71154	0.3174	0.082	-0.0614	1.4845
Tamhane	Rural	Urban	0.18881	0.1520	0.522	-0.1819	0.5595
		Unknown	-0.52273	0.3856	0.53	-1.7704	0.7249
	Urban	Rural	-0.18881	0.1520	0.522	-0.5595	0.1819
		Unknown	-0.71154	0.3757	0.296	-1.973	0.55
	Unknown	Rural	0.52273	0.3856	0.53	-0.7249	1.7704
		Urban	0.71154	0.3757	0.296	-0.55	1.973

Table 12: Multiple comparisons results from one-way ANOVA regarding receiving training

A one-way ANOVA was utilized to examine the effects clinic location (urban, rural, and unknown) by their clinic's process of screening patients for prior military service.

The results of the one-way ANOVA show no overall significant difference in the mental healthcare clinic's screening of patients for prior military service based on their clinic's location (rural, urban, and unknown) ($F = 1.69$; $df = 2, 101$, $p > .05$; see Table 14).

The results of the post hoc Bonferroni test show no significant difference between urban and rurally located mental health care providers ($p = 1$, $p > .001$; see Table 15). The results also show no significant difference with rural located clinics and those clinics who are unsure of the location of their clinics ($p = .236$, $p > .05$; see Table 15). Urban clinics reporting slightly higher levels in screening of patients (mean = 1.38; see Table 13) than rural clinics (mean = 1.3; see Table 13). However, even those who were unsure (unknown mean = 1.67; see Table 13) if their clinic was in a rural or urban designation, the distribution between means does not dictate a significant difference.

The results of the Kruskal-Wallis *H* nonparametric test show significant screening processes for prior military service among mental healthcare patients based upon the location of the clinics ($\chi^2 = 7.69$, $df = 1$, $p < .05$).

The results of the post hoc Tamhane's T2 test show no significant screening processes for prior military service among mental healthcare patients difference between the rural and urban located clinics ($p = .741$, $p > .05$; see Table 15). Also, no significance was found between unknown location and urban or rurally located mental health care clinics.

Does the clinic screen patients for military service? (yes/no) (Descriptives)

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean Lower Bound	Upper Bound
Rural	44	1.2955	0.46152	0.06958	1.1551	1.4358
Urban	52	1.3846	0.49125	0.06812	1.2479	1.5214
Unknown	6	1.6667	0.5164	0.21082	1.1247	2.2086
Total	102	1.3627	0.48317	0.04784	1.2678	1.4576

Table 13: Screening of military service with patients by respondents

ANOVA

Does the clinic screen patients for military service? (yes/no)

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	0.778	2	0.389	1.69	0.19
Within Groups	22.8	99	0.23		
Total	23.578	101			

Table 14: One-way ANOVA results for respondents screening patients for military service

Multiple Comparisons

Dependent Variable: Does the clinic screen patients for military service? (yes/no)

	(I) Respondent's location of clinic (rural, urban, unknown)	(J) Respondent's location of clinic (rural, urban, unknown)	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Bonferroni	Rural	Urban	-0.08916	0.0983	1	-0.3286	0.1502
		Unknown	-0.37121	0.209	0.236	-0.8798	0.1374
	Urban	Rural	0.08916	0.0983	1	-0.1502	0.3286
		Unknown	-0.28205	0.2069	0.528	-0.786	0.2219
	Unknown	Rural	0.37121	0.209	0.236	-0.1374	0.8798
		Urban	0.28205	0.2069	0.528	-0.2219	0.786
Tamhane	Rural	Urban	-0.08916	0.0974	0.741	-0.3259	0.1476
		Unknown	-0.37121	0.222	0.374	-1.0922	0.3498
	Urban	Rural	0.08916	0.0974	0.741	-0.1476	0.3259
		Unknown	-0.28205	0.2216	0.577	-1.0035	0.4394
	Unknown	Rural	0.37121	0.222	0.374	-0.3498	1.0922
		Urban	0.28205	0.2216	0.577	-0.4394	1.0035

Table 15: Post hoc results in screening of patients for military service

Two-way analysis of variance (ANOVA). A two-way ANOVA was utilized to examine the effects of respondents location, sector, and location by sector of clinic on the methods of treatment among 102 mental healthcare clinics respondents.

Main effect one (location): the results of the two-way ANOVA show no overall significant difference in location of clinics and the treatment of methods they provide ($F_{(2,102)} = 2.64$, $p > .010$, $\eta^2 = .052$; see Table 17).

The results of the post hoc Bonferroni test show no significant difference between urban and rurally located clinics ($p > .001$; see Table 17), with rural clinics having a slightly higher level in methods of treatment (mean = 9.6; see Table 16) than urban clinics (mean = 9; see Table 16). Clinics who were unsure of their location designation report a slightly lower level of methods of treatment than rural and urban clinics (mean = 7; see Table 16). No significance was found between unknown locations and rural or urban clinics ($p > .05$; see Table 17).

Overall, location of clinic accounted for only 5.2 percent of the variance in methods of treatment, indicating a weak relationship between the two variables.

Main effect two (sector of clinic): The results of the two-way ANOVA also show no overall significant difference in levels of methods of treatment among mental health providers based on the sector of their practice ($F_{(2,102)} = .999$, $p > .05$, $\eta^2 = .020$; see Table 17).

Due to the lack of responses from those in the public sector, the post hoc Bonferroni test could not be utilized to show any significant differences between public, private, and non-profit sectors of mental health care providers. Private practice sector (mean = 9.14; see Table 16) reported a slightly higher level in methods of treatment than non-profit mental health care providers (mean = 9.13; see Table 16). No significant differences were found between non-profit and private sector mental health care providers based on their methods of treatment ($p >$

.05; see Table 17); face-to-face, phone, video application, other, and any combination of treatment methods.

Interaction effect (location by sector): The results of the two-way ANOVA also show no significant location of clinic by sector of clinic interaction effect on methods of treatment provided ($F_{(1,102)} = .611$, $p > .05$, $\eta^2 = .006$; see Table 17). However, this interaction effect accounted for less than one percent of the variance in methods of treatment provided.

Finally, overall, the three effects accounted for a total of 6.7 percent of the variance in methods of treatment provided.

Descriptive Statistics

Dependent Variable: Methods of treatment provided				
Location	Sector	Mean	Std. Dev.	N
Rural	Private Practice	9.6098	2.71917	41
	Public Health	6	.	1
	Non-Profit	11	0	2
	Total	9.5909	2.69641	44
Urban	Private Practice	9	2.78887	46
	Non-Profit	8.5	4.1833	6
	Total	8.9423	2.93333	52
Unknown	Private Practice	7	3.28634	6
	Total	7	3.28634	6
Total	Private Practice	9.1398	2.8307	93
	Public Health	6	.	1
	Non-Profit	9.125	3.72012	8
	Total	9.1078	2.89043	102

Table 16: Descriptive statistics of methods of treatment by location and sector

Tests of Between-Subjects Effects

Dependent Variable: Methods of treatment provided					
Source	SS	df	Mean Sq.	F	*p*
Clinic_Location	43.23	2	21.615	2.636	0.077
Sector_of_Clinic	16.384	2	8.192	0.999	0.372
Clinic_Location * Sector_of_Clinic	5.013	1	5.013	0.611	0.436
Error	787.256	96	8.201		
Total	9305	102			
Corrected Total	843.814	101			

$R^2 = .067$ (Adjusted R Squared = .018)

Table 17: Test between location of clinic, sector of clinic, and location by sector

A two-way ANOVA was utilized to examine the effects of respondents willingness to treat with VA training support, VA funding support, and VA training by funding support based upon 102 mental health care respondents location.

Main effect one (training support): the results of the two-way ANOVA show no overall significant difference in the willingness of mental healthcare providers with VHA training support and the location of their clinics ($F_{(2,102)} = .378$, $p > .010$, $\eta^2 = .008$; see Table 19).

The results of the post hoc Bonferroni test show no significant difference in clinics willingness to provide treatment to veteran patients with VHA training support ($p > .001$; see Table 19), with those clinics not willing to provide treatment with VHA supported training having reported slightly higher levels (mean = 1.65; see Table 18) than those clinics willing to provide treatment with VHA supported training (mean = 1.63; see Table 18). Also, clinics already taking part in VHA supported training treatment reported no significant difference between those willing and not willing to provide treatment with VHA supported training ($p > .05$, mean = 1.57; see Table 18).

Overall, training support accounted for less than one percent of the variance in location of clinic, indicating a weak relationship between the two variables.

Main effect two (funding support): the results of the two-way ANOVA also show no significant difference in levels of willingness to provide treatment to mental health veteran patients with funding support from the VHA based upon the location of their clinic ($F_{(2,102)} = 1.33$, $p > .05$, $\eta^2 = .028$; see Table 19).

The results of the post hoc Bonferroni test show no significant between mental health care clinic's willingness to provide treatment with VHA supported funding and those who are not willing to provide treatment to veterans with VHA supported funding ($p > .001$; see Table 19),

with those not willing to provide treatment to veteran mental health patients with funding support from VHA reporting slightly higher levels (mean = 1.8; see Table 18) than those who are willing to treat veteran health care patients with VHA funding support (mean = 1.6; see Table 18). Also, clinics already taking part in VHA funding supported treatment reported no significant difference between those willing and not willing to provide treatment with VHA supported training ($p >$ .05, mean = 1.4; see Table 18).

Overall, funding support accounted for less than three percent of the variance in location of clinic, indicating a weak relationship between the two variables.

Interaction effect (training support by funding support): the results of the two-way ANOVA also show no significant training support by funding support of clinic interaction effect on the location of the mental health care clinic ($F_{(3,102)} = .12$, $p > .05$, $\eta^2 = .004$; see Table 19). However, this interaction effect accounted for less than one percent of the variance in methods of treatment provided.

Finally, overall, the three effects accounted for less than five percent of the variance in location of mental health care providers.

Descriptive Statistics

Dependent Variable: Respondent's location of clinic (rural, urban, unknown)				
Is clinic willing to provide treatment to veteran mental health patients with training support from the VHA?	Is clinic willing to provide treatment to veteran mental health patients with funding support from the VHA?	Mean	Std. Deviation	N
Yes	Yes	1.6207	0.58722	58
	No	1.7778	0.83333	9
	Already taking part	1	.	1
	Total	1.6324	0.62065	68
No	Yes	1.5	0.52705	10
	No	1.8	0.63246	10
	Total	1.65	0.58714	20
Already taking part	Yes	1.75	0.5	4
	No	2	.	1
	Already taking part	1.4444	0.52705	9
	Total	1.5714	0.51355	14
Total	Yes	1.6111	0.57053	72
	No	1.8	0.69585	20
	Already taking part	1.4	0.5164	10
	Total	1.6275	0.59572	102

Table 18: Two-way descriptive statistics in regard to training and funding support

Tests of Between-Subjects Effects

Dependent Variable: Respondent's location of clinic (rural, urban, unknown)					
Source	SS	df	Mean Square	F	*p*
Receive_VA_Training	0.276	2	0.138	0.378	0.686
Receive_VA_Funds	0.976	2	0.488	1.338	0.267
Receive_VA_Training * Receive_VA_Funds	0.131	3	0.044	0.12	0.948
Error	34.283	94	0.365		
Total	306	102			
Corrected Total	35.843	101			

R^2 = .044 (Adjusted R Squared = -.028)

Table 19: Two-way ANOVA between subjects in regard to location by training and funding.

Lastly, in regard to the findings of the community needs assessment survey, respondents were asked to rank their knowledge, confidence, and training interest for 14 different areas that are within the mental health treatment services with a ranking of “high”, “some”, “very little”, and “none”, with some not responding to the ranking of areas within the research indicate by a

response of "no response." Based upon the percentages shown below in Table 20, the need for training among mental health care professionals in Texas in comparison to their own self assessed level of confidence can greatly benefit veterans in their communities, and in turn benefit the providers in their knowledge and confidence in treating veterans and identifying those who require service that exceed their professional knowledge base.

Level of knowledge, confidence, and training interest in mental health care providers (N=102)

Knowledgeable in Treating					
Level	High	Some	Very Little	None	No Response
Anger	76.2%	20.8%	1.0%	1.0%	1.0%
Anxiety	96.0%	3.0%	0.0%	0.0%	1.0%
Stress	96.0%	3.0%	0.0%	0.0%	1.0%
Depression	95.0%	4.0%	0.0%	0.0%	1.0%
Family/Relationship Problems	85.1%	10.9%	2.0%	1.0%	1.0%
Family and Domestic Violence	57.4%	30.7%	9.9%	1.0%	1.0%
Grief and Bereavement	71.3%	26.7%	1.0%	99.0%	1.0%
Military Sexual Trauma	41.6%	29.7%	17.8%	9.9%	1.0%
Pain Management	21.8%	30.7%	30.7%	15.8%	1.0%
PTSD	80.2%	11.9%	5.9%	1.0%	1.0%
Sleep Disorder	31.7%	40.6%	20.8%	5.9%	1.0%
Substance Abuse/Dependence	40.6%	37.6%	18.8%	2.0%	1.0%
Suicide and Suicide Ideation	77.2%	20.8%	1.0%	0.0%	1.0%
Traumatic Brain Injury	14.9%	39.6%	37.6%	6.9%	1.0%

Confidence in Treating					
Level	High	Some	Very Little	None	No Response
Anger	76.2%	16.8%	2.0%	1.0%	4.0%
Anxiety	95.0%	1.0%	0.0%	0.0%	4.0%
Stress	95.0%	1.0%	0.0%	0.0%	4.0%
Depression	94.1%	2.0%	0.0%	0.0%	4.0%
Family/Relationship Problems	83.2%	7.9%	3.0%	2.0%	4.0%
Family and Domestic Violence	51.5%	31.7%	7.9%	5.0%	4.0%
Grief and Bereavement	71.3%	20.8%	4.0%	0.0%	4.0%
Military Sexual Trauma	39.6%	26.7%	14.9%	14.9%	4.0%
Pain Management	17.8%	33.7%	24.8%	19.8%	4.0%
PTSD	75.2%	12.9%	5.0%	3.0%	4.0%
Sleep Disorder	25.7%	35.6%	21.8%	12.9%	4.0%
Substance Abuse/Dependence	33.7%	34.7%	19.8%	7.9%	4.0%
Suicide and Suicide Ideation	72.3%	20.8%	2.0%	1.0%	4.0%
Traumatic Brain Injury	13.9%	30.7%	32.7%	18.8%	4.0%

Training Interest in Treating					
Level	High	Some	Very Little	None	No Response
Anger	44.6%	28.7%	10.9%	10.9%	5.0%
Anxiety	47.5%	22.8%	11.9%	12.9%	5.0%
Stress	46.5%	22.8%	12.9%	12.9%	5.0%
Depression	46.5%	22.8%	11.9%	13.9%	5.0%
Family/Relationship Problems	45.5%	24.8%	10.9%	13.9%	5.0%
Family and Domestic Violence	40.6%	32.7%	11.9%	9.9%	5.0%
Grief and Bereavement	43.6%	28.7%	8.9%	13.9%	5.0%
Military Sexual Trauma	49.5%	28.7%	5.9%	10.9%	5.0%
Pain Management	40.6%	26.7%	9.9%	17.8%	5.0%
PTSD	65.3%	15.8%	5.9%	7.9%	5.0%
Sleep Disorder	44.6%	20.8%	13.9%	15.8%	5.0%
Substance Abuse/Dependence	28.7%	27.7%	21.8%	16.8%	5.0%
Suicide and Suicide Ideation	48.5%	26.7%	8.9%	10.9%	5.0%
Traumatic Brain Injury	51.5%	20.8%	12.9%	9.9%	5.0%

Table 20: Providers Knowledge, Confidence, and Training levels

Interview Results

Texas Department of Health and Human Services. The State of Texas as of 2009 has increased their involvement with veterans residing in the state, most notably in the areas of

mental health care. The catalyst for change and pushes in new state legislation was the incident at Fort Hood, TX that involved Major Nidal Hasan and the killing of multiple people at the deployment readiness center (TX Health and Human Services, personal communication, September 18, 2020). In regard to the legislation directed towards Texas veterans' mental health, the following legislation in Texas has been created, but not limited to: Specialty Courts Advisory Council, TX H 1771, 2011 (enacted); Veteran Service Officer Training, TX S 846, 2013 (enacted); Mental Health Programs for Veterans, TX H 2392, TX S 898, 2013 (enacted); Coordinating Council, TX S 1892, 2013 (enacted); Assistance Animals, TX H 489, 2013 (enacted); Donations of Juror Reimbursements, TX H 3996, 2015 (enacted); Veterans Court Programs Participants, TX H 3729, 2015 (enacted); Study on Providing Care to Veterans with PTSD, TX H 3404, 2015 (enacted); Training for Peace Officers and First Responders, TX H 1338, 2015 (enacted); Community Mental Health Programs for Veterans Grants, TX S 55, 2015 (enacted); Preventive Services Program and Mental Health Program, TX H 19, 2015 (enacted); Administration of Veteran's Treatment Court Program, TX H 3069, 2017 (enacted); Veteran Suicide Prevention Commission, TX S 578, 2017 (enacted); Mental Health Program for Veterans, TX S 27, 2017 (enacted); Mental Health First Aid Training Inclusion, TX H 4429, 2019 (enacted); Veterans Treatment Court Programs, TX S 1180, 2019 (enacted); Missing Military Members, TX H 833, 2019 (enacted); Veteran Mental Health Program Grants, TX S 822, 2019 (enacted); and Calendar Designation, TX HCR 148, 2019 (enacted).

Under the provisions of these pieces of legislation many programs and initiatives emerged that have allowed the State of Texas to address many gaps that were identified to be filled with state funded resources; noting the State of Texas does not receive VA funding to support these programs (TX Health and Human Services, personal correspondence, September 18, 2020).

Taking into consideration the amount of the veteran population in rural areas with limited resources, the State of Texas under Senate Bill 27 is providing six pilot programs in the following cities: Tyler, Abilene, Round Rock, Nacogdoches, Waco, and Edinburg (TX Health and Human Services, personal correspondence, September 18, 2020). These sites serve 39 counties in their consolidated surrounding areas and use a network of veteran and peer-to-peer counselors that assist in serving these veterans through a collaborative effort of all providers involved, including the Texas Veterans Commission and Health and Human Services Commission (TX Health and Human Services, personal correspondence, September 18, 2020).

In furtherance of this legislation, the State of Texas has also enacted a major piece in regard to veterans mental health in TX Senate Bill 55, all in efforts to provide mental health treatment to veterans across the state. Under this bill, grants are provided in a collaborative effort between the state and providers to generate programs to treat veterans; since 2016 a multi-phase program has rolled out serving tens of thousands of veterans and providing over $50 million in matched state funding (TX Health and Human Services, personal correspondence, September 18, 2020). Participants in these programs are from all sectors (private, non-profit, and public) of mental health care providers and pushes to enhance many aspects of mental health treatment and the involvement of community members, along with mental health professionals, to provide them with the skills to identify and make referrals in regard to veterans in need of potential mental health treatment, to include others means of support to assist them in receiving their treatment (TX Health and Human Services, personal correspondence, September 18, 2020).

The State of Texas has grown in many ways in their efforts and methods in providing treatment to veterans and opening doors and pathways for veterans in rural areas to gain access to treatment for such ailments and afflictions regarding their mental health. Along with the

Texas Veterans Commission, the Veterans Mental Health Department incorporates technical expertise and assistance to provide a large span of personnel, organizations, and mental health care providers in Texas with assistance in treating veterans. These efforts also include assistance to veterans who are affected with mental health issues and have unfortunately become involved in the criminal justice system and the difficulties they will encounter in a Texas corrections facility (TX Health and Human Services, personal correspondence, September 18, 2020).

The basis of many of the initiatives that have taken place in Texas, through their enacted legislation, is creation and interaction of networks. The networks encompass many of those professionals previously mentioned and other members of the community to bolster the access and ability to provide treatment based upon the what is perceived as the state's view of the capability gap that exists between veterans and the Department of Veterans Affairs. The networks focus on giving in depth training to the complexities that military veterans mental health have that non-military service members may not be subject to in their lives TX Health and Human Services, personal correspondence, September 18, 2020). By focusing on outreach and training efforts to these different members of the community that have a higher probability of interacting with veterans, the efforts to intercede and pinpoint needs that these veterans may have can increase their accessibility and provide them treatment that may prevent serious problems for the veterans, their families, and potentially their community (TX Health and Human Services, personal correspondence, September 18, 2020).

According to Texas Health and Human Services Veterans Mental Health Coordination and Programs, the state has plenty of programs and resources available to serve its veterans across the state, regardless of where the resident resides (TX Health and Human Services, personal correspondence, September 18, 2020). Legislation based programs through coordination of the

TX HHS and designees under this department's programs across the state are serving veterans mental health needs without the need of the Department of Veterans Affairs involvement (TX Health and Human Services, personal correspondence, September 18, 2020). The state has seen so much need for mental health services to veterans that in addition to the programs created, it also has implemented *Veterans Counselors*, who are mental health care providers, but have a much more in depth experience and familiarity with the unique needs that veterans may suffer from in regard to their mental health care (TX Health and Human Services, personal correspondence, September 18, 2020). Furthermore, these specific counselor services and training, as applied to serving Texas veterans, aligns with the legislation outlined in the MISSION Act of 2018; these counselors have been identified in those aforementioned pilot programs, where resources are minimal in comparison to the density of veteran population (TX Health and Human Services, personal correspondence, September 18, 2020). Military Informed Care Training (MITC) is a program that has been introduced to provide training to licensed mental health care providers in efforts to expand the network of providers for veterans with mental health care needs; research suggests that Texas, like many others states, have identified capability and needs gaps between what is offered and provided by the Department of Veterans Affairs and is finding a means to fill those gaps, as the perceived ability for the VHA to reach veterans is difficult. The State of Texas has recognized the pathways the MISSION Act does provide, yet not all areas by their accounts are being fulfilled, or in other words, are easily achieved due to the processes in place between federal and state programs and legislation.

Department of Veterans Affairs – MISSION Act of 2018. Through multiple attempts with different groups within the Veterans Health Administration that deal with rural veterans, Office of Rural Health, and veterans mental health providers in Texas, no response to an interview

request was returned and those who did reply, denied the opportunity to participate with this research. Therefore, an analysis will be made within the framework and structure of the legislation of the MISSION Act of 2018 and the results of the interview with the representative of the Texas Department of Health and Human Services and the data collected and tested within this study to reinforce the framework and design of this study in relation to the VA Mission Act and the foundation of this research: accessibility of care for mental health care, training for non-VHA mental health practitioners, and funding to non-VHA mental health care practitioners.

Accessibility to care. Health care providers are to be provided to veterans through the Veterans Community Care Program; health care providers are identified as "Any health care provider that is participating in the Medicare program under title XVIII of the Social Security Act, the Department of Defense, the Indian Health Service, any Federally-qualified health center of the Social Security Act, any health care provider not otherwise covered under any [previously mentioned] criteria established by the Secretary for purposes of this section" (Public Law 115-182, 2018, p. 1396). Within the MISSION Act, the legislation must give the confines in which non-Department providers must be furnished for care of veterans. The Act states the Secretary must provide these services with qualified non-Department providers with the caveat of the availability of funds then to furnish care if the VHA does not offer the care or service, it does not operate a "full-service medical facility" in the state the veteran resides, "the covered veteran was an eligible veteran under section 101(b)(2)(B) of the Veterans Access, Choice, and Accountability Act of 2014 as of the day before the date of the enactment of the Caring for Our Veterans Act of 2018", the veterans must still reside in a location that would qualify them for such services, and either the veteran lives in one of the five states with lowest density population per the 2010 census or "resides in a State not described in subclause (I)" and "received care or

services under this title in the year preceding the enactment of the Caring for Our Veterans Act of 2018; and is seeking care or services within 2 years of the date of the enactment of the Caring for Our Veterans Act of 2018" (Public Law 115-182, 2018, p. 1396-7). Furthermore, through consult with the veterans' clinician and the veteran, it is agreed that the non-Department provider is who serves the veterans best interest based upon criteria of the Secretary (Public Law 115-182, 2018).

The criteria, per the surety of the Secretary, must include the consideration of many factors: distance from the covered veteran to the facility [or any service needed]; the nature of the care; the frequency in which the covered veteran needs to have treatments or care; the timeliness available for care based upon the needs of the veteran; and whether the veteran faces "unusual or excessive burden" to care from the Departments facilities, which taking into consideration the distance to facilities for the veteran, the care being sought is provided by a medical facility of the Department that is reasonably accessible to the veteran, the condition of the veteran affects their ability to travel, and if there is a "compelling reason, as determined by the Secretary", that shows that the veteran needs services at a non-Department facility (Public Law 115-182, 2018). The Act goes into further detail as to some of the other considerations that the Department, with the direction and discretion of the Secretary, dictating the qualifications the covered veteran and their condition must meet in order to receive care – it must be noted that the conditions often rely on the confines and qualifications of the State in which the veteran resides in order to receive care, yet it does not limit the access based upon these factors, more so, it appears the dependence is on the availability or subjectivity thereof in regard to funding.

In order for a non-Department provider to give care to covered veterans under the MISSION Act, an agreement must be made by the Secretary and the non-Department care provider; these

are known as a *Veteran Care Agreement.* Taking into consideration those criteria that must be met for the veteran to receive treatment from a non-Department facility or a facility already under contract with the Department, these agreements must be reviewed and approved by the Secretary within the totality of all circumstances and needs of treatment (Public Law 115-182, 2018). With all such agreements, there is the ability for the agreement to not be renewed; furthermore, providers must be eligible to provide treatment to covered veterans – providers who have enrolled and entered into an agreement under section 1866(a) of the Social Security Act [SSA] and under 1842(h) for physicians who entered into an agreement of the same Act; "any provider participating under a State plan under title XIX of SSA"; and "any entity or provider nor described [previously] of this subsection that the Secretary determines to be eligible pursuant to the certification process" (Public Law 115-182, 2018, p. 1405). Within Chapter One Section 102, the MISSION Act outlines the process for non-Department providers to be certified as an eligible provider to covered veterans, to include the renewal of certification, the rates of services, and the terms of the Veterans Care Agreements, all of which can be considered cumbersome to non-Department care providers.

When it comes to the coverage of the service and care, the Secretary must ensure that the standards of treatment are met in this Act, to include the access to the services, which must be commensurate with the medical benefits package of the Department of Veterans Affairs, this also includes that veterans have accessibility to "relevant comparative information that is clear, useful, and timely, so that covered veterans came informed decisions regarding their health care" (Public Law 115-182, 2018, p. 1409). In regard to the access standards of care, the Secretary shall consult with other entities that include the Department of Defense, Department of Health and Human Services, private sector, and nongovernmental entities; additionally, the Secretary

shall ensure that the health care providers comply with the accessibility of care – with the caveat that the veteran may inquire about their eligibility for non-Department providers when the Department cannot provide the care needs for the veteran (Public Law 115-182, 2018, p. 1410).

Under the legislation of the MISSION Act and the manner in which services are provided to covered veterans from non-Department providers, the means to compensate or give payment to these providers is a major piece of this legislation that must be addressed. It is explicitly stated in the MISSION Act that the Secretary "shall pay for hospital care, medical services, or extended care services furnished by health entities or providers under this chapter within 45 calendar days upon receipt of a clean paper claim or 30 calendar days upon receipt of a clean electronic claim" (Public Law 115-182, 2018, p. 1418). But the fiscal complications in how the money is presently being allocated and redistributed throughout the VHA facilities across the United States is making the application of this part of the legislation difficult for the VA. The Act goes into further detail in the event of denial of claims and other forms of payment or what can also be considered reimbursement, to include the event fraudulent claims are made to the Department. In furtherance of the checks and balances of filing of claims, the Secretary "shall seek to contract with a third party to conduct a review of claims described…that includes – a feasibility assessment to determine the capacity of the Department to process claims in a timely manner and a cost benefit analysis comparing the capacity of the Department to a third party entity capable of processing such claims" this applies to the claims made under this Act and those amended by the Caring for Our Veterans Act of 2018 (Public Law 115-182, 2018, p. 1420). Lastly, the Secretary shall submit to Congress a report that details on the mechanisms and feasance of those similar to other Federal agencies to allow a contracted entity to "act as a fiscal intermediary for the Federal

Government to distribute, or pass through, Federal Government funds for certain non-under-written" care and services (Public Law 115-182, 2018, p. 1420).

Within the scope of the MISSION Act, the Secretary shall provide training to veterans to teach them about their health care options under the umbrella of the VA. This includes the covered veterans eligibility for care, how the priority groups work, financials involved, quality and access standards, and the interaction between the VA insurance programs and other forms of insurance from private or other government provided plans, and their right to complain about the treatment they have or have not received (Public Law 115-182, 2018).

It is also the responsibility of the Secretary to develop and implement a training program for the Departments employees and contractors on how to administer non-Department health care programs that includes reimbursement for non-Department emergency room care and management of prescriptions. Additionally, evaluations and levels of effectiveness to the training programs shall be implemented; furthermore, the Secretary shall "establish a program to provide continuing medical education material to non-Departmental medical professionals" which shall include: "[i]dentifying and treating common mental and physical conditions of veterans and family members of veterans, [t]he health care system of the Department of Veterans Affairs, [and] [s]uch other matters as the Secretary considers appropriate" (Public Law 115-182, 2018, p. 1424).

In furtherance of this training program, non-Department medical professionals shall have access to the same materials provided to those within the Department to ensure that all providers throughout the community are supported with same core competencies (Public Law 115-182, 2018). The Act further states that administration of the program must be through the VA's internet website and that the credits for participation must be monitored by the Secretary, to

include its accreditation and the licensing of participants in the state in which they practice (Public Law 115-182, 2018).

Continuing with the lines of the licensing and accreditation of non-Department providers, they must also meet the standards of competency set forth by the Secretary. "Non-Department of Veterans Affairs health care providers furnishing care pursuant to a contract, agreement, or other arrangement shall, to the extent practicable as determined by the Secretary, fulfill training requirements established by the Secretary on how to deliver evidence-based treatments in the clinical areas for which the Department of Veterans Affairs has special expertise" (Public Law 115-182, 2018, p. 1427). Those non-Department of Veterans Affairs health care providers must meet the standards and requirements established within 6-months of entering into the contract or agreement upon taking effect.

As with the previously mentioned covered health care providers and veterans, the same transcends to the same coverage in relation to tele-health. Additionally, "[t]he provisions of this section shall supersede any provisions of the law of any State to the extent that such provision of State law are [sic] inconsistent with this section" (Public Law 115-182, 2018, p. 1431). This further extends that no State shall deny the license or alike of health care providers as long as they meet the qualifications in regard to practicing tele-health, meaning practicing remotely from the covered veteran if they reside and practice in separate states. The inclusion of tele-health in this Act comes with the evaluation and reporting of its use that includes the satisfaction of veterans, satisfaction of providers, the effects of tele-health in the provisions of both Department and non-Department providers, the productivity of the providers, wait times for an appointment, the use of in-person services by veterans from all providers, types of appointments under the use

of tele-health, and the overall savings in the use of tele-health during the reporting period (Public Law 115-182, 2018, p. 1432).

Under the MISSION Act, it outlines the Center for Innovation for Care and Payment; under this organization within the Department, the Secretary can determine the appropriate initiatives for delivery of services and payments thereof while maintaining the quality of care, improving access, timeliness, and patient satisfaction, and ultimately lessening the costs to the Department (Public Law 115-182, 2018). Tests administered by the Secretary will focus on models that address deficiencies in services of care to poor clinical outcomes and avoidable expenses; with these modeling tests, the effectiveness of links between other sectors payment models and the monitoring of all areas of such models (Public Law 115-182, 2018). Through the monitoring, testing of models, and continuous assessment, the expansion or removal of programs can be assessed for their effectiveness to treating veterans and the costs associated.

Underserved areas designated by the parameters of this Act are an important aspect of the services available to rural veterans. The Secretary "shall develop criteria to designate medical centers, ambulatory care facilities, and community based outpatient clinics [of the VA] as underserved facilities" (Public Law 115-182, 2018, p. 1470). Those considered underserved include the ratio of veterans to health care providers within the VHA; the clinical specialties within an area; whether the community itself is medically underserved; the type, age, and number of open consults; the wait-times at the facility meet those requirements set forth by the VA; and any other information that is deemed important in determining facilities for these respective areas (Public Law 115-182, 2018, p. 1470). To address the underserved communities, the Act provides the provisions in which the pilot program of delivering mobile teams to the designated underserved areas; with the consideration of the medical positions of greatest needs,

the size and composition of the teams, and any other elements considered important by the Secretary (Public Law 115-182, 2018, p. 1472).

Chapter 5 – Discussion, Limitations, and Conclusion

Discussion

The framework of legislation that gives authority to the Secretary of Department of Veterans Affairs is vast and encompasses many areas and the gaps that many studies have identified in providing quality medical treatment to veterans, notably to rural residing or in the case of the verbiage of the MISSION Act, underserved communities. Through the respondents of the community needs assessment, the majority of providers identified as private sector mental health care providers with 43% of respondents noting that they practice in rural areas, taking into consideration that by the definition of rural that has been established for this study, as that of the designating governmental departments, the majority of the counties in Texas are considered to be rural. The correlation of the limited amount of responses in regard to mental health care providers and those who participated in the assessment can lend to thought that the many rural counties of Texas are underserved.

In considering that the majority of Texas is rural and underserved with a large population of veterans in these areas, another aspect that must be considered in the treatment of veterans in these areas is that of the 102 respondents, almost 65% do not accept insurance plans that are specific to veterans, i.e. Tricare or CHAMPVA. With the gap identified that a large area of Texas is rural and the majority of respondents do not accept VA-supported insurance plans, legislation like the MISSION Act is needed to bring these services, which it appears through the Act itself, there is a mechanism in place to provide them in these underserved areas. However, as this Act was enacted in 2018 and the responses were provided in 2020, the gaps appear to still be prevalent.

Of those who responded, less than 20% have noted they have received training from the VA to provide treatment to veterans while 66 respondents (*n =102)* have identified that time, cost, no interest, not enough personnel, and other reasons as to why they are unable to participate. Therefore, it can be assumed that with the majority of respondents being in the private sector, and the majority of those who are unwilling to participate, the reliance for organizations to support the VA with the mandates of the MISSION Act appears to fall more so onto the State (public), non-profit organizations, and ultimately, the Department itself. Yet, this point also hinges on the aspect of funding for treatment; according to the assessment, respondents willingness increased when the variable of funding was given to those mental health providers. Additionally, almost the same number of respondents showed an increased willingness if training was provided. However, based upon this assessment, the majority of respondents have not taken part in any VHA related mental health training, to include an even greater amount have not participated due to no funding mechanism in place for their practices involvement in treatment.

As research suggests, based upon the willingness of mental health providers and their willingness to treat veterans based upon their location, rural (underserved) or urban, there is no significant difference between the two, therefore the mechanisms provided by the VA to support these entities, the Department itself and ultimately, the needs of veterans appear to be a continuing capability gap that the VA is not meeting. The findings of this study align with the findings in no significant differences between rural and urban located providers, like that of Hudson et al.'s study, which can allow for reasoning in the regard that this finding can be considered the norm for rural and urban providers across the United States. As noted within the responses, only 21.6% are aware of the MISSION Act, which means that the majority are not knowledgeable of the legislation that provides mechanisms to providers in regard to training and

funding, which gives credence as to why the data shown from the assessment substantiates why there appears gaps in providing care to underserved areas and the veterans that reside within these locations.

Based upon the interview with the representative of Texas Health and Human Services Veterans Mental Health Programs, their pilot programs and initiatives that have been implemented at the state level are addressing these gaps, much like the manner in which the studies that have taken place in other states are also working to provide treatment to veterans across their respective states. According to the manner in which their programs are implemented, the need for involvement of the Department of Veterans Affairs appears to not be required, which allows Texas HHS to operate unilaterally in their treatment programs and initiatives – *no support is given to TX HHS veteran mental health programs by the Department of Veterans Affairs.* As stated, the number one improvement that the VA can provide is a better mechanism to provide funding; often funding or reimbursement filed to the VA through the MISSION Act claims process appears to be a defunct process that does not meet the legislative language of payment of claims in a *timely manner.* Followed by funding, advocacy from the VA for their training programs to non-Departmental providers by the states can immensely help in providing treatment commensurate to the VA standards and be another area in which collaborative governance between the states and federal governments can emerge.

Overall, there appears to be a disconnect between the Department of Veterans Affairs and the mental health providers in rural (underserved) areas, to include those from the VA itself. Although the VA is to produce reports on their efforts and where their programs stand, there is little to be found in regard to mental health treatment as it relates to the provisions outlined in the MISSION Act. However, the VHA's Office of Rural Health has released their findings in their

studies relating to providing care via tele-health. According to the study that was coordinated by the VHA ORH, but led by the VA Palo Alto Health Care Center, the deployment of tablets to veterans showed an increase in those veterans attendance in appointments and controlling of their prescriptions, furthermore, they also stated that of the recipients of these tablets these veterans met the standards of the VA's continuity of care (Jacobs et al., 2019, p. 979). Based upon their study, the group who received tablets appears to have fared better in the treatments than those who did not, which exhibited a lower amount in attendance to their appointments in regard to psychotherapy (Jacobs et al., 2019, p. 979). Which brings about the future of such a program in regard to if the VA plans to distribute a tablet to all veterans who meet the increased access for their mental health treatment and what will their qualifiers entail for the veteran to receive a tablet? Will the cost-benefit analysis meet the standards of the MISSION Act to lessen costs, yet increase treatment methods and access? The answer to these questions resides with the Office of Rural Health and ultimately the Department of Veterans Affairs.

The increase and expansion of Texas' own mental health care programs for veterans leads to questions about the services the VA is and is not providing. Furthermore, from the findings of similar studies, it appears that each state is often creating their own programs and in the case of Texas, there is legislation and funding behind their programs. But, their funding is not to the level that the VA is at and per their own declaration (which as mentioned previously the $55 Billion is not funded and the VA has been asked to find the funding within their approved budget) reimbursement for their services under the provisions of the MISSION Act are often left unmet. Although the Veterans Health Administration Office of Rural Health is the advocacy branch of the VA in regard to research on mental health issues for rural residing veterans, which part of their advocacy program is to partner with state and local organizations to meet the needs

for these covered veterans? Research suggests that their partnership is limited in regard to Texas, at least through the information gathered in the interview with the representative of Texas Health and Human Services.

With the limitations in regard to referrals, the advocacy programs suggested by Kirschner et al. is substantiated here within this study as other states, Texas in this instance, is reaching out to members of the community. Yet, the expansion of those members in the community should be looked at more heavily in Texas and all states, where collaboration between the states and local communities can get public servants (i.e. law enforcement), members of the clergy, and social workers to become a group the can be the mechanism for referrals to mental health care providers. Just as the VHA ORH have deployed in studies, with positive feedback, the use of tablets in tele-health is proving to be a suitable means of treatment and allowing for increased accessibility, much like this study suggests, along with the study of Teich et al., the need for increased accessibility with the use of mobile applications can lessen many of the barriers that are discussed within this research. Also, by using a similar approach and framework, like that of Koblinsky el al., where needs assessments were utilized to determine the status of mental health care providers within Maryland and their self-identified comprehensive knowledge, confidence, and training levels in regard to mental health issues, this research is able to look at the gaps that are present in delivering to treatment to rural veterans in Texas. While also looking at how the different studies that are similar in substantive research can be used by all other states and ultimately utilized in with the Department of Veterans Affairs in administering their programs, but to highlight even more so the need for the funding under the MISSION Act to be provided and utilize collaborative governance and partnerships among all agencies and organization

involved to close the gaps and to provide treatment effectively and with as little barriers as possible, as the overall purpose of this research suggests.

Limitations

As previously noted, the VHA Office of Rural Health declined to be interviewed for this study and multiple VA mental health providers in the State of Texas ignored attempts to be participate, which provides a great limitation to this research. Their denials to participate in research that is centric to their Department creates issues not only for the researcher, but can also be contributed to their own policies and practices that prohibit their involvement at their levels, however, the lack of responses from the VHA public affairs and media relations offices lends to questioning their motivations in gathering more information that can be used to support their programs and further the treatment methods of veterans with mental health issues. A lack of transparency and accountability from the VHA and their Office of Rural Health greatly limits research from outside organizations and universities who are looking to subsidize their research with data and studies that can bolster their mission. Additionally, by not participating in independent research, leads one to question where their programs truly are in their success to closing the gaps in providing mental health treatment, and all treatment for that matter, to veterans. Their inclusion in the study could provide a benefit as to the status of their mental health programs and as to why there appears to be so much onus on the states to provide services. Even though their research suggests the accessibility to care and ability to provide treatment to rural (underserved) veterans is increasing for the better for their mental health needs. Although the VA has published many studies and has grown their programs to meet the mental health needs of rural, the ability to discuss these programs and determine where the gaps are

presently and the methods that are being developed and employed could answer many of the looming questions as to what efforts are closing the gaps between treatment and veterans.

A major area that needs to be addressed in the State of Texas, along with other states, which according to the VA MISSION Act legislation, the satisfaction level of veterans needs to be ascertained and determine if their needs are being met and if so, who is meeting them, the VA or other organizations and other states. Future studies may want to consider a joint study between academic or other professional mental health organizations in conjunction with the VA to determine what veterans need and the best practices to deliver treatment methods—whether it includes the deployment of tablets, other electronic devices, or greater use of the mobile treatment teams until more permanent solutions for underserved areas can be delivered, be it from the VA or other organizations, private or public. The involvement of veterans in studies regarding their treatment is an important aspect to consider in any study that is centric on the delivery of the mental health needs.

Recommendations

Through the implementation of the MISSION Act and pilot programs from both the VA and Texas Health and Human Services many solutions to the issues of accessibility of mental health services to rural veterans appear to be closing the gap. But, when you look closer at the situation at hand, the closing of that gap can be considered slow moving and have some redundancy. Much like the Kirchner et al. study, the use of clergy as a source of access and referral for veterans mental health needs has been a practice that has been adopted by the State of Texas and has expanded under the VA itself. According to the VA, they report that their use of clergy in this setting is having a significant impact in increasing accessibility. However, the fact that states are adopting this same program within the confines of their veterans mental health

programs, may lend thought that the division of this program in two different programs may create issues that may be providing a disconnect for this service if the two programs are not commensurate with one another. An additional aspect to be considered when it comes to members of the community with an increased interaction with veterans, especially those with mental health needs, are law enforcement. Again, as suggested by Kirchner et al., the use of law enforcement is a major factor in accessibility to care, by providing awareness training and intervention methods to law enforcement personnel that can be a means to take a veteran into protective custody or provide the veteran with resources and referrals for veterans can be a great measure in providing underserved areas with mental health resources to veterans.

As it is shown, there is a lack of communication and awareness from the Department of Veterans Affairs and the legislation that gives them the authority and latitude to assist state, local, and private entities to provide treatment, as well as, receive training and funding in the efforts to give services to veterans. With a majority of respondents stating that they have not heard of the MISSION Act should be of concern to the VA, it can lend thought to the notion that although the VA has created a mechanism to provide more access to treatment methods, the message of their support to providers outside of the VA or their contracted designee is failing to reach them. This is also supported by the research showing the increase in pilot programs on behalf of the VA to reach veterans, but growing population of veterans and the lack of interaction on part of the VA to states and private providers, as stated by the representative from Texas Health and Human Services gives credence that the VA's ability meet the needs of all of the veterans is an overwhelming endeavor they are not at this time able to achieve.

Department of Veterans Affairs in their placement of offices, facilities, and clinics across the United States and its territories provides them a large footprint to give them access to the

respective states and territories, especially an involvement with their own veterans programs, the VA should become more involved in supporting the state's programs who are farther reaching than the VA to these veterans. Ultimately, in an increased involvement with each state and territory, the mechanisms that are in place by the VA to fund and train personnel should be established to be more seamless, as it has been stated by the TX HHS representative that if there was anything the VA can be doing better it would be the reimbursement and funding process, as it is a difficult process (TX Health and Human Services, personal correspondence, September 18, 2020). This fact compounded by the findings of this study, there are major disconnects between the VA and service providers that are inhibiting their willingness and involvement in the treatment of veterans, especially with any partnership with the VA. Furthermore, with the budgets of states set through their own states' legislative mandates, funding by the VA through streamlined mechanisms and subsidization to the states can allow for the growth on part of the states and support the VA in their overall goals. Collaborative governance among the VA, states, and territories can lessen the communication issues that appear prevalent through research and increase the knowledge of the service the VA and state provide amongst community providers and allow for those non-Department providers to be involved, or at the least, aware of new and changing legislation that is centric among their profession.

The VA has developed a program called CREATE, *Collaborative Research to Enhance and Advance Transformation and Excellence;* that is focused in the provisions regarding their community-based outpatient clinics (CBOC) with focuses in closing the gaps regarding mental health care to veterans. Yet again, the ability for the VA to provide services through their mobile teams, CBOC, and other VA sources are only limited to the resources themselves when there is an avoidance in a partnerships with states, to include their limited resources on providing tablets

to veterans needing treatment, even though their research suggests that the use of the tablets has proven to be beneficial. The deployment can prove to be a costly endeavor, yet the use of applications themselves, downloadable by the veteran on their own device, lessens the fiscal cost and has already been rolled out by the VA and other Departments. Therefore, the increased use and promotion of such treatment can lend to the closing of gaps in treatment to underserved areas. But, in the instance of severe cases where in-person treatment is much more suitable or even based upon the preference of the veteran, community involvement with non-Department providers and assistance through the state can immensely help the VA in the large scope of their responsibilities. Yet, as previously mentioned, the funding of these government and non-governmental organizations, along with the inclusion of clergy as already condoned and practiced by the VA, other public servants of the community (i.e. law enforcement) with the proper training can assist in the referral and identification of veterans with mental health needs that may be overlooked.

Conclusion

If all VHAs operate unilaterally, then the VA needs to determine the mechanisms for funding and training. With each state also creating their own legislation and programs to address veteran mental health issues, one can assume that the more resources developed to address the problem, must be a good thing. But, if the totality of the agencies directing these resources are not working together, then there is bound to be conflicts; also, there will be redundancies in services, and in that case, there is a use of funds that can be used in another area of these issues, instead of funding programs that are being addressed elsewhere. The collaboration of the VA and States must be addressed and provide a means in which they can work closely and more seamlessly, as opposed to a deferment of resources from one to the other.

Knowing that the VA is the lead Department for veterans mental health issues, their involvement is necessary and leading the way to assist states in both their own respective legislation for veterans issues should be addressed. Involvement of the community and other mental health professionals can assist the VA tremendously in their efforts to bring services to rural and underserved areas, additionally, the need for funding needs to be addressed, not only in the manner in which public (states) and private providers are reimbursed, which is a major issue in increasing their involvement, but the VA needs to secure the funding of the MISSION Act appropriately and by the needs of the enacted legislation, not cherry picking funds from other programs to try to fund the MISSION Act, which will lessen the effectiveness of other programs that are also deemed necessary. Therefore, a deeper look by the VA with their involvement in all states needs to be accomplished to provide a better means of funding, training, and awareness of services for the veterans in their areas. Working in collaboration is a better means to a solution, rather than assuming that other entities are addressing their needs without a clear assignment of duties and responsibilities can lessen the gaps that research suggests exists. The VA appears to be on the right path forward, but the implementation seems broken and secular across the VA that forces states to address veteran mental health issues on their own because of the perception of the gaps existing and the states identifying the need for their involvement on their own accord to address these issues. Conversely, states may want to increase their liaison offices responsibilities more to let the Department become more aware that they are an asset to their mission and not a detriment to the delivery of their services, again collaborative efforts and governance between the federal and state level can greatly benefit the veterans.

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Appendix A – Veterans Mental Health Needs Assessment

Project Overview:
Participation in this research project is voluntary and is being done by Jeremy Buchanan as part of his Doctoral Dissertation to research and gather data from professional mental health providers in private, public, and non-profit sectors to assess the probability that these respective sectors are capable or willing to provide mental health treatment at clinics and practices that are located near their residences, as opposed to traveling long distance to seek their needed treatments. Your participation will take about 10 minutes to complete an online survey. There is a minimal risk to no risk that have been identified with this research. The benefits allow for the State of Texas and the Dept. of Veterans Affairs to get another point of view of the status of mental health care resources available in rural areas. To provide a deeper awareness to those public administrators whose duties are to make such treatments available to veterans by lessening the barriers to treatment. The primary benefit is to broaden the scope and accessibility of treatment to rural residing veterans and their access to mental health care treatment.

If you would like to take part, West Chester University requires that you agree prior to taking the survey.

You may ask Jeremy Buchanan any questions to help you understand this study. If you don't want to be a part of this study, it won't affect any services from West Chester University. If you choose to be a part of this study, you have the right to change your mind and stop being a part of the study at any time.

1. **What is the purpose of this study?**
    - The purpose of this research is to gather data from professional mental health providers in private, public, and non-profit sectors to assess the probability that these respective sectors are capable or willing to provide mental health treatment to veterans at clinics and practices that are located near the veterans' residences, as opposed to traveling long distance to seek their needed treatments.
2. **If you decide to be a part of this study, you will be asked to do the following:**
    - Take an online survey which will last approximately 10 minutes
3. **Are there any experimental medical treatments?**
    - No
4. **Is there any risk to me?**
    - No possible risks or sources of discomfort.
    - If you experience discomfort, you have the right to withdraw at any time.
5. **Is there any benefit to me?**
    - Benefits to you may include: Allowing for the State of Texas and the Dept. of Veterans Affairs to be given statistical data, with analysis and tests, that provide a status of mental health care resources available in rural areas. To provide a deeper awareness to those public administrators whose duties are to make such treatments available to veterans by lessening the barriers to treatment.
    - Other benefits may include: The primary benefit is to broaden the scope and accessibility of treatment to rural residing veterans and their access to mental health care treatment.
6. **How will you protect my privacy?**
    - The answers for the responses will be stored on the Qualtrics survey platform controlled by West Chester University. The password is only known to the researchers and is available to West Chester University Institutional Review Board upon their request. Data will also be stored from the survey on the researchers password protected laptop in password protected documents.

- No sensitive information or personal identification information will be collected, recorded, or re-transmitted in any other form of medium.
- Your records will be private. Only Jeremy Buchanan, Amanda Olejarski, and the IRB will have access to the responses.
- Your name will **not** be used in any reports.
- Records will be stored:
  - Password Protected File/Computer
- Records will be destroyed after manuscript development, at a minimum of three years, July 7, 2024.

7. **Do I get paid to take part in this study?**
   - No
8. **Who do I contact in case of research related injury?**
   - For any questions with this study, contact:
     - **Primary Investigator:** Jeremy Buchanan at 210-336-2615 or jb922158@wcupa.edu
     - **Faculty Sponsor:** Amanda Olejarski at 610-436-2448 or AOlejarski@wcupa.edu
9. **What will you do with my Identifiable Information/Biospecimens/Future Use of information?**
   - Not applicable.
   - There is no plan for use of the information collected from this data to be used in the future outside of this study. If the interview is to be used outside of the scope of this research, it will only be done so by the expressed written consent of the interviewed person and in conjunction with WCU IRB approving this study.

For any questions about your rights in this research study, contact the ORSP at 610-436-3557.

By clicking the button below, you acknowledge: Your participation in the study is voluntary. You are 18 years of age. You are aware that you may choose to terminate your participation at any time for any reason.

Agree ☐ Disagree ☐

1. What specialties does your clinic/facility practice (Check all that apply)?
   Primary Care ☐ Specialty Care ☐ Mental Health Care ☐
   Addiction Treatment ☐ Prescription Medicine ☐ Other ☐ __ (please specify)

2. Within what sector is the setting of your clinic/practice?
   Private practice ☐ government (state / county / city) ☐ Non-profit ☐

3. Where is your clinic/practice located?
   Rural ☐ Urban ☐ Unknown ☐

4. What county are you located in? _____

5. What types of professionals are employed at your clinic/practice?
   Social Worker ☐ Professional Counselors ☐ Psychologists ☐
   Marriage and Family Therapists ☐ Psychiatrist ☐
   Other ☐ _____
6. Does your practice / clinic accept Tri-Care or Dept. of Veterans Affairs insurance plans like CHAMPVA or Choice Care?
   Yes ☐ No ☐

7. What types of treatment methods does your clinic/practice provide (check all that apply)?

Face-to-face ☐ Telephone ☐ Video/Mobile Application ☐ Other ☐ _____

8. If your clinic/practice only provides face-to-face treatment, would your clinic/practice be willing to provide a video/mobile application for providing mental health treatment?
   Yes ☐ No ☐ If no, why not?_____ Service already provide ☐

9. Does your clinic/practice provide emergency mental health treatment to veterans?
   Yes ☐ No ☐

10. If your clinic/practice does not provide emergency mental health treatment to veterans, would your clinic/practice consider being a resource for the VA in your community to assist them in the event of an emergency?
    Yes ☐ No ☐

11. Does your clinic/practice screen patients for prior military service (active/guard/reserve/veteran)?
    Yes ☐ No ☐

12. Does your clinic/facility have a mechanism for referring veteran patients if their needs are outside of your practice's capabilities?
    Yes ☐ No ☐

13. If your clinic/practice does make referrals, what would you say is the frequency of referrals?:
    Often ☐ Sometimes ☐ Never ☐ Unsure ☐

14. Do any of the following factors prevent your clinic/practice from making a referral (Check all that apply)?
    Lack of knowledge about eligibility requirements ☐ Lack of knowledge on how to refer ☐ Concerns about wait times for veterans to be seen ☐ Concerns about the quality of care they will receive ☐ Clients are not eligible for VA services ☐ Concerns about the distance to the nearest VA clinic that provides mental health care ☐ Client concerns about career impacts of seeking VA care ☐
    Other ☐ None of the above ☐

15. Does your clinic/practice receive funding from government sources to support veterans' mental health treatment?
    Yes ☐ No ☐

16. If not already doing so, would your clinic/practice provide mental health treatment to veterans in support of the Dept. of Veterans Affairs ?
    Yes ☐ No ☐ Already taking part in such a program ☐

17. If not already providing mental treatment to veterans in a VA supported program, would specified training encourage the clinic/practice to treat veterans?
Yes ☐ No ☐ Already taking part in such a program ☐

18. If not already providing mental health treatment to veterans in a VA supported program, would funding from a government source encourage treatment of veterans?
Yes ☐ No ☐

19. If your practice/clinic does receive support from the Dept. of Veterans Affairs or Texas Health and Humans Services, how would you rate your interactions with them?
Excellent ☐ Above Average ☐ Average ☐ Below Average ☐
Unsatisfied ☐ Not Applicable ☐

20. Does your clinic/practice receive any support from the State of Texas to assist in the mental health treatment of veterans?
Yes ☐ No ☐

21. Has your clinic/practice received training from the VA or a VA supported entity to provide mental health treatment to veterans?
Yes ☐ No ☐

22. If your clinic/practice has received training from the VA or a VA supported entity, how long ago did your personnel receive training?
Less than a year ☐ 1-2 years ☐ 2-3 years ☐ 3-4 years ☐
Over 5 years ☐ Not Applicable ☐

23. If your clinic/practice has received training to treat veterans with mental illnesses, have any of your personnel received follow-up or reoccurring training from the VA or a VA supported entity?
Yes ☐ No ☐ Not Applicable ☐

24. Has your clinic/practice ever been approached by the VA or State of Texas to provide mental health treatment to veterans?
Yes ☐ No ☐ Unknown ☐

25. If yes, who approached your clinic/practice?
Dept. of Veterans Affairs ☐ State of Texas ☐ Both ☐ Unknown ☐

26. Would your clinic/practice be willing to receive training from the VA or a VA supported entity to provide mental health treatment to veterans?
Yes ☐ No ☐ Unsure ☐

27. If your clinic/practice would not be willing to receive training from the VA or a VA supported entity, what reasoning supports your clinic's/practice's decision?
Time ☐ Costs ☐ No Interest ☐ Not enough personnel ☐ Other ☐

28. Is your clinic/practice aware of the MISSION Act (Public Law 115-182)?
    Yes ☐ No ☐

29. For the following please note your clinic/practice's level of knowledge for the following issues:
    Anger High ☐ Some ☐ Very Little ☐ None ☐
    Anxiety High ☐ Some ☐ Very Little ☐ None ☐
    Stress High ☐ Some ☐ Very Little ☐ None ☐
    Depression High ☐ Some ☐ Very Little ☐ None ☐
    Family/Relationship Problems High ☐ Some ☐ Very Little ☐ None ☐
    Family Violence High ☐ Some ☐ Very Little ☐ None ☐
    Grief and Bereavement High ☐ Some ☐ Very Little ☐ None ☐
    Military sexual trauma High ☐ Some ☐ Very Little ☐ None ☐
    Pain Management High ☐ Some ☐ Very Little ☐ None ☐
    PTSD High ☐ Some ☐ Very Little ☐ None ☐
    Sleep disorder High ☐ Some ☐ Very Little ☐ None ☐
    Substance abuse and dependence High ☐ Some ☐ Very Little ☐ None ☐
    Suicide and suicide ideation High ☐ Some ☐ Very Little ☐ None ☐
    Traumatic Brain Injury High ☐ Some ☐ Very Little ☐ None ☐

30. For the following please note your clinic/practice's level of Confidence for the following issues:
    Anger High ☐ Some ☐ Very Little ☐ None ☐
    Anxiety High ☐ Some ☐ Very Little ☐ None ☐
    Stress High ☐ Some ☐ Very Little ☐ None ☐
    Depression High ☐ Some ☐ Very Little ☐ None ☐
    Family/Relationship Problems High ☐ Some ☐ Very Little ☐ None ☐
    Family Violence High ☐ Some ☐ Very Little ☐ None ☐
    Grief and Bereavement High ☐ Some ☐ Very Little ☐ None ☐
    Military sexual trauma High ☐ Some ☐ Very Little ☐ None ☐
    Pain Management High ☐ Some ☐ Very Little ☐ None ☐
    PTSD High ☐ Some ☐ Very Little ☐ None ☐
    Sleep disorder High ☐ Some ☐ Very Little ☐ None ☐
    Substance abuse and dependence High ☐ Some ☐ Very Little ☐ None ☐
    Suicide and suicide ideation High ☐ Some ☐ Very Little ☐ None ☐
    Traumatic Brain Injury High ☐ Some ☐ Very Little ☐ None ☐

31. For the following please note your clinic/practice's level of Training Interest for the following issues:
    Anger High ☐ Some ☐ Very Little ☐ None ☐
    Anxiety High ☐ Some ☐ Very Little ☐ None ☐
    Stress High ☐ Some ☐ Very Little ☐ None ☐
    Depression High ☐ Some ☐ Very Little ☐ None ☐
    Family/Relationship Problems High ☐ Some ☐ Very Little ☐ None ☐
    Family Violence High ☐ Some ☐ Very Little ☐ None ☐
    Grief and Bereavement High ☐ Some ☐ Very Little ☐ None ☐

Military sexual trauma High ☐ Some ☐ Very Little ☐ None ☐
Pain Management High ☐ Some ☐ Very Little ☐ None ☐
PTSD High ☐ Some ☐ Very Little ☐ None ☐
Sleep disorder High ☐ Some ☐ Very Little ☐ None ☐
Substance abuse and dependence High ☐ Some ☐ Very Little ☐ None ☐
Suicide and suicide ideation High ☐ Some ☐ Very Little ☐ None ☐
Traumatic Brain Injury High ☐ Some ☐ Very Little ☐ None ☐

Appendix B – Structured Interview with Texas Health and Human Services

- Currently, what would you say is the overall status of Texas Health and Human Services in providing mental health treatment services to veterans who reside in Texas? Answered
- Is there a qualification that must be met for veterans to receive assistance through the State of Texas to qualify for health benefits, like the Hazelwood Act?
  - Like with the VA, do veterans in Texas have to have a qualifier to get treatment? I.e. have enlisted in Texas? Have a dishonorable discharge? No qualifiers have to be in place – veteran in Texas.
- What mechanisms are in place with TX HHS that a veteran who resides in a rural area without access to a VA facility have in place to seek treatment?
- In 2019 a report was released titled, New Effort Enhances Access to Mental Health Treatment for Veterans: Veteran Counselors have Begun Work at Pilot Sites, which established six pilot sites in Tyler, Abilene, Round Rock, Nacogdoches, Waco, and Edinburg that serve 39 Texas counties, with the majority of the counties of Texas being considered rural and this amount of counties being less than a quarter of the amount of counties in Texas, have these pilots provided any success in providing mental health care to veterans? Are there plans to expand? These six sites provide services to veterans across 39 Texas counties. Factors such as veteran population density, the availability of mental health services and the need for those services were considered in selecting the pilot sites. The pilot program was established by **Senate Bill 27,** which was passed by the Legislature in 2017. Answered in introduction – demonstration pilot – legislative – no expansion program – factors inhibiting state admin code.
- Do you find it to be a challenge or allow for more flexibility that the states are implementing their own veteran services rather than the VA providing the guidelines and policy in which programs will be implemented? Do you see that it's a balance between the two, VA directed and State initiated? Is this correct to say that the state is implementing these programs?
- TX State Senate Bill 55 (TX Vet + Family Alliance) laid out a multi-phase program to improve the quality of life of Texas veterans and their families by Texas communities across the state to expand the availability of, increase access to, and enhance delivery of mental health treatment and services. How does this program compare with Senate Bill 27 previously mentioned? Do these two bills work in tandem or does one create issues for the other?
- With the roll out of these programs, have mental health care providers from all sectors been given the opportunity to participate or are there qualifying requirements they must meet in order to participate?
- In your experience and opinion, what factors would you say are a major barrier for veterans in rural areas of Texas to seek treatment?
- Conversely, what factors would you say makes the mental health programs for TX vets more accessible and more favorable in their implementation compared to other states or even with the Dept of VA?
- What technologies have been advocated or are supported by your office that can assist veterans in rural areas in seeking more accessible mental health treatment?
- With the implementation of the US Congress Public Law 115-182, MISSION Act, what has this legislation done in regard to the actions of the State of Texas in providing mental health care, specifically, to TX veterans?

- From my research, it shows that there is no significant difference between rural and urban mental health care providers nor those in the respective sectors of health care (private, public, and non-profit), with that said, what is being done across the State of Texas to solicit more involvement from mental health care providers to assist in the treatment of veterans mental health care issues, especially rural veterans due to their lack of resources in their areas from the state and VHA?
- Has the state solicited providers to assist in the treatment of veterans regarding their mental health care? And conversely, have providers approached TX HHS or Veterans commission to be in the network of providers? Collaboration and training requirements
- What involvement does the State of Texas have with the Department of Veterans Affairs to provide treatment to veterans? Are all of the actions taken by the State alone unilaterally? If so, what has been the reasoning for such actions, when it's the VHA who is responsible to provide treatment?
- Like the study in Arkansas (Kirscher), do any of the programs utilize other people in the community to make referrals? I.e. clergy, law enforcement, or others? Community advocacy programs to assist.
- What is TX HHS involvement with private, public, and non-profit providers in regard to assisting veterans seeking treatment?
    - Secondly, what is TX HHS involvement regarding their solicitation for assistance in treating veteran mental health patients in regard to rural versus urban designation? Does the state have a focus on rural veterans versus urban residing veterans?
- According to the responses I received only one public health provider responded to the survey, is there a policy in place that prevents their response or other reasoning other than personnel preference to take part in the survey that would prevent them from participating?
- What is it that your office, Office of Mental Health Coordination do for Veterans? Is this a unilateral function or is there a responsibility at all to the VA?
- What do you believe that the Department of Veterans Affairs can do to support the State of Texas in providing mental health resources to veterans, primarily those who reside in rural areas?

Appendix C – Citi Certification

CITI PROGRAM

Completion Date 13-Sep-2019
Expiration Date 12-Sep-2022
Record ID 32963347

This is to certify that:

Jeremy Buchanan

Has completed the following CITI Program course:

Social & Behavioral Research - Basic/Refresher (Curriculum Group)
Social & Behavioral Research - Basic/Refresher (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

West Chester University of Pennsylvania

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wdb198c08-dd53-4d8a-90e9-355d98d990a6-32963347

Appendix D – IRB Approval

Office of Research and Sponsored Programs | West Chester University | Ehinger Annex
West Chester, PA 19383 | 610-436-3557 | www.wcupa.edu

Protocol ID # 20200616A
This Protocol ID number must be used in all communications about this project with the IRB.

TO: Jeremy Buchanan and Amanda Olejarski

FROM: Nicole M. Cattano, Ph.D.
Co-Chair, WCU Institutional Review Board (IRB)

DATE: 6/16/2020

Project Title: Rural Veterans of Texas and Their Accessibility to Mental Health Care Services

Notification of Initial Study Exemption Determination

☒**Exempt From Further Review**

This Initial Study submission meets the criteria for exemption per the regulations found at 45 CFR 46.104 (2)(ii). As such, additional IRB review is not required.

The determination that your research is exempt does not expire, therefore, annual review is not required and no expiration date will be listed on your approval letter. If changes to the research are proposed that would alter the IRB's original exemption determination, they should be submitted to the WCU IRB for approval, using the IRB application form (check off I.G. Revision).

Your research study will be archived 3 years after initial determination. If your Exempt study is archived, you can continue conducting research activities as the IRB has made the determination that your project met one of required exempt categories. The only caveat is that no changes can be made to the application. If a change is needed, you will need to submit a NEW Exempt application. Please see www.wcupa.edu/research/irb.aspx for more information.

However, it is very important that you *close-out your project when completed or if you leave the university*. Faculty mentors are responsible for oversight of student projects and should ensure exempt studies are completed and closed-out before the student leaves the university.

The Principal Investigator and/or faculty mentor is responsible for ensuring compliance with any applicable local government or institutional laws, legislation, regulations, and/or policies, whether conducting research internationally or nationally. Please contact the WCU Office of Sponsored Research and Programs at irb@wcupa.edu with any questions.

Sincerely,

Co-Chair of WCU IRB

WCU Institutional Review Board (IRB)
IORG#: IORG0004242
IRB#: IRB00005030
FWA#: FWA00014155