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VHA's Office of Community Engagement and the
Center for Compassionate Care Innovation

Celebrating Collaboration and Innovation that Bring Veterans High-Quality Health Care

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VA



U.S. Department of Veterans Affairs
Veterans Health Administration





A Note From the Acting Director

In this edition of our quarterly newsletter, we're highlighting several partnerships and initiatives that utilize the combined resources of VHA and other entities — these may be nongovernmental organizations, community partners, or other VHA offices. We know that when stakeholders team up, the care offered to Veterans as a result is even better.

These updates will inform you of initiatives like Choose Home, for which many organizations and agencies are partnering to bring Veterans care in their homes instead of in unfamiliar institutions. You'll also learn about VHA's MOVE! Weight Management Program, which helps Veterans manage their weight and stay active — MOVE! can be found at some YMCA facilities throughout the country, for instance, thanks to partnerships between local YMCAs and VA medical centers.

We're also giving you an inside look into how other VHA offices utilize OCE's partnership expertise to strengthen several collaborations. Additionally, be sure to read about how continuity of care among various health care providers and programs enhances Veterans' wellness, as well as how Veterans are cared for when experiencing homelessness – collaborations are essential in these instances, too.

These are exciting times within VA and VHA. OCE continues its ongoing work to manage or facilitate national and localized partnerships that bring specialized services to Veterans and is also working on VA-wide initiatives like Choose Home. CCI, meanwhile, is always working to explore emerging, safe, ethical therapies to enhance Veteran's well-being in innovative, unique ways, such as through CCI's substance use disorder (SUD) proof of concept at the VA San Diego Healthcare System. We're pleased to present the details of how Veterans can benefit from many programs, partnerships, and innovations through CCI and OCE.

Be sure to take a look on page 8 at how you can participate in the upcoming #BeBoldForVets social media campaign; we want to hear your stories, too!

Sincerely,

Dr. Tracy L. Weistreich

*Acting Director, Office of Community Engagement and
the Center for Compassionate Care Innovation*

How continuity of care ensures Veterans' safety and well-being

Continuity of care, as **defined by the American Academy of Family Physicians**, refers to the quality of care a patient gets over time. It is how the patient and the care team are involved together in ongoing health care management.

VHA makes sure that Veterans' care meets a high standard for continuity. This is especially important for Veterans who move into and out of VHA care, as all health care providers should have access to their Veteran patients' individual needs. Veterans in VHA care have access to the **VA Continuity of Care Document**, also known as the VA Health Summary, a summary of their health information that makes it possible for electronic exchange between the systems providing care. Wherever Veterans are within VHA, their important health information goes with them.

CCI and OCE have helped to ensure continuity of Veteran care through many partnerships and programs. Here are a few examples:

VHA Mental Health Substance Use Disorder program

In January 2018, CCI facilitated a SUD proof of concept at the VA San Diego Healthcare System. This proof of concept includes the coordinated care for Veterans with SUD offered by the VA San Diego Healthcare System emergency department, the VA Alcohol Drug Treatment Program, and a community SUD treatment option called Casa Palmera.

One of the goals of this CCI initiative is to improve Veterans' access to SUD treatment when their local VA medical center has delays that prevent it from offering SUD care within the time frame that is acceptable to the patient and VA provider. Patients in the program can move between different levels of care or between more than one health care provider during their treatment.



Whether a patient is treated within VHA or in the community, the VHA care team is involved to ensure seamless return to VHA. This is all coordinated with the patient while maintaining strict privacy standards.

For this proof of concept, both VHA and Casa Palmera have dedicated case managers who promote good communication, continuity of care, and easy return to VHA.

CCI is committed to the exploration of emerging and innovative methods of treatment for Veterans. Initiatives like this intend to enhance the care already offered by VHA.

For more information on CCI and its work, please visit: www.va.gov/HEALTHPARTNERSHIPS/CCIMission.asp

Partnerships with the Marcus Institute of Brain Health and Wounded Warrior Project

To support Veterans who have sought care outside VHA and want to return to VHA care, OCE has facilitated partnerships with the **Marcus Institute of Brain Health (MIBH)** in Aurora, Colorado, and with the **Wounded Warrior Project**.

The MIBH partnership, which involved VHA Care Management and Social Work Services, was formed in January.

MIBH provides services for complex needs related to traumatic brain injury (TBI) through a three-week outpatient program. For Veterans who self-refer to MIBH for health care services, the partnership makes sure that their transition back to VHA is as smooth as possible.

When an eligible Veteran resumes care with VHA after treatment at MIBH, VHA will assign him or her a VHA social worker or nurse to serve as a liaison (a point of contact). That person coordinates follow-up and ongoing care at a VA medical center near the Veteran's home.

Nearly three years ago, this VA liaison role originated as part of the Warrior Care Network (WCN). WCN is a partnership between VHA, the Wounded Warrior Project, and four academic medical centers that can connect thousands of Veterans with care for post traumatic stress disorder and TBI.

Within WCN, VHA liaisons teach active duty service members who have returned to civilian life about VA benefits and services and help them enroll in the VA health care system after treatment at a WCN site. Liaisons also make sure that Veterans' care continues when they restart or begin care at a VA facility and connect Veterans with the Care Management team at their nearest facility.

The liaison program involves assigning Veterans a VHA program manager who ensures the care needs, plan, and progress are discussed with the patient, providers, and others involved in the direct care of the patient. Sometimes, even though VHA has a care or case manager assigned, community providers may not. Through this program, care or case managers can have person-to-person conversations with patients and providers. This builds continuity of care, lessening the risk of providers losing follow-up directions or important patient information. The VHA Care Management team ensures each Veteran receives ongoing case management as needed. It also helps Veterans navigate the VA health care system and access resources and care.

Choose Home Initiative

VA's Choose Home initiative is focused on giving Veterans at risk for being admitted to a skilled health care agency a choice in where they receive care. Veterans who are at risk of needing institutional care are saying that they want to remain in the comfort of their homes instead of moving to an unfamiliar place. The Choose Home initiative augments VA programs currently in place to help Veterans receive coordinated case management and other services that help prevent them from, or offer alternatives to, skilled care admissions. It unites existing models and programs for noninstitutional care and services for Veterans, their caregivers, and their families and provides patients and providers with tools for making care choices.

Community partners such as food pantries, agencies such as the Administration on Community Living, faith-based support services, and Veteran Service Officers help bring needed services to Veterans in their communities, adding to the programs available through VA. Community partners and VA work together to bring Veterans the best, safest care options, at home or wherever Veterans choose.

Through Choose Home, VA case managers coordinate the care and services each Veteran receives from VA and work with community providers to supplement VA programs and services. Case managers make sure that all aspects of a Veteran's chosen care plan are aligned while ensuring the plan helps with daily living tasks such as housekeeping or transportation. Through Choose Home, VA offers coordinated services that put each Veteran at the center of the care model.



Continually improving, VA's MOVE! Weight Management Program helps Veterans manage their weight, reduce risk for chronic diseases

The free **MOVE! Weight Management Program for Veterans**, led by the VHA National Center for Health Promotion and Disease Prevention (NCP), has been promoting weight loss and physical activity since 2006 to help Veterans reduce their risk for chronic health conditions. Now, new developments in the program will enhance the services delivered to Veterans and increase their access to weight management care.

Having overweight or obesity (which is how some clinicians phrase "being overweight or obese") can contribute to chronic health conditions such as diabetes, high blood pressure, high cholesterol, and some types of cancer. Among Veterans receiving care in VHA, 80% have overweight or obesity based on their **body mass index**, said Dr. Susan Raffa, national program director for weight management with VHA's NCP. In the general U.S. population, there are nearly 72% of adults who have overweight or obesity.

The MOVE! Program offers Veterans the opportunity to participate in a lifestyle change program that targets dietary and physical activity changes and suggests behavioral strategies such as goal setting and problem-solving to support these changes. The overall goal of the MOVE! Program is to help Veterans achieve weight loss of 5% or more, as research shows that this level of weight loss reduces an individual's risk for certain chronic diseases. Every VA medical center has a dedicated MOVE! coordinator or a VA provider who can help Veterans get started with the program.

According to Dr. Raffa, more than 850,000 Veterans have participated in MOVE! since 2006. About 20% of participants have achieved the program goal of losing at least 5% of their body weight.

"Given what we know about how difficult healthy weight loss can be, this is a really good number," said Dr. Raffa.

The program also boasts excellent Veteran satisfaction, with participants giving it an average rating of 86 points out of 100 in a survey.

MOVE! helps Veterans optimize their weight loss strategies, encourages them to meet physical activity benchmarks, and includes an eight-week physical activity program called "Be Active and MOVE!" for Veterans of all fitness levels.

A popular component of the MOVE! Program is the group sessions, in which participants support one another in their fitness, nutrition, and weight management efforts.

The program recently released an updated curriculum, including a new **Veteran Workbook**, which is a compilation of interactive tools, resources, and activities across 16 education modules, and a food and physical activity log.

Veterans can also access MOVE! through several different types of technology. The MOVE! Coach mobile app, available in Apple and Android versions, has been downloaded more than 85,000 times and provides Veterans with access to MOVE! where and when they want it. TeleMOVE! provides Veterans with another alternative to in-person participation and delivers services through daily web messages or telecommunications. NCP has also developed a weight management protocol for the **Annie App for Veterans**, which reminds users to track health metrics and sends them educational and inspirational reminders.

Dr. Raffa said Veterans can ask the MOVE! coordinators at their local VA facilities about getting started with the program and where they can access its services; no referral is needed. Additionally, the MOVE! Program can sometimes be found at community-based facilities such as YMCAs that have partnered with VA medical centers.

"The link between physical activity and overall health and well-being is very important," stated Dr. Tracy Weistreich, acting director of VHA's OCE.

“Whether at the YMCA, a VA medical center, or the local mall, Veterans need to move to get and stay well.”

OCE is proud to serve as a trusted resource and catalyst for the growth of partnerships that bring programs such as MOVE! to Veterans. For more on OCE’s work, visit www.va.gov/healthpartnerships/.

For more information on the MOVE! Program and to read Veterans’ success stories, visit www.move.va.gov/.

Lending a helping hand to other VHA offices to establish meaningful partnerships

As a consultative office that facilitates patient-driven health care partnerships, VHA’s OCE recognizes that Veterans benefit when VHA offices and nongovernmental organizations combine resources, tools, and expertise.

OCE applies its expertise to its work with partners, whether they’re other VHA offices, such as Rural Health and Connected Care, or nonprofit organizations such as the Humane Society of the United States. OCE also facilitates and manages collaborations that are part of broad, departmentwide priorities, such as the Choose Home Initiative.

One of the entities currently working on partnerships with OCE is the Ensuring Veterans Food Security Workgroup. This interdisciplinary group works with OCE in a number of ways, including on the 100 Million Healthier Lives campaign and on the MAZON: A Jewish Response to Hunger (MAZON) and the Food Research and Action Center (FRAC) partnerships.

OCE and the work group have joined with the Institute for Healthcare Improvement for the 100 Million Healthier Lives campaign, a coalition of agencies and individuals working toward the result of 100 million people living healthier lives by 2020. The campaign consists of seven topical “hubs,” including the Veterans Hub, which OCE oversees. The Veterans Hub aims to

help 20 million Veterans live healthier lives by 2020. The entire 100 Million Healthier Lives campaign focuses on the social determinants of health, which include food security.

Food security is also a key element of the MAZON and FRAC partnerships with VHA. MAZON works to protect and strengthen national nutrition programs in the United States and Israel and advocates for public policies that address the root causes of hunger. FRAC is working to eradicate poverty-related hunger and undernutrition in the United States. Both organizations address the needs of many Veterans.

“OCE has made connections for us with groups outside the scope of the current work group,” said Christine Going, co-chair of the work group. “The office has assisted in building relationships and has provided opportunities to share our work with partners that we would not usually work with.” Ms. Going explained that OCE has brought exposure to the group’s work through a number of information-sharing portals. “We struggle to get our message out nationally so that everyone is aware of our work and the impact that food insecurity has on our Veteran population,” Ms. Going said. “OCE has helped us break down that barrier.”

Ms. Going said she encourages any interested party to contact OCE if they have questions, want to explore ideas, or need assistance with nonmonetary partnerships. “The people at OCE are very easy to work with,” she said. “They are enthusiastic partners that share our passion for helping Veterans. Take some time to understand OCE’s purpose, read their past success stories, and understand that there may be an opportunity for your program to benefit from their expertise.”

As Dr. Tracy Weistreich, acting director of OCE, illustrated in a [series of articles on partnerships](#), OCE specializes in making interagency connections. To read about OCE’s many successful partnerships, visit www.va.gov/healthpartnerships.

To discuss a partnership opportunity or consult with OCE on a nonmonetary, nongovernmental partnership, email the office at communityengagement@va.gov.

How partner collaboration can lead to decreased homelessness among Veterans

Homelessness among Veterans has declined by nearly 50% since 2010, according to a 2018 report from the Department of Housing and Urban Development (HUD). This achievement was made possible by the Department of Veterans Affairs' commitment to ensuring that every Veteran has a safe and stable place to call home.

Working with partners that augment VHA programs and services also leads to this kind of success. The work of VHA's Homeless Programs Office (HPO) is a profound example of how collaboration with a variety of organizations can positively impact the health and well-being of our nation's Veterans.

Many Veterans who are at risk of or experiencing homelessness need multiple services to get back on their feet, in addition to housing assistance. HPO provides clinical support and access to affordable housing, collaborating with local and national organizations to meet Veterans' needs. As a result, Veterans facing homelessness are receiving the support they need to regain their independence in safe and stable housing.

HPO has established formal partnerships with Veterans Matter and the Benevolent and Protective Order of Elks, for example, to provide access to housing and food assistance, household goods, clothing, and employment. These essentials lead to healthier lives. When Veterans are without safe and stable housing — a social determinant of health — they might consider their well-being a lesser priority. When that happens, they might develop negative or worsening health conditions.

"Partnerships are extremely important to the work we do," said Anthony Love, senior advisor and director of community engagement for HPO. He added, "As an



example, Veterans with HUD-Veterans Affairs Supportive Housing vouchers often struggle to pay a deposit and first month's rent on an apartment, which will often delay the Veteran's ability to move into housing. We have a program to help with this, but it is not in every community. This partner is able to fill that gap and allow Veterans to move into their apartments soon after signing the lease."

Not all HPO partnerships are formal, with a memorandum of agreement that establishes written objectives and responsibilities of the partners. Some are informal partnerships, which may be short-term or address a specific need for a small number of Veterans — and may not require regular coordination or follow-up.

Formal partnerships are guided by written expectations for both VA and community partners. Informal partnerships can fulfill an immediate need, serve an event-based purpose, and provide an opportunity for community organizations to develop a relationship with local VA offices that may grow into a formal partnership later.



As VHA's partnership development experts, OCE celebrates HPO and others who are partnering with external organizations to augment VHA programs and services. Veterans deserve all the services and assistance that VHA has to offer, and the collaborative efforts of HPO, OCE, and others are making sure that happens.

- For more information on VHA's HPO and its partnerships, visit www.va.gov/homeless.
- For more information on OCE and its partnerships, visit www.va.gov/healthpartnerships/.

Help us help spread the word!

OCE and CCI are participating in the **#BeBoldforVets** social media campaign this month. This campaign is highlighting partnerships and innovations that are going above and beyond to provide Veterans with unique resources and treatment options. Please join us in sharing about your partnerships and innovations by posting on Facebook or Twitter using the hashtag **#BeBoldforVets!**

