NACCHO
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2017 Model Practices

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Model Practice Title

Please provide the name or title of your practice: *

VetSET Nebraska

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select all the practice areas that apply.: *

- ☐ Access to Care
- ☐ Advocacy and Policy Making
- ☐ Animal Control
- ☐ Coalitions and Partnerships
- ☐ Communications/Public Relations
- ☐ Community Involvement
- ☑ Cultural Competence
- ☐ Emergency Preparedness
- ☐ Environmental Health
- ☐ Food Safety
- ☐ Global Climate Change
- ☐ Health Equity
- ☐ HIV/STI
- ☐ Immunization
- ☐ Infectious Disease
- ☐ Informatics
- ☐ Information Technology
- ☐ Injury and Violence Prevention
- ☐ Marketing and Promotion
- ☐ Maternal-Child and Adolescent Health
- ☐ Organizational Practices
- ☐ Other Infrastructure and Systems
- ☐ Organizational Practices
- ☐ Primary Care
- ☐ Quality Improvement
- ☐ Research and Evaluation
- ☐ Tobacco
- ☐ Vector Control
- ☐ Water Quality
- ☑ Workforce
- ☐ Conference Theme: Bridging Clinical Medicine and Population Health

Other::

Is this practice evidence based, if so please explain. :

with a $2 million grant from

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly.Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following:: *

- ☐ Food Safety
- ☐ HIV in the U.S.
- ☐ Nutrition, Physical Activity, and Obesity
- ☐ Tobacco
- ☐ Healthcare-associated Infections
- ☐ Motor Vehicle Injuries
- ☐ Teen Pregnancy
- ☑ None

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
  - Were all of the objectives met?
  - What specific factors led to the success of this practice?
- Public Health impact of practice
- Website for your program, or LHD.

750 Word Maximum

Please use this portion to respond to the questions in the overview section. : *

VetSET Nebraska is a collaboration between the members of Nebraska's SACCHO, the Nebraska Association of Local Health Directors (NALHD). The project is active in 15 local health departments (LHDs) covering 68 rural and frontier counties. Collectively, these LHDs employ 192 full and part-time staff. The average staff size is 15. Each LHD in Nebraska is a stand-alone agency with distinct governance, structure, and programs. Each serves a jurisdiction of from 1 to 11 counties that are collectively home to approximately 78,000 Veterans. VetSET is active in 68 of Nebraska's 93 rural counties. The total population of this area is 912,410. Public Health Issue Military service is associated with negative health outcomes for Veterans and their families, including suicide and behavioral health issues, that impact overall community wellbeing. VetSET Nebraska is informed by the report Building Communities of Care for Military Children and Families which asks… "How does a nation develop communities of care that maximize resilience and minimize the health risks that military children and their families face?… [We must] develop a public health approach that harnesses the strengths of the communities that surround them." VetSET Nebraska applies upstream approaches (consistent with Public Health 3.0) knowing that many rural Veterans' and family members' challenges could be better-addressed if the divide between community and Veteran service systems is bridged and the local community system is better prepared to serve Veterans and their families. VetSET Goals 1. Outreach to and connect with Veteran and their families in rural communities. a. Train, deploy, and support LHD liaisons (VetSET Coordinators) to work with Veterans and families. 2. Build collaboration between military-serving and civilian-serving partners across the rural public health system. a. Establish local Veteran task forces to engage broad participation across each LHD jurisdiction. 3. Increase military cultural competence across the public health system. a. Provide outreach and tailored training and technical assistance to civilian partners across each LHD jurisdiction. How the Practice was Implemented Leveraging a 2-year Rural Veteran Coordination Pilot grant from the Veteran's Administration (VA) Office of Rural Health, NALHD has made military cultural competence part of the foundational skill-set within 15 participating Nebraska LHDs. LHDs hired/designated VetSET Coordinators to lead local implementation. All LHD staff participated in Military 101 Training and other awareness-raising activities and a minimum of 25% of staff at each LHD attended at least one No Wrong Door training (described below). Staff at these LHDs have, in turn, worked to develop 810 new (sometimes unusual) community partnerships, with the purpose of serving rural Veterans and improving military cultural competency across the public health system—among military-serving and civilian-serving providers. NALHD provides extensive training and expert support to VetSET Coordinators who act as local liaisons—across the entire public health system—on behalf of Veterans and their families. In addition to their work with system partners, VetSET Coordinators have worked directly with over 560 Veterans and their family members. Collaborating organizations in this work include the VA, civilian healthcare providers, and individuals and agencies involved in meeting health-related social needs such as education, housing, social services, recreation and other resources. A cornerstone of how VetSET prepares LHD staff and community partners to recognize and address the unique culture, experience and language of military service members and their families is the day-long, No Wrong Door training. To date, 647 individuals have participated in 9 events. Comparison of pre-training military cultural competency and 2 to 6 month follow-up shows dramatic improvements in No Wrong Door participants' familiarity with military and Veteran culture and improved self-efficacy/comfort in working with Veterans and their families. Factors that lead to the success of VetSET The VetSET team is championing multi-disciplinary, cross-sector partnerships at the local level. As a result, a range of provider types – from employment, financial, health, education, spiritual and various other sectors – are better networked to leverage services for the benefit of Veterans and their families. Instead of asking the Veteran and their families to bear the entire burden of connecting military and civilian resources, these partners are positioned to be more responsive to the unique experiences and needs of this population. Public Health Impact of the Practice Nebraska's rural Veterans and their families (a previously underserved and somewhat invisible sub-population) now often encounter providers across the local public health system who better-understand the opportunities and challenges of military life and, themselves, feel more ready to engage and serve Veterans and their families. This work supports LHDs broader efforts to address community-wide wellbeing as Chief Health Strategists. Website https://nalhdorg.presencehost.net/our-work/vetset.html

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR **(2) a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
    - What is the target population size?
    - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
    - Is it new to the field of public health
      OR
    - Is it a creative use of existing tool or practice:
      What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)

- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

2000 Word Maximum

Please state the Responsiveness and Innovation of your practice (2000 Word Maximum) : *

Public Health Issue and Target Population Military service is associated with negative outcomes for Veterans and their families, including suicide, behavioral health issues, and physical health needs associated with service injuries. VetSET Nebraska's approach to addressing the needs of Veterans and their families is informed by the report Building Communities of Care for Military Children and Families which asks… "How does a nation develop communities of care that maximize resilience and minimize the health risks that military children and their families face?… [We must] develop a public health approach that harnesses the strengths of the communities that surround them." Services specifically for Veterans in the sparsely populated areas covered by VetSET are limited. Services tailored for Veteran families are largely absent. In addition to limited access to VA healthcare, rural Veterans and their families face unique challenges. These can include behavioral health problems associated with combat injuries, impacts of deployments on relationships manifesting in separations and divorce, substance abuse, financial issues and a myriad of other stressors. Although there may be support in active military communities, Reserve and Veteran families are often isolated from military resources. A 2014 RAND Study determined the limited extent to which community providers, primarily mental health, are prepared to address the needs of Veterans, service members and their families. The results were sobering with only 1 in 4 respondents being very familiar with general or deployment-related stressors for Veterans, even as these stressors are often the source of mental health struggles at home. Many Veterans may choose to receive treatment for behavioral health issues through the VA facilities. However, Veteran families are not eligible for services at the VA and may face obstacles accessing resources and care that are responsive to Veteran families' needs. Target population is affected Approximately 78,000 Veterans live in the 68 rural and frontier counties included in VetSET Nebraska. Military spouses and children are conservatively estimated to outnumber service members by a ratio of 1.4 to 1. The age range of Nebraska's Veterans is wide (including elderly Veterans from the WWII, Korean, and Vietnam era as well as younger and middle aged Veterans whose active duty occurred during the Post 9/11 period or in the first Iraq war). Rural Veterans are a diverse, unique group with specific needs. In 2014, the U.S. Department of Veterans Affairs' (VA) Office of Rural Health (ORH) Veteran Snapshot described rural Veteran demographics as follows: • A quarter of all Veterans in the United States, 5.2 million, returned from active military careers to reside in rural communities. • Veterans choose rural communities for a variety of reasons: closer proximity to family, friends, and community; open space for recreation; more privacy; lower cost of living; less crowded towns and schools. • While they may enjoy the benefits of rural living, these Veterans may also experience typical rural health care challenges (e.g., provider shortages; geographic and distance barriers; fewer housing, education, employment and transportation options) that may be complicated by injuries and illnesses related to military service. • Rural Veterans range from young men and women who served in recent conflicts to Vietnam Veterans and elderly Veterans from World War II • Rural Veterans enroll in the VA health system at higher rates than their urban counterparts; 56 percent of all rural Veterans (2.9 million) are enrolled in the VA health care system—significantly higher than the 36 percent enrollment rate of urban Veterans. At the same time, rural Veterans are more likely to live further from these VA services and need to negotiate distance and transportation as an additional barrier to accessing this care. • Of these enrolled rural Veterans, 82 percent have other health insurance (e.g., Medicare, Medicaid, TRICARE, private insurance) in addition to their VA benefits In Nebraska, Veterans are typically o Male (94%) o Caucasian (91%) o Older (over 33%) o Married (over 65%) Rural communities already struggle with health disparities, many of which are summarized in the 2014 Update of the Rural-Urban Chartbook published by the Rural Health Reform Policy Research Center. The underlying drivers of these disparities can exacerbate and be exacerbated by struggles of Veterans and their families. The VA estimates that 4 out of 10 rural Veterans have at least one service-connected disability that often limits their productivity and/or their ability to fully-engage in some aspects of their community and family life. Of younger Veterans, 15 percent of VA enrolled rural Veterans, nationally, served in Iraq and/or Afghanistan. In Nebraska that percentage is higher, at 65%. Many of this generation of rural Veterans are faced with multiple medical issues related to military service that require significant, ongoing access to care. Injuries that in previous generations would have been fatal are, today, sources of long-term physical or mental disability that impact the quality of life of Veterans and their families. These Veterans of the more recent conflicts suffer from Traumatic Brain Injury (TBI), Post-traumatic Stress Disorder (PTSD), musculoskeletal diseases, diseases of the nervous system and chronic illnesses such as diabetes, high blood pressure, or heart conditions—all of which can be impacted by public health interventions that target community context as well as individual behavior. What is the target population size? Initially, VetSET sought to serve up to 900 rural Veterans and their families. Additionally, the project aimed to train and support up to 300 LHD staff, healthcare providers, community members and professionals from various sectors who work with Veterans and their families in rural Nebraska. What percentage did you reach? VetSET trained over 200% of its provider target and directly worked with 62% of its Veteran and family target. However, including reach to Veterans and families that VetSET Coordinators interacted with directly at outreach or education events, VetSET reached 8,500 to 10,500 Veterans and their family members (or roughly 10 times its target reach). VetSET Coordinators have worked directly with over 560 Veterans and their family members, providing resources, referrals, and in some cases, direct services in relevant LHD programs. In terms of VetSET Nebraska's work building military cultural competence across the rural public health system, 647 LHD staff and partners participated in No Wrong Door trainings. Many more took part in shorter, tailored Military 101 trainings at LHDs and at partner organization sites. What has been done in the past to address the problem and why is the current practice better? Prior to VetSET, there had been no comprehensive effort to engage LHDs and the wider public health system in directly identifying and addressing Veterans and their families as an at-risk sub-population, relative to community health improvement plans and priorities nor to specific LHD programs. There were very limited opportunities to build military cultural competence for rural providers in the "civilian" realm, and virtually none that were in-person or were tailored to the context of rural Nebraska communities. VetSET Nebraska is the first and only effort of its kind to build capacity for LHDs and others in a vast, rural public health system to effectively work with Veterans and their families. Leveraging a 2-year Rural Veteran Coordination Pilot grant from the Veteran's Administration (VA) Office of Rural Health, NALHD has made military cultural competence part of the foundational skill-set within 15 participating Nebraska LHDs. LHDs hired/designated VetSET Coordinators to cover all 15 jurisdictions. All LHD staff participated in Military 101 Training and other

awareness-raising activities and a minimum of 25% of staff at each LHD attended at least one of the day-long No Wrong Door trainings. The VetSET day-long No Wrong Door workshop is a unique method for widespread education across diverse sectors. Participants learn to recognize and address the unique culture, experience and language of military service members and their families. To date, 647 individuals have participated in 9 No Wrong Door trainings across the state. NALHD's partners at the Statewide Veterans Task Force facilitated by the Brain Injury Alliance of Nebraska had developed the precursor to the current No Wrong Door, but had only limited penetration into rural areas of the state. This original training was also very clinically focused and therefore of limited use to the many public health partners who are not clinical providers. The training has evolved to a broader focus making it applicable to multi- sector providers (education, business, government, social services, etc.). The training now includes a military primer and sections on PTSD, TBI, suicide awareness, a From the Front Porch section focusing on the impact of service upon families, resources, and VA 101 in addition to an interactive panel discussion with Veterans and family members strategically selected to represent a variety of experiences. To date, attendees at No Wrong Door have come from the VA or other military organizations (16%), Hospital/Medical Facility (10%), Mental Health (14%), Education (7%), Non-profits (21%), State Agencies (14%), and others including the faith-based organizations, law enforcement, general public, family, and many Veterans themselves. Evaluation data (discussed below) indicate that participants learned the impact that military experience and culture has on individuals and families. They exhibited statistically significant gains in confidence in their ability to work with client/patients/constituents connected to the military and/or Veterans. LHDs in Nebraska have solid reputations for leveraging tools, processes and partners to improve health opportunities and outcomes in local communities. Veterans and their families have always been a population served by LHDs in this capacity. However, prior to VetSET, Veterans and their families were little-understood and a relatively invisible sector of local communities. VetSET is the only large-scale program where LHDs, as Chief Health Strategists, are systematically engaging cross-sectoral partners in building capacity to authentically consider Veterans and families as a special sub-population served by the public health system. Nebraska LHDs and their partners are now aware of the many unique challenges that impact this population and better positioned and networked to assist Veterans and their families, to help them thrive. Since many health outcomes highlighted in Nebraska LHDs' Community Health Improvement Plans (CHIPs) have been found to be associated with military experience (including suicide prevention and behavioral health access), capacity built to effectively engage and work with Veterans and their families will help with progress on these goals across rural communities. Is the current practice evidence-based? VetSET is a novel practice informed by other evidence-based public strategies including… 1. Health Equity: Programs to Recruit and Retain Staff Who Reflect the Community's Cultural Diversity available at https://www.thecommunityguide.org/sites/default/files/assets/HealthEquity-Culturaly-Competent-Healthcare.pdf 2. Implications of Health Literacy for Public Health- IOM Workshop Summary available at http://nationalacademies.org/hmd/reports/2014/implications-of-health-literacy-for-public-health.aspx 3. A Treatment Improvement Protocol Improving Cultural Competence available at http://store.samhsa.gov/shin/content/SMA16-4931/SMA16-4931.pdf

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
    - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?
    - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

Enter the LHD and Community Collaboration related to your practice (5000 words maximum): *

VetSET Goals 1. Outreach to and connect with Veteran and their families in rural communities. a. Train, deploy, and support LHD liaisons (VetSET Coordinators) to work with Veterans and families. 2. Build collaboration between military-serving and civilian-serving partners across the rural public health system. a. Establish local Veteran task forces to engage broad participation across each LHD jurisdiction. 3. Increase military cultural competence across the public health system. a. Provide outreach and tailored training and technical assistance to civilian partners across each LHD jurisdiction. What did you do to achieve the goals and objectives? NALHD provided financial resources, technical assistance and other support to enable 15 LHDs to address the goals above. Highlights of local implementation work included internal LHD training, small-scale onsite technical assistance (TA), widespread identification of and outreach to Veterans and families by LHDs and partners, and large-scale community based training opportunities around military cultural competence. Steps taken to implement the program As early as 2013, LHD directors, in their CHIPs, noted the relative absence of military and Veteran engagement and worried about the implications of this. These directors used their state association of county and

city health officials (NALHD) as a vehicle to apply to the VA Office of Rural Health, Rural Veteran Coordination Pilot program. The proposal they submitted was one of five projects funded nationally. The majority of the $2,000,000 VA award was distributed over two years between the 15 LHDs that either hired a dedicated person for the project or selected an existing staff member to take lead in their LHD's work. To assure broad access to high-level expertise in military, Veteran, and family issues, NALHD hired a 32-year Air Force Veteran as the state-level Project Director. Throughout the project period, the Project Director, working in the NALHD office in Lincoln, has provided expert leadership and assistance to the LHDs and cultivated state-level partnerships that support and pave the way for the local-level work. The project was named VetSET (Serve, Educate, Transition) to reflect LHDs' goals and those of the VA. VetSET adopted the tagline "Readying Communities to Serve Veterans and their Families." The local leads at each LHD were called VetSET Coordinators. Assessing Needs and Assets. In early 2015, all LHDs conducted assessments of available assets and capacities to serve Veterans in their communities. These assessments helped inform this project at a local level and highlighted the need to find appropriate resources and partners to engage and serve Veterans and their families. One of the primary issues brought to light was the misconception that most if not all care for Veterans were covered by the VA; and therefore, Veterans and their families were not on the radar of many in the public health system. While two-thirds of eligible Nebraska Veterans use the VA, most are geographically distant from VA facilities and the vast majority of families are not eligible for VA services. The extreme distance between rural Veterans and VA facilities is a primary driver behind the VA's quest to build community partners to serve rural Veterans, and where VetSET has proven to be a valuable resource. Preparing LHDs. The implementation of VetSET included a variety of start-up training and one-on-one meetings with the outlying LHDs. Leadership from each LHD and several key staff participated in start-up training including group trainings on data collection tools mandated by the VA, introduction to military culture, and an overview of Veteran Administration facilities and services across Nebraska. Needs identified in the initial and ongoing assessments helped LHD's to prioritize which partners to engage with at the local and state level—including Veteran Service Officers, local behavioral health providers, primary and secondary schools, and others. Contracts and sub-awards tied to rigid performance measures were established in the first month between NALHD and each LHD. NALHD also contracted an independent evaluation team, Schmeeckle Research. Each LHD as well as NALHD completed an Organizational Assessment to establish a baseline of organizational capacity related to Veteran services. This assessment was then modified and deployed to partnering agencies as part of asset mapping and as a jumping off point for training and TA provided by or facilitated by LHDs. VetSET Coordinators came from diverse backgrounds related to military experience. The first team of VetSET Coordinators included a combat Veteran, a non-combat Veteran, a Veteran spouse, other immediate family members, and a few with no direct relation to a Veteran. VetSET Coordinators worked to build supportive Outreach Teams (including other LHD staff and community members) to connect public health system providers to each other and to connect Veterans and their families to appropriate care and benefit programs locally. Meanwhile NALHD worked at the state level to assure that partners were helping to prime their local counterparts for the introductions and dialogs that would move VetSET forward. When assessing LHD organizational demographics, very few, if any staff identified as Veterans or immediate family of Veterans. As the VetSET Coordinators were on-boarded, this new diversity represented a microcosm of the project, epitomizing the communities who knew little about the Veteran culture and the Veteran who knew little of Public Health. The focus in the first few months was on establishing and nurturing the LHD VetSET Coordinators' team dynamic. It was vital that the VetSET Coordinators establish a community of practice and recognize that they had a great deal to learn from each other's experiences and talents. Resource sharing and cross-talk remains a key to successfully leveraging the diverse talent and connections across the state. Refining the role of the VetSET Coordinator was a collective process to ensure they adapted and were responsive as the program evolved at each individual LHD. Equally taxing was establishing new and reorienting existing partnerships between LHDs and community stakeholders from a range of sectors. These partnerships continue to allow our VetSET Coordinators to 1) act as conveners of local task forces—closely tied to Outreach Teams and dedicated to Veterans issues, 2) engage with their community partners in ways that increases partners' knowledge and awareness about Veteran-specific issues and concerns, 3) be a resource for partners going forward. Engaging Partners. Stakeholder involvement and collaboration has been key to the success of VetSET. NALHD focused on engaging LHD personnel, as well as numerous state and community-level stakeholder groups from the start. The VetSET Coordinators engaged with local service providers focused on the military and Veterans as well as community partners such as schools, law enforcement, employers, community organizations and many others. This cross-sector, community-wide approach helped to broaden the base of people in the rural communities were working towards the same goal of awareness and service to Veterans. Between 2014 and 2016, over 800 partners were engaged in VetSET work. Training Partners. Within the first few months of the initiative, community training curriculum, including a statewide schedule for offering the day-long No Wrong Door training was finalized. The VetSET Coordinators helped to secure sites for the trainings across the state and promote the opportunities to professionals and community providers in their local communities. Having these robust trainings scheduled, armed VetSET Coordinators with a strong reply to newly engaged partners who were interested in serving Veterans and wanted to know "what next?". VetSET Coordinators also selected strategic partners who they sponsored as guests at No Wrong Door training, to maximize the community benefit garnered from these activities. The revision of the content of No Wrong Door was driven by the VetSET Project Director and included input from experts in Public Health, Traumatic Brain Injury, and military and Veteran issues. Revisions sought to make this training less clinical and more relevant to a broader range of rural participants: health professionals, counselors, community members, clergy, law enforcement, employers–anyone who needs to be ready for Veterans and their families when they walk through the door. The resulting curriculum significantly enhances participants' awareness and understanding of the particular needs of service members, Veterans and their families as they face the challenges on the home front. No Wrong Door introduces community providers to the "invisible" wounds of war, services, and resources so all can support Veterans and their families in local communities. No Wrong Door provided a way for LHDs, their staff, and their key partners to build shared expertise on Veteran's issues in Nebraska that they can apply to their work, including with VetSET. No Wrong Door has remained a key piece of the VetSET program and continues to serve as a great mechanism for engaging partners across the state. Over 2 years, 647 partners and LHD staff attended No Wrong Door. At the 6-month point of the project, NALHD hosted a VetSET Showcase event, which included key state partners. This event served to elevate the VetSET project's profile across the state and win additional supporters. Attending the event were a number of military liaisons including, four U.S. Senators and Congressmen; four State Senators; the Lieutenant Governor; the Adjutant General of the National Guard, the Assistant Adjutant General for Army, Army State Command Chief Warrant Officer, and Air Force Wing Command Chief Master Sergeant; senior leadership from Nebraska Health and Human Services' Division of Public Health; numerous representatives

from the Veterans Administration; and other key community leaders and partners. Those attending interacted one-on-one with the VetSET Coordinators and LHD Directors. Each LHD's VetSET Coordinator staffed a display table showing a sampling of grass-roots activities and demographics of their areas. In addition to the Showcase, NALHD supported LHDs' local training efforts with workshops at the Nebraska Rural Health Association (NeRHA) and Public Health Association of Nebraska (PHAN) annual state-wide conferences. In year two of the project, the American Public Health Association (APHA) selected VetSET to present at their Annual Meeting. The briefing was titled "Applying public health approaches to support health and wellbeing of Veterans, service members and their families: An innovative pilot project lead by Local Health Departments in rural Nebraska". This was an opportunity to share Nebraska's strategies in identifying military families, creating and leveraging partnerships between military and civilian worlds, and enabling ongoing efforts for rural communities to support and care for Veterans and their families in ways that highlight prevention. Identifying Veterans and Families. From the start of implementation, NALHD looked to establish better mechanisms for understanding the public health implications of military service… for both Veterans and their family members in Nebraska. NALHD developed and implemented demographic screening questions that ask not just about an individual's experience with the military, but also asks about experience of close family members. In this way, LHDs and their partners who adopted the screeners are developing more complete understandings of the populations they serve. On a state level NALHD also invested in adding similar screening items in the 2016 implementation of the Behavioral Risk Factors' Surveillance System (BRFSS) survey. Those data should provide a better picture of correlations between proximity to military service and other priority health outcomes for LHDs. Working with Veterans and Families. Much of the VetSET work revolved around community capacity building. That said, between 2014 and 2016, VetSET Coordinators worked directly with over 560 Veterans and family members, often providing referrals to partners. These referrals addressed a broad array of needs. Health care was a need for a plurality (47.0%) of individuals who Coordinators directly helped. Rounding out the top five needs were housing assistance (29.4%), education (20.9%), mental health services (19.4%), and employment/job (19.4%). Of referred individuals 85% were male, 97% were white, 5% were Hispanic/Latino, 1/3 had a high school diploma but no further educational completion, 43% were working and 16% reported that they were not working due to disability or illness. VetSET Coordinators worked to maximize local and state resources relevant to the needs of these Veterans and family members. Based upon available satisfaction data, they were successful. Satisfaction was high with the VetSET Coordinator (i.e. "the person from the local health department"), and the perceived knowledge of the VetSET coordinator about services and issues facing Veteran families was also high. Criteria for Eligibility? VetSET targets post 9/11 Veterans and their families; however, no Veterans or their families were excluded from services. As an example, Vietnam-era Veterans frequently requested long over-due assistance and service through VetSET. Ultimately the primary target for this practice is Veterans living in rural communities without access to services and support they might be able to receive from the VA or in cities with a larger network of providers. Timeframe VetSET was started September 2014 and is ongoing, though scaled-back since the end of the original grant in the fall of 2016. Were other stakeholders involved? What was their role in the planning and implementation process? As VetSET has evolved, NALHD continues to look for and engage other community stakeholders. One of the strengths of this model has been working with both traditional and non-traditional partners. Since start of VetSET, NALHD has leveraged its relationship with the statewide Veterans Task Force. This long-standing group is comprised of representatives from civilian, military and key government agencies working together to enhance awareness and provide education to Nebraskans who are working with military members, Veterans and their families. The Veterans Task Force had taken the lead in implementing action-oriented steps to improve statewide awareness and education about the particular needs of Veterans and their families as they face the challenges of Traumatic Brain Injury (TBI), Post-Traumatic Stress Disorder (PTSD) and reintegration. The passion of VetSET bolstered the commitment of other long-standing and new partners of the Veterans Task Force. The renewed focus is statewide coordination and collaboration, commitment to community outreach and education, community capacity building, and establishing strategic partnerships. This Veterans Task Force model has been replicated many times across the state with the LHDs' VetSET Coordinators at the helm. These groups have increased awareness through informational briefings, advocating on behalf of Veterans and their families, connecting organizations, and fostering collaboration among partners in small towns in all corners of the state. Budget Summary VetSET was primarily funded September 2014-September 2016 by the VA Office of Rural Health through their Rural Veteran Coordination Pilot program. Total funding over the 24-month period was $2 million. The bulk of these fund were distributed as $22,000-46,000 annual sub-award to the 15 participating LHDs who used the funds to support the VetSET coordinators (time and effort and local travel, primarily). The remaining funding supported administrative costs at the state, association-level—including a full-time VetSET Project Director who is both a 32-year Veteran of the Air Guard, former Command Chief, and the spouse of a post-911 combat Veteran. This expertise at this position was absolutely critical in terms of providing all LHDs with ready access and strategic insights related to Veteran and military culture and resources. VetSET generated limited income from registrations for the No Wrong Door trainings ($50 per participant).

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
    - List any primary data sources, who collected the data, and how (if applicable)
    - List any secondary data sources used (if applicable)
    - List performance measures used. Include process and outcome measures as appropriate.

- Describe how results were analyzed
- Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Please enter the evaluation results of your practice (2000 Words Maximum): *

VetSET Objectives: 1. Train, deploy, and support LHD liaisons (VetSET Coordinators) to work with Veterans and families. 2. Establish local Veteran task forces to engage broad participation across each LHD jurisdiction. 3. Provide outreach and tailored training and technical assistance to civilian partners across each LHD jurisdiction. NALHD employed a variety of tools to monitor and evaluate VetSET implementation and impact. These included several tools mandated by the VA as part of its initial funding: Screening Tool is a brief needs assessment for initial intake of Veterans or family members. 1,894 Screening tools were completed by LHD staff. Veteran and Family Intake is an online survey used to collect in-depth data from each Veteran or family member whose Screening Tool indicated a need for resources or referrals. 626 Intakes were completed. Summary statement about what the data say. Referral Tool captures every referral of Veteran/Family to services or organization. 561 formal Referrals were made to (list some frequent/types of) Referral Follow-up Satisfaction Survey was e-mailed to referred Veterans and family members. The response rate was fairly low and just 35 completed satisfaction surveys were received. Among those who did complete a satisfaction survey, satisfaction was high with the VetSET Coordinator (i.e. “the person from the local health department”), and the perceived knowledge of the VetSET coordinator about services and issues facing families was also high. Outreach Event Tool collects information about outreach events/activities where Veterans or family members were engaged and/or provided information and resources. VetSET participated in 345 outreach events, reaching over 4,500 Veterans and Veteran families. Partnership Tool collects information about instances where LHDs engaged system partners to meet the needs identified by Veterans and their families. 810 partnerships were established and documented. To ensure that the VetSET evaluation could adequately address the areas of emphasis most important to LHDs as Chief Health Strategists, NALHD implemented several other evaluation tools with the input of an outside evaluation team. These were: Comprehensive No Wrong Door Evaluation No Wrong Door participants represented LHDs (20%), Community Organizations (12%), Health Care (14%), Government (12%), VA (6%) and other partners. Participants’ familiarity and comfort with aspects of military and Veteran culture, increased significantly and those improvements persisted over time as indicated by pre, post and 6-month follow-up surveys. Immediately following the trainings, just under 75% of participants agreed or strongly agreed that their overall impression of Veterans has changed as a result of attending the training. Over 90% agreed or strongly agreed that they are more aware of the challenges facing Veterans and their families as a result of the training. Over 78% agreed, post-training that they now know effective communication skills to use when working with Veterans – up from 35% pre-training. All No Wrong Door training attendees were twice invited to participate in a brief survey of military cultural competency. This tool was based upon the tool that was used in the 2014 Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families study by the RAND Corp. The purpose of NALHD’s version of this tool was to ascertain the impact the No Wrong Door training had on participants’ understanding of military and Veteran culture and their level of comfort in serving Veterans. A total of 290 individuals responded to the pre-survey (response rate: 57.1%). The response rate dropped considerably for the follow-up, but was still a respectable 36.6%, with 186 responses collected. The pre- and follow-up surveys were administered via SurveyMonkey, to all participants (the week prior to the given No Wrong Door and again 6 months after the workshop). All data were analyzed with SPSS version 22. Frequencies and cross-tabs were performed. All of these survey items showed a statistically significant improvement from pre- to follow-up ($p<.05$). Participants’ perceived knowledge of military culture and perceived knowledge and ability to communicate with Veteran clients improved. Participants perceived ability to provide needs-based services for Veterans and their families improved.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation.*)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

Lessons learned in relation to practice Successful implementation of VetSET is most evident where the local team has been passionately involved. We have found our most meaningful impact has come from coordinators and partners that have a personal stake as a Veteran, spouse, or immediate family of a post 9/11 Veteran, and sites with highly-engaged LHD leadership. VetSET has become an integral part of all participating LHDs. To make the program most effective at individual sites, NALHD has worked with each LHD and given them flexibility to address local priorities within the parameters of the VetSET project goals. For example, in the Western part of the state, homelessness among Veterans was a significant focus and behavioral health, relationship support, and suicide prevention was a primary emphasis in the northeast part of the state. Allowing each LHD to craft their focus based on need, partner relationships, and core capacity of the LHD increased opportunities to sustain VetSET work. In several instances, LHDs have incorporated VetSET Coordinators' core responsibilities into the job descriptions of other, foundational staff positions. Military cultural competence is evolving into being a core skill in Nebraska's LHDs, and at the state level NALHD is helping to develop training resources and policies that can be adopted by all LHDs to assure this continues to be the case. One of the major goals for this project was to create a space within the work of public health that addresses the needs of Veterans and their families, especially in communities that are not prepared to address these needs or in many cases are not even aware of them. With LHD's serving as Chief Health Strategists in local communities across Nebraska, we are seeing a path forward to sustain this orientation. Lessons learned in relation to partner collaboration The basis for this project came from a need to connect isolated Veterans and their families living in rural communities. Part of this process included educating the communities they lived in, on ways to better serve this population. As we began to implement VetSET, it became clear that we had severely underestimated the need for "military cultural competency." Even in sectors we would have expected knowledge of Veterans and families to be higher (such as in behavioral health circles and among VA staff) this familiarity was surprisingly lacking. Early on in VetSET implementation, a civilian behavioral health provider in a mid-sized community asked a VetSET Coordinator "why would it matter?" when that Coordinator suggested that the site screen patients for military experience. In many instances VA staff were among the most complementary evaluators of the value of what they had learned from No Wrong Door. One of the greatest take-aways from VetSET and No Wrong Door has been to recognize the legitimate need for this project across all sectors of business and public service. What we have learned is that the best way to serve Veterans and their families is to prepare and educate their communities. Even the simple act of identifying a Veteran or their family members can positively affect how a provider, employer, or educator might interact with them and better understand their needs. Is there sufficient stakeholder commitment to sustain the practice? Describe sustainability plans. Program, practice, and policy has been the path NALHD has set up for VetSET, ultimately creating a way forward for each LHD that has taken on this project. During the final months of VA funding, NALHD worked with LHDs to ensure that they were positioned to reorient their VetSET activities to assuring that LHDs will be "set to serve Vets" over the long term. This includes developing policy and procedure resources around orienting new staff and refreshing and updating training for existing staff around Veterans' and families' needs. Funding for LHDs is generally challenging, but individually and by way of NALHD, the 15 LHDs involved in VetSET continue to seek resources to allow them the flexibility to devote more staff time to work explicitly targeting Veteran's and their families' needs. To this end, NALHD received and is implementing a grant from the Prevention Institute and the Movember Foundation that is targeting peer support-type interventions for Veteran families and is extending the funding for the ongoing capacity at the level of VetSET Project Director. The Project Director, along with NALHD leadership, are also continuing their efforts to educate policy makers at the state and national level of the needs that drive LHDs' work in this area and the successes achieved. Recognizing the significance and need for addressing this issue, especially in rural communities, all partners and stakeholders are looking for ways to maintain and even expand the work that has been accomplished by VetSET through NALHD LHDs.

Additional Information

How did you hear about the Model Practices Program:: *

- [x] I am a previous Model Practices applicant
- [x] At a Conference
- [x] NACCHO Website
- [ ] Public Health Dispatch
- [ ] Colleague in my LHD
- [ ] Model Practices brochure
- [ ] NACCHO Exhibit Booth
- [ ] NACCHO Connect
- [ ] Colleague from another public health agency
- [x] E-Mail from NACCHO
- [ ] NACCHO Exchange