Oklahoma Veterans Pilot Program

An Initiative to Improve Healthcare Access and Service Delivery to Oklahoma Veterans

Report to the Governor

Prepared by
The Leadership Team
Oklahoma Veterans Pilot Program

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NOT PRINTED AT STATE EXPENSE
REPORT TO THE GOVERNOR

THE OKLAHOMA VETERANS PILOT PROGRAM
An Initiative On Healthcare Access and Service Delivery
THE
EXECUTIVE SUMMARY
THE EXECUTIVE SUMMARY

On September 13, 2016, Oklahoma Governor Mary Fallin kicked off an initiative to develop a healthcare access and service delivery network to enhance and support the efforts of the United States Department of Veterans Affairs in providing healthcare services to Oklahoma veterans. That initiative would become known as the Oklahoma Veterans Pilot Program.

Over the past two years, volunteer professionals from the private healthcare community, state agencies and federal agencies would come together to provide expertise and recommendations in support of the Oklahoma veterans community. Over 100 healthcare professionals and 500 Oklahoma citizens and businesses statewide would provide in-kind services and over 10,000 hours to support the pilot program mission.

This Report to the Governor exemplifies the bi-partisan commitment, compassion and single-minded purpose of the Oklahomans that participated in this worthy endeavor. We commend and extend our personal thanks to each member and business.

The following is an attempt to capsulize a very in-depth and detailed program initiative and present findings and recommendations. Coupled with the program model and implementation plan developed, we support a 3-year test period to demonstrate the proposed changes in healthcare access and delivery can be more cost-effective and efficient than the current system.

To that end, the undersigned believe that a more cost-effective and efficient service model would be possible by moving healthcare outsourcing under state control and management, as opposed to continuing the contracting of services through the Veterans Choice Program.

By moving current contracted services to the state, it would allow for:

1. A greater multi-disciplinary and statewide service network of providers;
2. A quicker response to issues that may develop within the provider network;
3. A quicker response to issues that may develop within the veterans community;
4. A greater transparency and accountability of funds being used;
5. An ongoing outcome measurement and survey process to address the changing healthcare needs of veterans; and,
6. A simplified application process and appointment scheduling system.

The Oklahoma Veterans Pilot Program began with two guiding principles:

1. That the model be a partnership between the private healthcare sector and appropriate state and federal government healthcare agencies; and,
2. That the model serves to support and enhance the existing federal Veterans Affairs healthcare system and support the agency mission of serving the American veteran.
Based on these principles, the pilot program organizers established ten (10) intermediate program objectives to assist in creating a service delivery and access model.

The overarching objectives were developed to:

1. Identify areas of need in veteran’s healthcare service through the analysis of existing data and information gathered from a comprehensive array of veteran services system stakeholders and conducting a statewide veterans survey.
2. Make recommendations on improving timely access to healthcare services for all Oklahoma veteran’s and their dependents.
3. Make recommendations on creating a network of transitional care for all Oklahoma veterans and their dependents.
4. Make recommendations for coordinating medical and behavioral healthcare needs.
5. Develop a communication and educational process accessible to all Oklahoma veterans and their dependents.
6. Explore healthcare coverage options that meet the needs of all Oklahoma veterans and their families.
7. Create strategies to these recommendations, evaluate for success and create long-term system change.
8. Assist the VA Medical Centers in Oklahoma City, OK and Muskogee, OK with identifying obstacles to access and service delivery.
9. Identify outcome measures to evaluate during the testing period.
10. Develop an implementation plan for conducting a 3-year testing period.

Focusing on the above objectives, the pilot program organized into two primary functions:

1. The Research, Analysis and Management (RAM) Function: This function organized the team members and task forces in a manner that allowed for developing ideas, necessary projects (the veterans survey), recommendations and action required to implement a 3-year pilot program to test a one transitional network of care model.
2. The Public Outreach and Awareness Function (The Force 50 Brigade): This function assisted in identifying healthcare resources in all 77 Oklahoma counties and assists in keeping the Oklahoma veteran’s community informed of the pilot program activities and important information. This function also assisted in organizing support for implementing the pilot program through the Force 50 Brigade. This function will remain operational during the test period.

A detailed breakdown of both functions can be found in the Pilot Program Overview section of this report. However, the supporting legislation that was passed, along with the data collected from the Oklahoma Veterans Survey, was significant in forming the final recommendations and in creating the program model.
The State of Oklahoma has always held the American veteran in high regard and worked to address the various needs of the Oklahoma veteran's community. One example would be the seven statewide Veterans Centers providing over 1400 long term nursing care beds to deserving veterans. Another example would be the way Oklahoma supports the many military installations and approximately 30,000 armed forces members that consider Oklahoma their home. In fact, veterans and active duty military personnel comprise nearly 9% of Oklahoma’s population. In addition, about 28% of the states service member population are National Guard and Reserve.

Currently, of the States, Oklahoma has the 10th largest veteran population per capita, but ranks only 18th among the States for federal allocations for Veterans Administration health care services. Oklahoma has approximately 302,000 veterans of which about 81% or 245,000 are veterans who served during eras designated by Congress as wartime periods. Vietnam veterans make up a wartime veteran population of about 34%, while the post 9/11 segment consists of approximately 40%. It should also be noted that 45% of the Oklahoma veteran’s population is over 65 years of age and that one out of every ten veterans are female.

The model will establish four service regions. The Northwest Region will have four districts, the Northeast Region will consist of three districts, the Southeast Region with four districts and two districts in the Southwest Region. Each region will have from two to four navigators to assist in coordinating care and case management.

Management of services, and coordination processes will vary by region based on veteran’s populations and provider participation. The goal will be to access healthcare services within 20 calendar days for routine appointments and within 24 hours for emergent care issues. Coordination of referrals to specialists will be made within 3 business days with the veteran’s knowledge. Referral appointments will also be secured within 20 calendar days to one of several participating providers.

The pilot program organizers have established a veteran’s appointment standard of 20 days due to concerns over wait times and survey findings. The Oklahoma survey showed only 47% of veterans were satisfied with their time to appointment, while 72% were satisfied with appointments to private healthcare providers.

The model also establishes standards to encourage provider participation. Service rates will be at or about the current Medicare rate. In addition, the pilot program will process and pay the provider claim within 30 days of receiving the invoice.

In short, the program model developed will accomplish the following:

1. Management and control residing at the state level will create a more efficient system, improve response time to issues that arise and provide for better communication and coordination of service.
2. Create greater healthcare accessibility
3. Establish a broad multi-disciplinary provider base through fair market-based rates and timely reimbursement.

4. Establish timely appointments for veterans with timely referral appointments made for the veteran.

5. Demonstrate cost effectiveness and network efficiency through outcome measures.

6. Create a positive healthcare experience.

7. Provide a transparent pilot program.

8. Demonstrate this change in healthcare delivery can be cost effective for the U.S. Department of Veterans Affairs.

9. Create a health information management system that promotes quality of care and reduces duplication of service.

10. Reduce and streamline application processes and steps to service, while identifying and offering solutions to regulations and rules that negatively impact service access.

The final program model presented is designed to also provide other states with a transportable blueprint for partnering with the United States Department of Veterans Affairs and addressing the unique healthcare needs of any veteran in every state.

The pilot program organizers understand that the following program model and implementation plan outlined has never been attempted anywhere before and, if successful, will offer a major paradigm shift in the way veterans healthcare services are provided. It is also understood that this model will likely receive resistance from some federal and state government entities due to a resistance to change that is a thoroughly documented characteristic found in any large social institution, whether it is in the public or private sector.

Every state is unique and different when addressing the healthcare needs of veterans. While many states have similarities, no state is alike and, therefore, no state can serve the healthcare needs of veterans the same way.

Each state has a different veteran population, a different total population and varying cultures and ethos service. Each state has an economic base and labor force unique to its people. There are different urban versus rural considerations. In addition, every state has a different gender, race and religious mix that must be considered when developing healthcare objectives, strategies and tactics.

The Oklahoma Pilot Program took the above into consideration when developing the model and implementation plan. The program has developed a model to meet the healthcare needs of Oklahoma veterans, while creating flexibility to use as a blueprint when addressing the veteran’s healthcare needs in other states.
The Oklahoma model incorporates ten components. Each component will require services, management and/or oversight. Therefore, each component will have benchmark performance objectives and outcome measurements. Monthly data collection, analysis, and monitoring reports will be required. These components are as follows:

1. Command and Control
2. Eligibility Criteria and Requirements
3. Service Regions and Resources
4. Outreach Services
5. Core Services
6. Health Information Management
7. Financial Management
8. Payer Sources
9. Transportation Access
10. State and Federal Policy Issues

Daily oversight and management of the Oklahoma Veterans Pilot Program will be placed at the Oklahoma Department of Veterans Affairs (ODVA.) The Executive Director of the ODVA will designate a manager to assume daily management responsibilities of the program.

The program will be kept independent from regular ODVA operations and a separate account will be established to receive and disperse program funds. This function is outlined in more detail under the Financial Management section of the plan.

The Oklahoma Veterans Pilot Program is requesting $250 million to conduct a 3-year test of the Oklahoma healthcare access and service delivery network model. The State of Oklahoma would receive the funds as an allocation from the federally funded Veterans Choice Program of the U.S. Department of Veterans Affairs.

The funding allocation would not be required in a one-time amount, but rather be divided as follows:

- Six-month start-up period $25 million
- Year one $75 million
- Year two $75 million
- Year three $75 million

The program intends to utilize $30 million or 12% of the total $250 million allocation in administrative costs. These costs will be spread out over the 3-year test period and are administrative projections.

A pilot program Review Board will be established to review provider applications, veteran’s eligibility activity, provide guidance on operational issues, discuss modifications to program processes and practices, review survey findings, review monthly outcome measures, and review monthly claims activity to ensure standards are being met.
The membership of the Review Board will consist as follows:

- Representative, Oklahoma Veterans Council
- Commissioner, ODMHSAS or designee
- Director, VAMC, OKC or designee
- Director, VAMC, Muskogee or designee
- President, UCO or designee
- Member, OK House of Representatives (appointed by the Speaker)
- Member, OK State Senate (appointed by the President Pro-Tempore)
- Governor Liaison, Office of the Governor (Ex-Officio/Non-voting)
- Private Sector Healthcare Professional appointed by the Governor
- Private Sector Healthcare Professional appointed by the Governor

This 9-member Review Board will meet monthly and receive all appropriate reports from the program manager. Appropriate reports will include activity summaries from all 10 program components, financial reports, claims reports and outreach activity.

Upon federal approval for the 3-year testing period and commitment to fund the pilot program, the following actions timeline will be established. The timeline to be established will require a six-month start-up period to ensure the program requirements are in place prior to program implementation. Those requirements will include, but are not limited to:

1. Pre-program outreach plan has been organized and marketing efforts implemented.
2. Veterans Registry sign-up period begins immediately and continues through year one of the testing period. Then an annual signup period will be implemented in years 2 and 3.
3. Recruitment and credentialing of Network Providers is finalized within all healthcare disciplines to be utilized and MOU's signed. It is anticipated that current Tricare provider credentialing will constitute Pilot Program credentialing.
4. Training and orientation include:
   a. Navigator duties, key metrics and expectations
   b. In-service training sessions monthly for all network providers and support contract services to clarify program processes, billing/claims procedures, overview of program, program timelines and other pertinent issues relevant to implementation.
5. Outcome measures established within each program component and special outcome measures established for program testing that may be required.
6. Pilot Program Review Board members are notified and in-service training is provided on member duties and expectations.
7. Preparation for receiving of funds is finalized.
8. Transportation support services are finalized and a one-day in-service training session is provided.
9. Health information system is finalized a coordination plan is prepared for implementation.
10. Telehealth services are finalized with the leasing company, contract finalized and implementation plan completed.

It is hoped federal approval can be obtained by April 1, 2019 so that the official 3-year pilot program can begin on October 1, 2019, the start of the federal fiscal year. Therefore, year 1 would begin on October 1, 2019 and end on September 30, 2020. Year 2 beginning in October 2020 and ending in September 2021 and year 3 concluding on September 30, 2022.
Finally, this report provides 15 recommendations. The most critical being Recommendations 1, 2, 3, and 15.

**Recommendation 1:**

That based on findings of the Oklahoma Veteran Pilot Program, the State of Oklahoma should assume management and control of services currently provided within the federally managed Veterans Choice Program.

This recommendation is considered critical to accomplish an improved healthcare access and delivery capability. Under state management:

1. The pilot program can respond more quickly and efficiently to issues that may arise with providers and the veteran.
2. The established appointment standards can be met more efficiently.
3. A greater provider base can be established with a greater multi-disciplinary option and broader statewide access.

**Recommendation 2:**

That the United States Department of Veterans Affairs allocate $250 million from the existing Veteran's Choice Program to the State of Oklahoma to test a three-year pilot program designed to improve healthcare access, create a more efficient and cost-effective network of care and enhance the current federal VA healthcare system for all Oklahoma veterans.

**Recommendation 3:**

That the Oklahoma Veterans Pilot Program be attached as an independent program to the Oklahoma Department of Veterans Affairs and that the ODVA assume the oversight responsibility of the 3-year testing period.

**Recommendation 15:**

That the Governor of Oklahoma form a delegation to present the Oklahoma Veterans Pilot Program findings, recommendations and program implementation plan to the President of the United States and the Secretary of Veterans Affairs.

We believe the information and recommendations in this report will successfully achieve our goals of developing an enhanced healthcare access and delivery model, while supporting our partners at the U.S. Department of Veterans Affairs. Furthermore, we believe the program model and implementation plan will prove to be cost-effective, efficient and accessible to veterans everywhere.
We believe the information and recommendations in this report will successfully achieve our goals of developing an enhanced healthcare access and delivery model, while supporting our partners at the U.S. Department of Veterans Affairs. Furthermore, we believe the program model and implementation plan will prove to be cost-effective, efficient and accessible to veterans everywhere.

We would like to thank Governor Fallin for her support and leadership during this process. She provided unprecedented access to resources and demonstrated her commitment to this initiative time and time again. We cannot begin to adequately express our sincere appreciation for her dedication and support of the Oklahoma veteran.

We would also like to express our gratitude and appreciation to the Oklahoma veteran. The Oklahoma veteran deserves and has earned through service and sacrifice, the best healthcare services available. It is hoped that the information contained herein, will present the best healthcare options moving forward for those who served our nation with courage and honor.

Yours in Service and Appreciation,

The Oklahoma Veterans Pilot Program Leadership Team

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THE
INTRODUCTION
THE INTRODUCTION

Under the leadership of Governor Mary Fallin, the State of Oklahoma launched an initiative in September of 2016 to address healthcare services and access issues facing Oklahoma Veterans. The Oklahoma Veterans Pilot Program was subsequently established as a joint research project to identify healthcare needs, access issues and a delivery system to assist and support the mission of agencies providing services to the veteran’s community.

The pilot program organization consisted of over 100 volunteer professionals providing ideas, experiences, management skills and recommendations. These statewide volunteers included healthcare professionals from the private sector, federal government and state government. The pilot program also involved legislative leaders, legal professionals, education professionals, business leaders, former leaders of the armed forces, and several leaders from federal and state governmental agencies.

Participating members of the pilot program were bi-partisan and understood the primary purpose was to enhance existing healthcare services to veterans and recognize that there would be only one agenda – The Oklahoma Veteran. There would be no place for a political agenda, a party agenda, a business agenda or a personal agenda.

Subsequently, each participating member should be acknowledged for their commitment and dedication in serving the Oklahoma veteran. Each member exemplified compassion, as well as experience in building a team approach and positive environment.

The pilot program activities included regularly scheduled meetings reviewing current healthcare service operations, management concepts and research data pertinent to the organizational mission. In addition, the pilot program initiated a statewide public awareness campaign and conducted a statewide veterans survey to ensure current healthcare needs were identified.

The findings and recommendations are presented in this veteran’s healthcare report. This report also presents a healthcare access and service delivery model for consideration and an implementation plan for a three-year testing period.

The American veteran deserves and has earned through service and sacrifice, the best healthcare services available. It is hoped that the information contained herein, will present the best healthcare options moving forward for those who served our nation with courage and honor.
THE MISSION
To lead in the creation of a veterans-centered network of accessible healthcare that meets all levels of need to those who served with honor.

THE VISION
To provide a positive and timely healthcare experience to every veteran seeking services and establishing a culture of trust and compassion within the veteran’s community.

THE MOTTO
Respect, Integrity, Service and a Passion for Care

THE OBJECTIVE
To develop a cost effective and efficient statewide multi-disciplinary healthcare access and delivery network for any veteran in need of service through a managed partnership of federal, state and private sector healthcare professionals, facilities and entities.

THE GOAL
To have the Oklahoma model serve as a blueprint for the unique healthcare needs of each state and have the United States Department of Veterans Affairs support and accept the Oklahoma plan as a national model for all American Veterans.
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GLOSSARY OF TERMS
THE GLOSSARY OF TERMS

APM – Alternative Payment Model

CMHC – Community Mental Health Center

CMS – Centers for Medicare/Medicaid Services

FQHC – Federally Qualified Health Center

HIE – Health Information Exchange

MOU – Memorandum of Understanding outlining the responsibilities of both parties.

Navigator – A licensed social worker used in coordinating veterans services and case management needs.

Network Provider – any healthcare professional, facility, clinic or entity that has signed an MOU to participate in the pilot program.

ODVA – Oklahoma Department of Veterans Affairs

ODMHSAS – Oklahoma Department of Mental Health and Substance Abuse Services

PPS – Prospective Payment System

UCO – University of Central Oklahoma and pilot program partner.

UI/UX – User Interaction/User Experience

VAMC – Veterans Administration Medical Center

VSO – Veterans Service Officer that assists veterans with claims and benefit issues.
THE PILOT PROGRAM OVERVIEW
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The Oklahoma Veterans Pilot Program is an initiative by the Office of the Governor to develop a one transitional network of care model designed to improve healthcare access and service delivery in a cost effective and efficient manner for all Oklahoma veterans.

Furthermore, the pilot program organizers focused on two guiding principles for model development.

They were:

1. That the model be a partnership between the private healthcare sector and appropriate state and federal government healthcare agencies; and,
2. That the model serves to support and enhance the existing federal Veterans Affairs healthcare system and support the agency mission of serving the American veteran.

Based on these principles, the pilot program organizers established ten (10) intermediate program objectives to assist in creating a service delivery and access model.

The overarching objectives were developed to:

1. Identify areas of need in veteran’s healthcare service through the analysis of existing data and information gathered from a comprehensive array of veteran services system stakeholders and conducting a statewide veterans survey.
2. Make recommendations on improving timely access to healthcare services for all Oklahoma veteran’s and their dependents.
3. Make recommendations on creating a network of transitional care for all Oklahoma veterans and their dependents.
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6. Explore healthcare coverage options that meet the needs of all Oklahoma veterans and their families.
7. Create strategies to these recommendations, evaluate for success and create long-term system change.
8. Assist the VA Medical Centers in Oklahoma City, OK and Muskogee, OK with identifying obstacles to access and service delivery.
9. Identify outcome measures to evaluate during the testing period.
10. Develop an implementation plan for conducting a 3-year testing period.
In order to efficiently address the above objective, the program organizers established three general areas of research, management, and outreach. These three areas are identified as sections for this report.

- **Section 1: Organization**
  This area focused on the leadership, management, coordination, communication method and activity timeline utilized by the pilot program members.

- **Section 2: Public Awareness and Outreach**
  This section identified outreach methods and resource information gathering techniques utilized in the pilot program. This area also focused on statewide survey activities and legislative requirements.

- **Section 3: Data Component**
  This activity focused on organizing the data collection process and analyzed appropriate information and verified data and information resources.

Finally, it was important to the pilot program organizers that the leadership established be representative of government, business, and education. Therefore, a co-chairperson team of three individuals were identified to ensure fair and equitable leadership was provided and that a facilitator be identified to manage the operations and coordination needs of the pilot program teams. An organization flow chart was developed and has been provided. (See Appendix I)

The following is an in-depth review of each section identified above.

**Section 1: The Organization**

The organization of the Oklahoma Veterans Pilot Program was designed to increase efficiency, reduce duplication, maintain consistency and serve volunteer participants as a program of inclusion, not exclusion. It was important to have statewide representation and volunteer members be focused only on serving the veteran community.

Over 100 healthcare professionals from various disciplines participated. In addition, the membership also included professionals from the legal and financial community; higher education and business leaders; legislative and community leaders; state and federal government leaders, and former members of the armed forces.

In order to maximize the contributions and experience of each participating member, the program was organized into various committees, task forces and management teams with specific duties and functions.

The following is a breakdown of the organizational structure:

**COMMITTEE AND TASK FORCE STRUCTURE**
A vital part of the project is the development of a steering committee, task force groups and management teams to look at existing system information and recommend system improvements to enhance access and quality of healthcare services for veterans and their families. The purpose of these groups is as follows:

**STEERING COMMITTEE**

This committee provided direction and approval on an as needed basis. It served to settle conflicting issues and topics when necessary to ensure continuity and consistency were maintained.

**JOINT TASK FORCE**

The task force served as the primary group within the pilot program. It was organized into three teams or tiers to maximize the strengths and expertise of its members.

The following is a brief description of each tier:

Tier #1 – Primary – Lead members of task force and assist in outreach efforts.

Tier #2 – Secondary – Provides guidance on certain healthcare issues, social and cultural program concerns and participates as needed.

Tier #3 – Specialized – Provides expert council on specific program aspects and assists with data analysis.

The Joint Task Force received all information, data, recommendations and suggestions that were developed, formed and submitted by the Task Force Groups. These task force groups had specific and targeted duties. These groups are discussed later in this section of the report.

The Joint Task Force organized and prioritized the information submitted by the task force groups. Furthermore, the Joint Task Force has specific responsibilities identified. Those responsibilities were as follows:

1. Development of the Transitional Network of Care Model
2. Prioritize Recommendations
3. Review and Organize Research and Survey Data
4. Assist in preparing the final report.
5. Develop test/action process and outcome measures for model

It was critical that the Joint Task Force develop an outline of the program model based on input from the task force groups. The following outline was developed and each area researched for inclusion in the final program model and implementation plan.

**The Model Outline Explored:**

I. Eligibility Criteria
   1. Regions of Service
II. Current Resources
i. OHA Contributor
   1. Medicare Regions
   2. Claims and Benefits (ODVA)
   3. KEN Regions

ii. Mental Health Service Areas

iii. American Indian Health Services

iv. ODVA Centers (State)

v. VA Locations (Federal)

vi. FQHC’s

vii. Hospital Systems

viii. Independent Rehab Facilities

b. City Resources

III. Veterans Outreach/Communications

a. Develop Application
   i. Toll Free Call Number/Call Center
   ii. Electronic Access
   iii. Website (Re-Design)

b. “No Wrong Door” Approach

c. Marketing Plan

d. Health Information Exchange

e. City/County Health Departments

f. Resources App for phones

IV. Core Services

a. Triage Needs
   i. Emergency
   ii. Acute
   iii. Chronic
   iv. Behavioral
   v. Long Term Post-Acute Care

   a. Emergent Care/Access
   b. Continuum of Care
      i. Primary Care
      ii. Behavioral Health
iii. Hospitalization
iv. Post-Acute Care
v. Long Term Care
vi. Specialty Care
c. Transitions/Coordination between Providers
d. Telehealth Network
   i. Real-time inter facility
   ii. Real-time residential-to-facility
   iii. Store and forward online consults and referrals

V. Health Information Management
   a. Health Record Portability
   b. Eligibility
c. Prior Authorizations
d. Information exchange Use Case
   i. Referrals
   ii. Case Management
   iii. Care Coordination
   iv. Care Transitions
   v. Readmissions
   vi. Triage
e. Inter-operability:
   i. Coordinated Care Oklahoma
   ii. MyHealth Access Network (Tulsa)
   iii. VLERHealth exchange (VA HIE)
   iv. HealthEOklahoma (Stae HIE)
   v. HIS (Indian Health HIE)

VI. Payer Sources
   a. VA/TriWest
   b. Tricare
   c. Commercial
d. Medicare/Medicaid
e. IHS/Native American
f. Uninsured
   i. Options
   ii. Eligibility
g. Self-Insured
   i. Options
   ii. Eligibility
h. Health Insurance Exchange
VII. Transportation
   a. Refer to Government Task Force Issues Section
   b. Medical Limitations
   c. Vouchers
   d. Telehealth Options
   e. Access Points
   f. Current Resources
   g. Special Populations

VIII. State/Federal Legislative Issues
   a. Policy Needs
   b. Existing Rules/Statute Suspension
   c. Funding Methods
   d. Feasibility
   e. Reimbursement
      i. Eligibility
      ii. Mechanisms for Integration

Task Force Groups – The task force groups met one day per week for 10 weeks, beginning the second week of September and conclude by the second week of November. A description of each task force and management team is as follows:

- **Government Task Force.** This task force consisted of state agency directors, representatives of the legislative branch and private sector healthcare professionals. These members were charged with identifying existing obstacles to service at the state and federal level as well as identifying new ways to deliver services.

- **Business Task Force.** This task force consisted of private sector healthcare professionals, insurance company representatives, executive and legislative branch representatives, and related associations. These members were charged with developing a transitional network of care model. In addition, this task force was charged with developing a communication and educational process.

- **Veterans Task Force.** This task force consisted of veterans representing various veterans service organizations and individuals. This task force was charged with surveying the veteran population, identifying current issues and participating as needed in the government and business task forces.

Management Teams – The management teams were responsible for monitoring the task forces and providing consultation and direction. These teams were also responsible for insuring the Oklahoma veteran’s population was represented, funding methods were
explored and outcome consistency was maintained. These teams were focused on the following areas of interest:

- **Legal Management Team.** This team consisted of attorneys and CPA’s charged with providing input to each task force as it relates to statutes, regulations, and funding mechanisms.

- **Media Management Team.** This team consisted of print and electronic media experts to assist each task force in providing accurate and consistent information. This team also assisted in accessing media markets.

- **Communication, Education and Grants Management Team.** This team consisted of education professionals and charged with assisting in the development of a communication and educational delivery system.

- **Legislative Management Team.** This team consisted of legislative members, congressional delegation staffers, executive branch staffers and legislative liaisons. This team was charged with assisting task forces in developing recommendations and providing consultation in regard to state and federal legislative processes.

- **Non-Profit/Spiritual Management Team.** This team consisted of leaders in the spiritual and non-profit organization community. This team was charged with identifying new ways to access related resources, communication methods and in-kind services.

**SPECIAL COMMITTEES AND SUB-COMMITTEES:**

Special committees and sub-committees were formed at the discretion of the Joint Task Force on an “as needed” basis. The task force formed only one sub-committee during the pilot program development phase.

The service model sub-committee was created to review the task force responsibilities. It was also determined a special focus was necessary to assist the Joint Task Force in targeting specific aspects of the service model being developed and addressing priority healthcare issues.

The sub-committee had a five-week window to accomplish its purpose. The team met once a week for approximately two hours. The result assisted the Joint Task Force in expediting specific areas of the service model.

The following is an overview of the sub-committee activities performed:

Review of Joint Task Force Responsibilities:

1. Development of the Transitional System of Care Model
   - Sub-Committee develops key service model details, structure and recommendations.
• Joint Task Force review sub-committee recommendations and suggests amendments.

2. Prioritize Recommendations
• Prepared by sub-committee and reviewed, modified and approved by Joint Task Force.

3. Collect, Review, and Organize Research and Survey Data
• Performed and accomplished by the University of Central Oklahoma and reviewed and approved by the Joint Task Force.

4. Prepare Final Report
• Prepared by Pete Reed with assistance from select Oklahoma Veterans Pilot Program members. The report is reviewed, modified and approved by the Joint Task Force.
• Once approved, the Final Report, with supporting documents and data, is presented to the Governor for distribution to the Oklahoma Congressional Delegation and the leadership of the Oklahoma Legislature.

5. Create Test/Action Process and Outcome Measures for the Service Model
• Developed by the University of Central Oklahoma and approved by the Joint Task Force.
• This action plan is incorporated into the final report. This process is approved by the Joint Task Force prior to presenting the final report to the governor.

Purpose of Service Model Sub-Committee

1. Develop the Outline of the System of Care Service Model
2. Establish Service Area Regions and Identify Services Required for each Region
3. Develop a Logistical Support System to Accomplish Access and Delivery Goals
   • Includes a funding method
   • Includes an accountability system for:
     o The funding method
     o The service delivery system
4. Establish Service Provider Criteria
5. Establish Veterans Eligibility Criteria (Tier 2 only)
   • Includes expansion of TRICARE services and eligibility
   • Includes recommendations on premiums, co-pay, etc.
   • Includes recommendations for existing VA eligibility criteria and simplifying current categories.

NOTE: The following reflects discussion by the sub-committee and subsequent decisions on Core Services and prioritizing the week of discussion for remaining key areas.

Core Services Reviewed and Modified
1. Triage Needs
   • Emergency
• Acute
• Chronic
• Behavioral
• Long-Term Post Acute Care

2. Emergent Care/Access

3. Continuum of Care
   • Primary Care
   • Behavioral Health
   • Hospitalization
   • Post-Acute Care
     o Outpatient Therapy
   • Long-Term Care
     o Home Health
     o Palliative Care
     o Hospice Care
     o Nursing Care
   • Specialty Care
   • Pharmacy Services
   • Laboratory Services
   • Dental Services
   • Vision Services
   • Hearing Services

The remaining key areas addressed by the sub-committees were as follows:

Week 2: August 9, 2017
Current Resources
Regions Veterans Outreach/Communications

Week 3: August 16, 2017
Logistical Support Services
Payer Sources

Week 4: August 23, 2017
Service Provider Criteria
Health Information Management

Week 5: August 30, 2017
Veterans Eligibility Criteria
Transportation

DIVISION OF PRIMARY FUNCTIONS:

There were primary functions of the pilot program made operational. They were:
3. The Research, Analysis and Management (RAM) Function: This function organized the team members and task forces in a manner that allowed for developing ideas, necessary projects (the veterans survey), recommendations and action required to implement a 3-year pilot program to test a one transitional network of care model.

4. The Public Outreach and Awareness Function (The Force 50 Brigade): This function assisted in identifying healthcare resources in all 77 Oklahoma counties and assists in keeping the Oklahoma veteran’s community informed of the pilot program activities and important information. This function also assisted in organizing support for implementing the pilot program through the Force 50 Brigade. This function will remain operational during the test period.

THE PILOT PROGRAM ACTIVITIES TIMELINE:

A pilot program timeline was developed to assist the program leadership in establishing benchmarks necessary to move all activities and functions forward in an organized and deliberate fashion.

The timeline created four phases. Each phase would serve as a level of completion for specific areas. The following is a breakdown of each phase in the pilot program process.

PHASE 1

I. Initial Organizational Activity Begins -- 10/1/15
II. Pilot Program Kickoff – 9/13/16
III. First Steering Committee Meeting – 9/22/16
IV. Task Force Meetings Begin – 9/29/16
   • Task forces met every week for 8 weeks
   • Task forces were:
     1. Business Task Force
     2. Government Task Force
     3. Veterans Task Force

PHASE 2

V. Joint Task Force Begins – 12/15/16
VI. Veterans Survey Kickoff
   • Governor Mary Fallin Press Conference – 6/6/17
VII. Legislature Passes Senate Concurrent Resolution 6 (SCR6)

PHASE 3

VIII. Begin Work on Preparing Final Report of the Oklahoma Veterans Pilot Program for the Governor, Legislature, and Congressional Delegation – 1/1/18
IX. Outreach Program (Force 50 Brigade Public Awareness) Begins – 9/1/17
   • Outreach Program Runs Concurrently with Phase 2 and 3.
X. Force 50 Created 11/14/17
Foundation supports the mission of the Oklahoma Department of Veterans Affairs and provides emergency assistance to all Oklahoma Veterans.

- Goal is to raise $50,000 before – 5/1/18

XI. First Annual Veterans Service Awards Banquet 5/10/18

PHASE 4

XII. Final Report Completed 9/2018

XIII. Target Date for Meetings with the Following – 12/2018
- Secretary of the Office of Veterans Affairs of the United States
- The President of the United States

XIV. Approval for Pilot Program Funding Target Date – 4/2019

XV. Oklahoma Veterans Pilot Program is Implemented 10/2019

Section 2: Public Awareness and Outreach

The second primary function of the Oklahoma Veterans Pilot Program was the Public Awareness and Outreach Service Component. This function operated as the Force 50 Brigade.

The Force 50 Brigade consisted of 50 well-known Oklahoma entertainers, sports figures, and professionals from the film and music industries. Their role was to assist in publicizing the program efforts to develop a transitional network of care model designed to deliver quality healthcare to veterans statewide.

Subsequently, there were three secondary functions established to manage the services and organizational requirements of the Force 50 Brigade. They were identified as:

1. Informational Structure
2. Outreach Activity
3. Support

INFORMATIONAL STRUCTURE:

The informational structure was organized to accomplish two tasks. The first task was to ensure that information flowed out to the statewide veteran’s community and was capable of receiving comments and input from all interested individuals, groups and population segments. The second was to create a statewide county network to identify healthcare resources and assist in communication efforts beyond the veteran’s community.

To address the complex issues of accomplishing both tasks, the pilot program organizers determined each task should be managed independently but housed under the Force 50 Brigade as two separate leadership teams.

Veterans Leadership Team
The first leadership team was established as Victor Company. This team consisted of seventeen (17) recognized veterans service organizations (See Appendix II)

Victor Company members assisted by keeping their service organization members informed of the pilot program activities, encourage veteran survey participation, gather individual veteran comments and publicize the pilot program progress.

The second leadership team consisted of one or more county chairpersons in all 77 counties of Oklahoma. The County Organizational Leadership Team assisted the program efforts by identifying healthcare resources in each county and assisted in providing contact information and communicating pilot program activities to healthcare professionals and the general public at large.

The volunteer county chairperson was asked to organize each county and determines the availability of the following healthcare and other related resources:

**County Organizational Leadership Team**

The county chairperson worked to:

1. Identifies and develops a team of community and county leaders that will assist in coordinating and communicating program information.
2. The team will include, but not limited to the following:
   - Healthcare professionals
     - Hospitals
     - Nursing homes
     - Home health agencies
     - Health clinics
     - Rehab facilities
     - Mental health services
   - Education leaders
     - Common Education
     - Higher Education (if applicable)
     - Career Tech (if applicable)
   - County Commissioners
   - County health department
   - City officials
   - Media professionals
   - Legislative leaders
   - Business leaders (includes Chamber of Commerce)
   - Civic leaders
   - Non-profit association leaders (if applicable)
   - Legal professionals
   - Spiritual leaders
   - Veterans organization leaders
Each leadership team would provide significant information to assist the pilot program organizers during all phases of the development process.

OUTREACH ACTIVITY:

This secondary function of the Force 50 Brigade was established to reach the veterans community and inform the general public of Oklahoma. Several ways of accomplishing this function were identified and made operational.

Speakers Bureau – This activity was designed to reach the public on a face-to-face basis and utilize local print and electronic media when possible. Members of this group included legislators, program leaders, Force 50 Brigade members and community leaders. The primary targets were civic clubs, veteran's groups and chambers of commerce.

Electronic Media – This area focused on reaching larger audiences with specific messages. Participants included program organizers and individuals well-known in the veteran’s community.

The scheduling of media opportunities was primarily accomplished by the Public Information Officer of the Oklahoma Department of Veterans Affairs and the Communications Directors of the Oklahoma Department of Mental Health and Substance Abuse Services.

Several local television and radio stations participated. Press conferences and specific television show segments were also utilized in the process. Public Service Announcements (PSA) were also created to assist with the veteran’s survey and other program projects. (See appendix III)

In addition, social media efforts were made to encourage public participation and invite comment. Social media was also used to publicize program websites that were created. (See appendix IV)

The Oklahoma Veterans Survey – Rather than depend solely on existing survey data and informational resources, the program organizers determined an Oklahoma specific survey was necessary to identify the unique healthcare issues of Oklahoma Veterans and lack of source and access within specific geographic areas of the state. Refer to Section 3: The Data Component for more detailed information, findings and media involvement.

For this activity, a PSA was produced and a press conference held to introduce the survey to Oklahoma Veterans. (See appendix V, Va, Vb, Vc, & Vd)
The survey was conducted for 60 days with efforts to publicize the activity on a bi-weekly basis. Media outlets were targeted in the Oklahoma communities of Oklahoma City, Tulsa, Lawton, Ardmore, Ada, Muskogee and the neighboring communities of Ft. Smith, AR and Wichita Falls, TX.

**The Oklahoma Veterans Registry** – In May of 2017, the Oklahoma Department of Veterans Affairs was given the task of creating a registry for Oklahoma veterans and granted authorization to promulgate rules. This registry will play a major role in assisting the pilot program with identifying potential participants, assisting in communicating information and improving the accuracy of veteran’s data and accountability.

The pilot program organizers plan on utilizing the registry during the implementation phase of the pilot testing period.

**Legislative Activity** – There were two components required in addressing legislative activity. The first was an initial effort to inform and educate legislative leaders as to the purpose and need to improve Oklahoma veteran’s healthcare issues.

This component was accomplished by providing legislative leaders printed information and face-to-face meetings to answer questions and receive comment and input toward resolution. The program leaders also made themselves available for related interim studies and committee meetings when appropriate.

It was important for program leaders to involve several legislators on program task forces and utilize their expertise on the speaker’s bureau activities when possible. These legislative leaders were a bi-partisan group committed to solving healthcare issues facing the veteran’s community.

The second component was passing legislation the program organizers believed to be essential in preparing the state for pilot program testing. These legislative efforts were as follows:

**Senate Concurrent Resolution (SCR)6:**
SCR 6 was passed in April of 2017 demonstrating support for the Oklahoma Veterans Pilot Program and recognizing program efforts and progress in addressing veteran’s healthcare issues. (See Appendix VI and VIa)

**House Bill (HB) 1198:**
HB1198 was passed in May of 2017 establishing the Oklahoma Veterans Registry and authorizing the promulgation of rules. This was an extremely important step in building a strong foundation for the Oklahoma Veterans Pilot Program. (See Appendix VII)
Senate Bill (SB) 1053:
SB 1053 authorized the Oklahoma Department of Veterans Affairs to obtain certification through the Centers for Medicare and Medicaid Services to accept payments and reimbursements for services provided at all seven Oklahoma Veterans Centers. This bill was passed in May of 2018. (See Appendix VIII)

Senate Bill (SB) 931:
SB 931 was also critical to the pilot program foundation. This bill authorized the Oklahoma Department of Veterans Affairs to accept gifts, donations, grants and more.

This will allow the Oklahoma Veterans Pilot Program to seek grant funding for the program testing period. In addition, this action assists in clarifying the activities of the Force 50 Foundation, a 501(c)(3) organization supporting the mission of the Oklahoma Department of Veterans Affairs. (See Appendix IX)

SUPPORT:
The remaining secondary function under the Public Awareness and Outreach service component was organized as “Support.” The Support section was identified publicly as the Force 50 Foundation. (See Appendix Xa)

The Force 50 Foundation is a 501(c)(3) organization, born of the Oklahoma Veterans Pilot Program to serve the emergency needs of veterans and directly support the Oklahoma Department of Veterans Affairs and their mission of caring and assisting all Oklahoma veterans. In addition, the foundation will also support other veterans service organizations in their efforts to serve the veterans community.

The foundation is committed to serving those in need by directing funds to:

1. Improve the quality of life for terminally ill and/or home bound patients and their families through the provision of needed care or services, special wishes, and community education of hospice services.

2. Veterans and their dependents requiring care or services, special assistance, and community education of veterans’ healthcare services in cooperation with the Oklahoma Department of Veterans Affairs.

3. Outreach services and public awareness programs designed to educate private and public-sector entities and individuals dedicated to serving the health needs of Oklahomans and the Oklahoma veterans; community in cooperation with the Oklahoma Department of Veterans Affairs.

Please refer to the following appendices for additional information:

1. The Force 50 Foundation Brochure (Appendix X)
2. The Inaugural Veterans Service Awards Banquet (Appendix XI)
   - Banquet Award Winners
   - Silent Auction Activities
   - Event Pictures

The initial goal of the event was to demonstrate through participation, a statewide, broad based support for the pilot program by individuals, businesses and cities across Oklahoma. Participation by businesses and communities was critical in seeking federal support.

The foundation banquet awards included individual citations for services and support, corporate award, non-profit award, higher education award, veteran's friendly community award and others. Also, former Governor George Nigh presented the George Nigh Lifetime Achievement Award and Governor Mary Fallin presented the Oklahoma Medal of Freedom.

The Force 50 Foundation banquet will be an annual event. It will also play a major role in recognizing pilot program providers and participants during the three-year testing period.

Section 3: The Data Component

The data component to the pilot program organizers was considered a vital piece of information. This section was organized into four collection zones. These zones were as follows:

Zone 1 – General Data: This information was used to assist in identifying such items as state rankings, national numbers, etc.

Zone 2 – Clinical Data: The data collected under this zone was used to compare costs of services within the state and national cost comparisons. It also served to identify mental health services, VA locations, FQHC locations, and miscellaneous clinical data as needed.

Zone 3 – Demographic Data: This information allowed for comparisons in veteran's populations, county populations and state demographic data.

All of the information used from the above zones are identified throughout this report by references to appendices and other sections.

Zone 4 – New Data or The Oklahoma Veterans Survey – This information was critical to identifying current healthcare issues and demographic data. Therefore, the following is an in-depth review of the Oklahoma Veterans Survey.
Oklahoma Veterans Survey Overview

During the course of the activities overseen by the Joint Task Force, it became apparent that a statewide survey of veterans was required to validate their predicted attitudes toward the ease and quality of access to health care.

As the work of the government, business, and veterans task forces was synthesized, four dominant theses emerged that were subsequently approved by the Steering Committee for exploration in a statewide survey:

1. Is information easily found on health care services and options for Oklahoma’s veterans?
2. Do rural and urban veterans have equal ease of access to health care services?
3. How satisfied are they with this access?
4. Are combat and non-combat veterans equally satisfied with access?

Coordinating the survey as co-principal investigators from the University of Central Oklahoma were Mark Kinders, Ed. D., vice president of public affairs, and Pilot Project Co-chair, and Tracy Morris, Ph.D., professor of mathematics and statistics, and vice chair of that academic department at UCO.

The investigators followed the standard practices under the approval process of the UCO Institutional Review Board and were designated IRB No. 17087 for a research survey involving human subjects. The UCO IRB Board retains oversight of this project, which remains in state with the expectation of future research as a Memorandum of Understanding is approved for the Pilot Project. Future studies will be conducted as longitudinal research panels with follow-up surveys to the more than 1,100 veterans who voluntarily offered their email addresses for future information about the study.

To initiate the survey, a review of the literature was conducted to determine if other states or individual research projects had occurred from which a survey instrument could be adapted. None was found. One survey was provided to the researchers by the U.S. Department of Veterans Affairs. This was a national survey on health care services previously conducted by the Veterans of Foreign Wars. Demographic profile questions were borrowed from that survey.
The instrument that was drafted (see Appendix XII) consisted of 25 questions. Estimated completion time was 7 minutes, hence the survey promotional title of “Take 10.” This title refers to a military maxim of taking a 10-minute break.

Participants to the survey were guaranteed anonymity. The survey was distributed randomly, and there was no coding methodology that could lead to the unintended identification of a respondent.

Question types included Likert-scale, multiple-choice, and open-ended. Categories included:

1. Finding helpful information on services:
   a. Sources of information

2. Health care experiences:
   a. Which health care services are most important?
   b. Which factors are most important in choosing a provider?
   c. Frequency and purpose of health care visits?
   d. Are VA services used?
   e. Why or why not?
   f. How far will the respondent drive for health care services?
   g. How many times in the past year has the respondent sought health care?
   h. Where were those services received?
   i. How long did it take to get a non-emergency health care appointment?
   j. How satisfied was the respondent with the wait time to appointment?
   k. Satisfaction with various aspects of access to health care?

3. Demographic profile:
   a. Gender
   b. Military Branch
   c. Military-era served
   d. Combat veteran
   e. Military service connected disability
   f. Home county and zip code
   g. Years served active duty
   h. Age
   i. Income
   j. Marital status
   k. Race

4. Open-ended question on any other comments on access to veteran’s health care services in Oklahoma.
Survey procedures

As a state-wide survey, this project was a comprehensive, complex initiative. Critical elements are synthesized below. For a complete analysis of the methodology and responses, please see the UCO report attached as Appendix XIII.

- Qualtrics was selected as the platform for the survey. This provided three means for electronic participation:
  - Online survey through the dissemination of a URL link.
  - Online access through a QR code attached to all printed materials.
  - Online access through a hand-held device.
- Qualtrics provided complete data that could be accessed and downloaded for all standard statistical analyses.
- Several questions were identified for comparison through wave analysis. With the assumption there would be waves of respondents as publicity generated participation, the analysis was conducted to ensure there was consistency in answering the questions. During the survey, the wave analysis confirmed due diligence to the survey by its respondents.
- Demographic data was researched for each category described and geographic distribution as described in Item 3 above.
- There were five participating partners in the distribution of the survey to their clientele through a Memorandum of Understanding with UCO. These included:
  - The Oklahoma Department of Veterans Affairs.
  - The Oklahoma Department of Mental Health & Substance Abuse.
  - The Oklahoma Association of Home Care & Hospice.
  - Lifespring Home Care.
  - Oklahoma City Variety Care.
- Paper surveys were made available by each of the above organizations for their clientele who did not have internet access. Those surveys were provided to UCO and entered into the Qualtrics database.
- A Beta test was conducted for clarity and relevancy with a dozen randomly selected veterans who were solicited by the MOU partners.
- The survey was made live from June through August 2017 by Oklahoma Governor Mary Fallin.
- As noted earlier in this report, a comprehensive publicity campaign was conducted throughout the survey period including promotional materials, media publicity, and television and radio appearances by Task Force leaders. The latter were conducted in critical markets as responses revealed under-representation by categories of veterans by geographic location or race.

Survey results. For brevity’s purposes, the key highlights of the survey are included in this synopsis. As previously noted, complete analytical data can be found in Appendix XIII.
Demographic profile

A thorough analysis was conducted of the demographic and geographic distribution of Oklahoma’s veterans, with required percentages of participation for each demographic variable. Although a repeated initiative throughout the project was to generate publicity to ensure representation, there were several response challenges:

- There was over-representation, when compared to the general population of Oklahoma veterans, by females, Vietnam veterans, post-Vietnam veterans, Gulf War veterans, and those aged 40-69.
- There was under-representation, when compared to the general population of Oklahoma veterans, to include WWII, Korean War, African-American, rural residents, and those either 18-29 years old, or over 70.
- As a result, statistical weighting criteria was employed for age, race, and location of residence.

Readers of this report should refer to the UCO report in Appendix XIII in which boxplots are presented on the weighted demographic categories. Additionally, where weighting is of significance among the 25 questions, the UCO report indicates the data in both weighted and unweighted forms.

Survey Findings

- A total of 4,170 surveys were opened. Of these, 2,898 surveys were completed and usable. Disqualified surveys fell into one of four categories: spam response, respondent was from outside Oklahoma, less than half the survey was completed; survey was opened but not started.
- Key findings to the four theses were:
  - Access to health care information:
    - Veterans reported a higher confidence in information shared with them through personal communication with other veterans rather than information provided online through service providers or official sources of information.
  - Health Care services sought:
    - Primary health care services were the highest category, at 60.2% of respondents.
    - For mental health care services, female veterans reported nearly double the need as did male veterans, by rates of 12.2% vs. 7%, respectively.
    - Female veterans reported a higher need for specialty care (20.1%), compared to male veterans (14.6%).
    - Younger veterans (18-39 years old) reported a rate nearly four times higher than older veterans (Over 40) for mental health care: 19% vs. 5.1%, respectively.
Older veterans (Over 40) reported five times greater need for prescriptions than younger veterans (18-39 years old): 10.1% to 2.3%, respectively.

Combat veterans reported a greater need for access to mental health care (9.9%) than non-combat veterans (4.3%).

Non-combat veterans reported a greater need for access to prescriptions (11%) than combat veterans (7.1%).

Survey respondents were allowed to select multiple answers among 13 reasons for selecting a health care provider. The top categories with “most important” were:
- Quality of care: 90%
- Insurance coverage: 86%
- Provider reputation: 76%
- Customer service: 73%
- Availability of appointments: 73%
- Cost: 71%
- Notably, “wait times” was selected as “not important” or “somewhat important” by 45% of the respondents.

The median (27.7%) annual frequency of visits was 3-4 times per year. The response range was from no visits to weekly visits. Generally, the frequency of visits by Oklahoma veterans conforms to national data for all patients as reported by the National Center for Disease Control.

Locations for seeking health care over the past 12 months were:
- VA Hospital, 48.9%
- Own physician though private insurance: 34.7%
- Own physician through Medicare/Aid: 25.8%
- Own physician through TRICARE: 24.2%
- VA satellite clinic: 24.1%
- Emergency care: 16.8%
- Veterans Choice Program: 16%

Acceptable driving distances based on Urban, Mixed, or Rural:
- Urban Median: 10-20 miles
- Mixed Median: 21-30 miles
- Rural Median: 41-50 miles

No significant differences were found in the most important required health care services, or the frequency of health care visits, whether a veteran lived in an urban, mixed, or rural location.

Respondents were asked their reasons for not using VA health care. They were offered four choices and were allowed to write-in responses. This question is best understood by reading the responses in the report in Appendix XIII. Briefly:
- 34.5% of respondents chose difficulty of appointments.
- 20% said the locations were too far away.
• 14.4% said they were using other providers (write-in response category).
• 13.1% said the needed service was not provided (write-in response category).
• 11.3% expressed concerns about quality (write-in response category).

Further analysis revealed significant variations in satisfaction with health care services:
• 47% of veterans who use VA facilities reported being satisfied or very satisfied with time to treatment, vs. 75% of veterans who seek treatment through another provider.
• 78% of veterans reported being satisfied or very satisfied with the quality of health care from their private provider, whereas 68% veterans who used VA facilities reported being satisfied or very satisfied with the quality of health care services.
• Veterans who use VA facilities reported accessing health care more frequently (median = 5-11 or more times), vs. veterans who did not use VA facilities (median = 3-4 or more times).

- Combat and non-combat veterans reported virtually identical response rates on their satisfaction. Respondents were given five choices, ranging from very dissatisfied to very satisfied. The average responses on “satisfied” or “very satisfied” between the two categories were:
  • Obtaining prescriptions: 77%
  • Quality of care: 71%
  • Scheduling follow-up appointments: 66%
  • Paperwork to access treatment: 61%
  • Out-of-pocket costs: 59%
  • Insurance paperwork: 57%
  • Time to treatment: 55%

It should also be known that the survey results were also presented to the House of Representatives on October 4, 2017 at an Interim Study Hearing on healthcare access. A complete copy of the slide presentation can be found in Appendix XIV.
THE PROGRAM MODEL AND IMPLEMENTATION PLAN

The State of Oklahoma has always held the American veteran in high regard and worked to address the various needs of the Oklahoma veteran's community. One example would be the seven statewide Veterans Centers providing over 1400 long term acute nursing care beds to deserving veterans. Another example would be the way Oklahoma supports the many military installations and approximately 30,000 armed forces members that consider Oklahoma their home. In fact, veterans and active duty military personnel comprise nearly 9% of Oklahoma’s population. In addition, about 28% of the states service member population are National Guard and Reserve.

Currently, of the States, Oklahoma has the 10th largest veteran population per capita but ranks only 18th among the States for federal allocations for Veterans Administration health care services. Oklahoma has approximately 302,000 veterans of which about 81% or 245,000 are veterans who served during eras designated by Congress as wartime periods. Vietnam veterans make up a wartime veteran population of about 34%, while the post 9/11 segment consists of approximately 40%. It should also be noted that 45% of the Oklahoma veteran’s population is over 65 years of age and that one out of every ten veterans are female. (See Appendix XV).

The above statistical factors and the current veteran’s healthcare service environment led the State of Oklahoma to form the Oklahoma Veterans Pilot Program and explore solutions and mechanisms that could enhance the healthcare services of the federal VA system. It should be noted that the Oklahoma Veterans Pilot Program strongly supports the United States Department of Veterans Affairs and its mission. The program organizers also support the commitment to our veterans and the leadership demonstrated by the Directors of the Veterans Affairs Medical Centers in Oklahoma City and Muskogee, Oklahoma in striving to provide exemplary health care services.

However, with inadequate funding and unmet needs, as demonstrated by the veteran’s survey, the pilot program model and implementation plan that follows is designed to establish a statewide network of healthcare services accessible to veterans when those needs cannot be met in a timely manner by VA Medical Centers or clinics. This model
was designed to ease conditions and allow the VA Medical Centers and clinics to function more efficiently by reducing wait times, improve management of existing resources and continue efforts to prioritize internal clinical and support services.

The following design model and plan for implementation has been developed based on the culture and environment that is the State of Oklahoma and the unique healthcare issues that exist within the Oklahoma veteran’s community. This model and plan has also been designed for a 3-year testing period that incorporates flexibility and assessment feedback loops to modify processes and practices to impact the efficiency and cost effectiveness of the program moving forward.

The end result of the 3-year pilot program testing period will be to present a program model that meets the healthcare needs of all Oklahoma veterans, creates a positive cultural environment within the veteran’s community, improves access to healthcare services across the state and ensures a quality continuum of care. In addition, this program model will demonstrate the value of developing a meaningful and coordinated partnership between the private healthcare sector and the federal and state veteran’s agencies and facilities in Oklahoma.

Furthermore, this program model will create a positive environment for healthcare providers through market-based reimbursement rates and prompt payments of claims that encourages program participation and quality of care. Lastly, testing results will demonstrate the final program model to be more cost effective and efficient in delivering healthcare services to Oklahoma veterans.

The final program model presented is designed to also provide other states with a transportable blueprint for partnering with the United States Department of Veterans Affairs and addressing the unique healthcare needs of any veteran in every state.

The pilot program organizers understand that the following program model and implementation plan outlined has never been attempted anywhere before and, if successful, will offer a major paradigm shift in the way veterans healthcare services are provided. It is also understood that this model will likely receive resistance from some federal and state government entities due to a resistance to change that is a thoroughly documented characteristic found in any large social institution, whether it is in the public or private sector.

However, the pilot program organizers hope the proposed model will be reviewed with an open mind and lead to a principled discussion and serious consideration. The America veteran deserves nothing less.

The Model:

Every state is unique and different when addressing the healthcare needs of veterans. While many states have similarities, no state is alike and, therefore, no state can serve the healthcare needs of veterans the same way.
Each state has a different veteran population, a different total population and varying cultures and ethos service. Each state has an economic base and labor force unique to its people. There are different urban versus rural considerations. In addition, every state has a different gender, race and religious mix that must be considered when developing healthcare objectives, strategies and tactics.

The Oklahoma Pilot Program took the above into consideration when developing the model and implementation plan. The program has developed a model to meet the healthcare needs of Oklahoma veterans, while creating flexibility to use as a blueprint when addressing the veteran’s healthcare needs in other states.

The Oklahoma model incorporates ten components. Each component will require services, management and/or oversight. Therefore, each component will have benchmark performance objectives and outcome measurements. Monthly data collection, analysis, and monitoring reports will be required. These components are as follows:

11. Command and Control
12. Eligibility Criteria and Requirements
13. Service Regions and Resources
14. Outreach Services
15. Core Services
16. Health Information Management
17. Financial Management
18. Payer Sources
19. Transportation Access
20. State and Federal Policy Issues

Command and Control

For purposes of implementing the program plan, command and control of the Oklahoma Veterans Pilot Program will be headquartered at the Oklahoma Department of Veterans Affairs. Daily management and operations oversight will become the responsibility of the Executive Director of the ODVA. The Executive Director will appoint a Program Manager to oversee all aspects of the program and report to the Executive Director.

The Program Manager will also prepare a report and conduct a monthly open meeting with the Pilot Program Review Board to monitor progress. The Program Manager will also provide information to members of the Legislative Oversight Committee on an as needed basis. Both the Review Board and Legislative Oversight Committee are discussed in more detail in the “Plan” segment of this section.

Eligibility Criteria and Requirements

This component outlines the eligibility criteria for veteran participation in the pilot program. Initial eligibility criteria will follow the established categories for eligibility currently being used by the U.S. Department of Veterans Affairs.
However, part of the testing period will be to assist the U.S. Department of Veterans Affairs in evaluating the current criteria and offering recommendations to make improvements in clarifying categories, expediting applications and simplifying processes.

Requirements for veteran participation will also be evaluated. Currently, the Oklahoma Veterans Pilot Program intends to establish three requirements for participation. They are:

1. Meet the eligibility criteria established by the U.S. Department of Veterans Affairs
2. Each participant must sign up in the Oklahoma Veterans Registry; and,
3. Must be a current Oklahoma resident with residency for at least one year.

**Service Regions and Resources**

The Oklahoma Veterans Pilot Program will follow the established regions currently utilized by the claims and benefits division of the Oklahoma Department of Veterans Affairs. Resources identified in a district will be visited by field staff on a regular basis to determine support needs and identify any issues that may arise. Additional detail is provided later in this section.

**Outreach Services**

The outreach component of this model will promote public awareness and provide program information to the veteran’s community. One part of this effort will be to build on the established Force 50 Brigade initiative. The program will utilize networks currently established by the Veterans Leadership Team and the County Organizational Leadership Team. Both entities will assist in providing accurate information to the veteran and serve as an intermediary to relay information from veterans to the program manager.

A second part of outreach services will be an awareness campaign promoted through a comprehensive marketing program. This part will include website creation, social media marketing, paid media acquisition, and publicity.

The comprehensive digital marketing goals for the Oklahoma Veterans Pilot Program will include increasing the programs online conversions/sign-ups for the services of the program and delivering measurable results.

This will be accomplished via the following services:

**Front End Website Creation:**

The creation of the UI/UX and content of Oklahoma’s Veteran Program website which is mobile responsive. The design will be done by leveraging best practices in increasing user engagement and organic rankings within Google. This effort will not include any backend system or webpages where the end user is interacting/using the products and services offered by the Oklahoma Veterans Program. Also, it will incorporate assistance from subject matter expert from the Oklahoma Veterans Program who can help with messaging the accuracy of content. Preferably, someone that possesses final sign off
capabilities. Monthly reporting will be provided by Google Analytics which will provide website traffic, engagement statistic, and data related to the demographic profile and location of program users.

Front End Website Creation Process. Signoffs will be provided by the Program Manager for each implementation stage:

- Wireframes
- Development of UI/UX
- Design Mock-ups
- Front End Coding
- QA Testing and submission of results
- Go Live

Social Media Marketing:
Management of the Oklahoma Veterans Programs Facebook environment which will include the creation and posting of content to drive engagement. The procurement, management, production of targeted Facebook ads and first responses to users. It will prompt them to visit the Oklahoma Veterans Program’s website or call the appropriate ODVA phone number for assistance. Monthly reporting will consist of impressions and engagement.

Paid Media Acquisition
A vital component of the digital marketing approach for the Oklahoma Veterans Program is paid media acquisition. This will consist of the creation of advertisements which will be distributed via targeted campaigns on Google AdWords and other websites which Oklahoma Veterans visit on a regular basis. This may include sites similar to: AmVets; Association of Iraq Veterans of America; Military.com; The Military Wallet; RallyPoint; and Military & Veterans. Monthly reporting will consist of leads generated through these efforts.

Remarketing:
This aspect of the strategy revolves around “search” and “behavioral” remarketing. “Search” remarketing will consist of display ads in content networks. An example is users who have searched and keywords related to the targeted keywords which the Oklahoma Veterans Program is leveraging through Search Engine Optimization routines. Also, the Program will continue to market to users who submitted their information via other marketing avenues through a consistent email drip. Finally, the Program will remarket to users who visited its website through display banners via a third-party content network. The network of partners would be similar to the organizations listed above or through additional state-based organizations. Monthly analytic reports will consist of impressions and engagement.

Projected Staffing Requirements:
Total Head Count: 7 individuals:
- Project Manager/Team Lead
Digital Marketing Specialist
(2) Content Marketers
(2) Writers
UI/UX Developer

**Anticipated Annualized Average Monthly Media Spend:**
$40,000 (Google AdWords; Facebook; Remarketing/Third Party Websites)

**Anticipated Tools:**
Google AdWords
Google Analytics
Sail Thru – email
Centralized Reporting Platform

The Oklahoma Veterans Pilot Program has already created two websites in preparation for the program testing period. Those websites are:

1. [www.okvetshealth.com](http://www.okvetshealth.com)
2. [www.force50foundation.com](http://www.force50foundation.com)

Accountability benchmarks and survey research will also play a vital role in the Outreach Services component. The funding requirement outlined below can also be reviewed in the Program Budget sheet found in Appendix XVI and XVIa.

The University of Central Oklahoma will have primary responsibility for establishing and monitoring accountability measures for the Pilot Program.

This will be accomplished through a Center for Health Care Analytics to be housed at UCO and staffed by a project coordinator, affiliated faculty, staff, and student research assistants. The Center will have three primary responsibilities during the life of the Pilot Project, and beyond.

First, it will establish benchmarks of performance as described in the Pilot Project report and in further consultation with key constituent private and government sector stakeholders. This will include the annual establishment of measurable objectives to be monitored for achievement.

Second, it will conduct longitudinal surveys of veterans and other key constituent groups with the purpose of measuring changes in behavior and attitudes as the program is implemented. It also will measure attitudes and behaviors of health care providers.

Third, the Center will analyze the data to assess if measurable targets have been achieved or if attitudes and behaviors have changed. Based on the research outcomes, the Center will provide a feedback loop for adjustments to the program, as required, to achieve project goals and objectives. It will issue periodic and annual reports as required by the Project MOU.
UCO projects a total budget requirement of $8 million to be distributed:

- Year 1: $4 million
- Year 2: $2 million
- Year 3: $2 million

The general categories of expenditure are to include:

- Secure hardware and encrypted software to gather and analyze program data.
- Center staff to include a director and consulting experts in such areas as: information technology, sociology, psychology, and student research assistants.

In addition to the overall benefit to monitoring the Pilot Project’s success, there are these additional indirect residual benefits.

- The Center Structure and function will serve as a transportable model to other states that seek to replicate the Oklahoma Veterans Pilot Program.
- The analytics processes will present extensive opportunities to develop case studies for university students across a broad spectrum of health-care disciplines. This will strengthen the ability of students to be exposed to and master applicable concepts and be transformed in their appreciation for resolving real-world problems of providing effective and efficient health care services.

**Core Services**

This component has been developed to support the U.S. Department of Veterans Affairs efforts in providing timely access and a broad scope of service. The core services of the Oklahoma Veterans Pilot Program are considered as an additional option for healthcare services and will be provided by contracted private sector healthcare professionals, clinics, facilities and entities required to meet the access and delivery of service statewide.

There will be five specific areas of service offered in the program. They are:

1. Triage Services – these services will include emergency, acute, chronic, behavioral and long term post-acute care.
2. Emergent Care – these services will provide timely access to care for emergency or after hours medical needs.
3. Continuum of Care – the pilot program network will include physicians, facilities and locations accessible to veterans to promote timely services. Participating network members will include services in primary care, specialty care, behavioral care, hospitalization coordination,
4. Transition Services – this will involve program navigators to assist in coordinating the transition of services between providers.
5. Telehealth Network – Telehealth services include the capability for asynchronous and real-time monitoring of vital signs and other biometrics for the most fragile veterans. The purpose of this monitoring is to facilitate early intervention and avoidance of hospitalization.

These services will be coordinated through home care agency participants and are anticipated to include real-time inter-facility services, real time residential-to-facility services and have a storing and forwarding capability regarding online consults and referrals. Program services will include specialty visits and educational services.

Points of entry for veterans participating in the program will be made available to conduct assessments and gather specific information as needed and when appropriate. Those points of entry will be the Comprehensive Community Addiction Recovery Centers (CCARC), the Community Mental Health Centers (CMHC) and the Oklahoma Community Health Centers (OCHC), which are Federally Qualified Health Centers (FQHC).

The CCARC availability includes 18 locations across the state, while the CMHC’s availability includes a total 89 locations. Both the CCARC and CMHC locations provide behavioral and addiction services.

The FQHC’s will provide a broad base of services and the pilot program intends to test payment and care models in year two and three at select FQHC locations. These locations will be identified during year one and will focus on Coordinated or Managed Care versus the planned fee for service model.

By design, Oklahoma’s community health centers serve areas of Oklahoma where health care services are limited. They serve Oklahoma’s designated Medically Underserved Area and Populations. In 2017, these private, non-profit organizations provided medical, dental, behavioral health, and a number of supporting services to over 220,000 patients. The 20 health center organizations in Oklahoma provide services via a network of nearly 100 locations around the state. With the development of health centers over the last fifteen years, most of Oklahoma is now within 30 minutes of a health center service location. Health centers report on a number of financial and clinical quality metrics, participate in continuous quality improvement activities, and, in recent years, have built a system of sharing quality data and participated in Health Information Exchange. This provides the opportunity for stronger coordination of care, improved patients outcomes, and greater health care system efficiencies.

Under Medicare and Medicaid, community health centers are paid via Prospective Payment Systems (PPS). In Medicaid, the PPS is developed by using a cost report to ascertain the total cost of service to Medicaid patients in an initial year of service. That total cost of care for all health center services is divided by the total number of face-to-face encounters with a list of qualified provider types. That effectively bundles costs of service and is paid when service is delivered at a fixed rate per encounter regardless of which services are provided. That rate is inflated annually based on the Medicare Economic Index to account for changes in overall costs of providing service over time.
Health centers also have the opportunity to amend their PPS rate by cost reporting due to changes in their scope of services provided. Further, within the law regarding Medicaid payments to health centers, they may also participate in alternative payment models (APMs) that are agreed upon both by the payor and individual health centers.

The plan will be to develop a similar PPS payment system for health centers in the Pilot Program to ensure costs are covered for these safety net providers while providing a system of timely services – this includes all health center services which may include supporting services such as transportation or other items necessary to ensure veterans access to preventive and primary health care. The test would also authorize opt-in APM(s) with PPS payments as a minimum payment backstop. Health centers would be able to individually elect to participate in an APM. An APM for health centers may involve monthly capitation payments and may include incentive payments for meeting certain benchmarks of care coordination, quality measures, or demonstrated system savings.

**Health Information Management**

This component will require coordination and communication between private sector contractors and government health information systems. In order to reduce duplication of service costs and manage veteran health information, certain agreements must be put in place and security measures established.

The health information management services will include health information portability, eligibility, prior authorizations and information exchange.

Use case examples are as follows:

1. Referrals
2. Case Management
3. Care Coordination
4. Care Transitions
5. Re-Admissions
6. Triage

In addition, it will be important to establish an inter-operability between the VA health exchange, the state HealthEOklahoma System and the private sector services the program intends to use as contract services.

**Utilizing Health Information Data to Coordinate Care, Reduce Costs, Improve Outcomes and Provide Accountability**

Selecting a successful Oklahoma Health Information Exchange (HIE) to integrate into the Oklahoma Veterans Pilot Program is essential to managing this program’s success, improving health outcomes for veterans, reducing costs, and providing accountability through quantitative measurements.
Successful integration of an Oklahoma HIE would allow the Pilot Program to connect with thousands of different providers within a community-wide information system that will assist in:

- Reducing health care costs associated with redundant testing, hospital admissions, and emergency department visits,
- Improving care coordination during transitions between health care settings,
- Improving patients’ experience and ability to take control of their own health,
- Improving quality care for the state of Oklahoma, and
- Bringing community leaders and organizations together to utilize health information in meaningful ways to improve community care.

Oklahoma’s largest HIE is successfully deployed throughout Oklahoma’s health care sector, providing secure data exchange, quality measurement and alerting to providers and other healthcare stakeholder thousands of times every day. As the convening organization, this HIE has enabled providers and payers participating in the Comprehensive Primary Care Initiative, a CMS demonstration project, to achieve improved quality and 4-7% reductions in the cost of care, which represents nearly 95% of the savings achieved by the entire national program.

In addition to helping to manage, coordinate and track traditional medical care, an HIE is being used to refer and coordinate services for social issues like addiction, post-traumatic stress and homelessness, for instance. Oklahoma’s HIE is an important asset that should be leveraged as a part of any value and quality driving initiative, because of its broad connectivity and data availability, advanced analytics, and proven track record of supporting successful innovative payment models.

**Financial Management**

The financial management component will include the management of the $250 million program allocation. Those funds will include administrative projections of 12% or $30 million of the total allocation. (See appendix XVI). The administrative projections estimated are expected to decrease over the course of the three-year period. We anticipate some costs may be picked up by several participating agencies as the program proceeds.

The major part of this component will be the payment of claims submitted by the participating network providers.

It is expected that the pilot project will push the envelope on established processes. In order to establish credibility as a viable challenger to the status quo, it is expected that new methodologies will need to be developed within the existing processes. Culture changes are seen as a threat to the success of the pilot program. An option will be to utilize existing processes already available to Oklahoma citizens.

Many programs across the State offer to pay for medical services in some form or fashion. Obviously, the ODVA has a network and processes to pay for medical services. In
addition, the State has a network of doctors and a structure to pay for medical services through the HealthChoice networks with OMES/EGID Division. The Oklahoma Health Care Authority also has a network for medical services. It is more efficient for several of the smaller agencies to piggyback off of these specialized services than internally house medical service and claim adjudication.

To the extent of the pilot, it is planned that the pilot program utilizes non-competing processes. This will allow for the pilot to maintain clarity of scope, perform unbiased evaluation of processes and provide accurate measurements of outcomes for veterans and providers.

The program is actively working to establish a partnership with an agency that can offer the full spectrum of financial processes. This spectrum would include an established MOU process and rate structure, pre-authorization of services to the provider for the veteran, the adjudication of claims from the provider and the resulting payment to the provider within 30 days of claim submission.

Monthly data would be transferred from an existing case management system to the independent data analytics team. Accounting services, receipt of funds, and reconciliations would be performed by the hosting agency. The hosting agency would be allowed to charge a negotiated indirect rate on the allowable program expenditures.

To facilitate the navigation of services to veterans, the pilot program is also planning to utilize existing networks. Private networks of activity are already established within the communities across the State. Providers that already service a community could bid for an area to be responsible for services to veterans within the county. It is expected that these providers would already have credentialed staff to authorize for care related medical services. Examples would be home health agencies, independent Licensed Professional Counselors or Durable Medical providers.

County assignments would be awarded through a competitive process, but with a set rate for those eligible and enrolled on the Veteran Registry. The proposed objective is that enrolled veteran will be seen by the navigator within five business days after contact and receives an appointment for services within 20 days of authorization.

The rate is designed to incentivize the navigation provider to establish an efficient local outreach services to enroll eligible veterans into the program. The number of eligible veterans would allow for the navigation services provider to manage caseload sizes to meet contract goals.

While final partnerships have not been established, this section is intended to identify the thought and planning has been applied to local outreach, case management, data analytics and reporting, claim adjudication and payments.
Payer Sources

While many pay sources were considered as secondary sources, it was concluded that veterans participating in the pilot program would be 100% covered with no out of pocket expenses required. All claims submitted by the program network providers would be paid by and through the funds allocated to the Oklahoma Veterans Pilot Program.

However, the program intends to explore the possibility of increasing the veteran’s eligibility criteria to some not currently eligible.

In year two or three, an additional insurance option requiring a small monthly premium may be considered. If successful through testing, this additional option would provide a renewable revenue stream for the program.

A program can be developed similar to Insure Oklahoma that will use the funding available to subsidize premiums in the fully insured marketplace.

At some point, hopefully in the not too distant future, a plan would be developed to create a self-funded program. This will allow the program to take advantage of some of the innovations happening in that arena such as “medical cost transparency” and “Market based reference pricing.”

Transportation Access

The transportation services will be limited in the beginning of the testing period. Current transportation resources and modes will be used. However, several areas will be tested for viability efficiency and cost effectiveness.

Such areas may include establishing access points, telehealth options, vouchers and competitive contracts. Coordination and a statewide system of multiple agencies and services will also be considered.

State and Federal Policy Issues

This component will examine existing rules, regulations, policies and statutes directly impacting veteran access to care and identify barriers to providing quality healthcare and access to services. In addition, the program will also identify policies, rules, regulations and statutes that create difficulty in providing cost effective and efficient services with the intention of modification as appropriate.

The Model in Brief

The Veterans Pilot Program will be housed at the Oklahoma Department of Veterans Affairs and be given management oversight of the testing period.

The model will establish four service regions. The Northwest Region will have four districts, the Northeast Region will consist of three districts, the Southeast Region with four districts and two districts in the Southwest Region. Each region will have from two to four navigators to assist in coordinating care and case management.
These regions are intended to follow the established regions and districts already operational within the claims and benefits division of the Oklahoma Department of Veterans Affairs. The Veterans Service Officers (VSO’s) assisting veterans statewide with benefits issues will assist the Regional Navigators when appropriate with contract information on veterans and resources within each district.

The healthcare services in each region will be multi-disciplinary and be accessible to veterans in their geographic area of the state. More providers will be encouraged to participate in areas where greater veteran populations exist, thereby creating more healthcare options and accessibility choices.

Management of services, and coordination processes will vary by region based on veteran’s populations and provider participation. The goal will be to access healthcare services within 20 calendar days for routine appointments and within 24 hours for emergent care issues. Coordination of referrals to specialists will be made within 3 business days with the veteran’s knowledge. Referral appointments will also be secured within 20 calendar days to one of several participating providers.

The pilot program organizers have established a veteran’s appointment standard of 20 days due to concerns over wait times and survey findings. The Oklahoma survey showed only 47% of veterans were satisfied with their time to appointment, while 72% were satisfied with appointments to private healthcare providers.

- Each participating provider can be an individual a clinic or facility. Each provider will be required to sign a Memorandum of Understanding (MOU) setting out certain requirements and rate agreements. Therefore, the program organizations will know in advance what services will be provided, where those services will be provided and the cost of each service or procedure.

In addition, pre-authorization will be obtained as a general rule. Guidelines will be developed in advance to assist the program and the provider. Additional detail is provided under the implementation plan section that follows.

The model also establishes standards to encourage provider participation. Service rates will be at or about the current Medicare rate. In addition, the pilot program will process and pay the provider claim within 30 days of receiving the invoice.

In short, the program model developed will accomplish the following:

1. Management and control residing at the state level will create a more efficient system, improve response time to issues that arise and provide for better communication and coordination of service.
2. Create greater healthcare accessibility
3. Establish a broad multi-disciplinary provider base through fair market-based rates and timely reimbursement.
4. Establish timely appointments for veterans with timely referral appointments made for the veteran.
5. Demonstrate cost effectiveness and network efficiency through outcome measures.
6. Create a positive healthcare experience.
7. Provide a transparent pilot program.
8. Demonstrate this change in healthcare delivery can be cost effective for the U.S. Department of Veterans Affairs
9. Create a health information management system that promotes quality of care and reduces duplication of service.
10. Reduce and streamline application processes and steps to service, while identifying and offering solutions to regulations and rules that negatively impact service access.
Goals for the Veterans Pilot Program

Right Care

Veteran

Right Time

Right Cost
The Plan:

While the initial research activity, program development, and model design concludes with the Final Report to the Governor, the implementation plan and testing period prepares to be initiated. Upon federal approval of the pilot program and funding, a three-year plan to test the pilot program model will begin.

Daily oversight and management of the Oklahoma Veterans Pilot Program will be placed at the Oklahoma Department of Veterans Affairs (ODVA.) The Executive Director of the ODVA will designate a manager to assume daily management responsibilities of the program.

The program will be kept independent from regular ODVA operations and a separate account will be established to receive and disperse program funds. This function is outlined in more detail under the Financial Management section of the plan.

Organization and Network

The organizational leadership and management of the pilot program will incorporate a manager with specific responsibilities outlined. Those responsibilities will include the management of daily operations, oversight of the provider network and the coordination of services.

The manager will also maintain communication and coordination between the ODVA and the University of Central Oklahoma, a program partner responsible for maintaining and analyzing research activity, conducting additional surveys and reporting information on outcome measures.

A pilot program Review Board will be established to review provider applications, veteran’s eligibility activity, provide guidance on operational issues, discuss modifications to program processes and practices, review survey findings, review monthly outcome measures, and review monthly claims activity to ensure standards are being met.

The membership of the Review Board will consist as follows:

- Representative, Oklahoma Veterans Council
- Commissioner, ODMHSAS or designee
- Director, VAMC, OKC or designee
- Director, VAMC, Muskogee or designee
- President, UCO or designee
- Member, OK House of Representatives (appointed by the Speaker)
- Member, OK State Senate (appointed by the President Pro-Tempore)
- Governor Liaison, Office of the Governor (Ex-Officio/Non-voting)
- Private Sector Healthcare Professional appointed by the Governor
- Private Sector Healthcare Professional appointed by the Governor
This 9-member Review Board will meet monthly and receive all appropriate reports from the program manager. Appropriate reports will include activity summaries from all 10 program components, financial reports, claims reports and outreach activity.

The Force 50 Brigade organization will remain active during the testing period and assist the organization with outreach activity through the County Leadership Team and the Veterans Leadership Team.

The pilot program network will consist of the participating providers and budgeted support personnel that will serve the program as facilitators. These individuals represent such core services as mental health, homecare, primary care services, and support services such as marketing services, telehealth services, health information support and claims processing activities.

The participating providers within the network will agree to certain services and reporting procedures outlined in a Memorandum of Understanding (MOU) between the program and the providers. It should also be noted that the ODMHSAS, certain homecare agencies, certain primary care agencies and the University of Central Oklahoma will also sign MOU’s outlining responsibilities and reporting procedures.

Action Timeline/Schedule of Activities:

Upon federal approval for the 3-year testing period and commitment to fund the pilot program, the following actions timeline will be established. The timeline to be established will require a six-month start-up period to ensure the program requirements are in place prior to program implementation. Those requirements will include, but are not limited to:

11. Pre-program outreach plan has been organized and marketing efforts implemented.
12. Veterans Registry sign-up period begins immediately and continues through year one of the testing period. Then an annual signup period will be implemented in years 2 and 3.
13. Recruitment and credentialing of Network Providers is finalized within all healthcare disciplines to be utilized and MOU’s signed. It is anticipated that current Tricare provider credentialing will constitute Pilot Program credentialing.
14. Training and orientation includes:
   a. Navigator duties, key metrics and expectations
   b. In-service training sessions monthly for all network providers and support contract services to clarify program processes, billing/claims procedures, overview of program, program timelines and other pertinent issues relevant to implementation.
15. Outcome measures established within each program component and special outcome measures established for program testing that may be required.
16. Pilot Program Review Board members are notified and in-service training is provided on member duties and expectations.
17. Preparation for receiving of funds is finalized.
18. Transportation support services are finalized and a one-day in-service training session is provided.
19. Health information system is finalized a coordination plan is prepared for implementation.
20. Telehealth services are finalized with the leasing company, contract finalized and implementation plan completed.

It is hoped federal approval can be obtained by April 1, 2019 so that the official 3-year pilot program can begin on October 1, 2019, the start of the federal fiscal year. Therefore, year 1 would begin on October 1, 2019 and end on September 30, 2020. Year 2 beginning in October 2020 and ending in September 2021 and year 3 concluding on September 30, 2022.

**Funding**

The Oklahoma Veterans Pilot Program is requesting $250 million to conduct a 3-year test of the Oklahoma healthcare access and service delivery network model. The State of Oklahoma would receive the funds as an allocation from the federally funded Veterans Choice Program of the U.S. Department of Veterans Affairs.

The funding allocation would not be required in a one-time amount, but rather be divided as follows:

- Six-month start-up period $25 million
- Year one $75 million
- Year two $75 million
- Year three $75 million

The program intends to utilize $30 million or 12% of the total $250 million allocation in administrative costs. These costs will be spread out over the 3-year test period and are administrative projections. For more detailed information on the business costs, please refer to the Financial Management component in the previous segment of this section.

Furthermore, upon federal approval of the above program, the State of Oklahoma would phase out in year one, participation with TriWest, the contracted organization currently serving the veterans of Oklahoma in the Veterans Choice program of the U.S. Department of Veterans Affairs.

At no time will veterans participating in the Oklahoma Veterans Pilot Program be discouraged from receiving services at the VAMC in Oklahoma City or Muskogee. Nor will the veteran be discouraged from receiving services at a VA clinic. Again, the Oklahoma Veterans Pilot Program is designed to provide the veteran additional options to on-site VA services.
Accountability

Accountability for this program and allocated funds is critically important. This program intends to make accountability a centerpiece of the testing period and completely transparent.

To that end, the pilot program organizers have established four instruments that will allow for appropriate checks and balances. These four instruments are as follows:

1. Pilot Program Review Board – as previously stated, this 9-member board will meet monthly and have representation from the federal VA, state agencies and the private healthcare community. It will have the authority to review every aspect of the program activities and operations. It will have the authority to review every aspect of the program activities and operations. It will also have the authority to make recommendations on processes, procedures, operations, financial management activities, outreach activities and program outcome measures.

2. Legislative Oversight Committee – members of the oversight committee will consist of four members of the House of Representatives and four members of the State Senate. Each member will be named by the Speaker of the House and the Senate President Pro-Tempore. This committee will conduct an open meeting every three months to discuss the program activities and recommended actions of the Review Board. This committee can request any and all information on the program and require testimony of any individual involved in the program. The committee can also make recommendations and request actions as appropriate.

3. Outside Auditing Team – The program will contract with a professional CPA and auditing firm to conduct two audits every six months after program implementation. The first audit, or mid-year audit, will include recommendations to improve practices, create greater efficiency and identify areas for corrective action. The close out audit, or end of year audit, will conduct a second complete audit and follow-up on recommended actions from the mid-year audit. Each audit conducted will be provided to the office of the Governor, the legislative oversight committee, the Oklahoma State Auditor and Inspector, the Secretary of the U.S. Department of Veterans Affairs and the Oklahoma Congressional Delegation.

4. State Auditor and Inspector – Finally, the Oklahoma State Auditor and Inspector will conduct an annual review of the Oklahoma Veterans Pilot Program. The office will not be limited in the scope of review and subsequent recommendations. A copy of the report will be provided to the Pilot Program Review Board, the Office of the Governor, the legislative oversight committee, the Secretary of the U.S. Department of Veterans Affairs and the Oklahoma Congressional Delegation.

Although some may consider the transparency efforts regarding the above checks and balances to be excessive, the pilot program organizers consider the actions a requirement and necessary in the delivery of healthcare services to veterans.
**Outcome Measures**

Outcome measures will be identified in three areas. Those areas are the 10 program components, the provider network and special programs.

Each area will consider the goals to accomplish when identifying outcome measures. Those goals are listed in the previous segment of this section.

The outcome measures identified and developed within the ten program components will vary depending on each planned activity of the component. While all ten components are considered important, the critical components will be the Core Services, Financial Management, Health Information Management, State and Federal Policy Issues, Eligibility Criteria and Outreach Services.

The provider network outcome measures will be focused on quality of care and duplication of services. In addition, timely access to each provider will be measured and considered critical.

Special Programs identified for testing will also have specific outcome measures developed. One special program under consideration may be in year two when the pilot program will look at Fee for Service versus Coordinated or Managed Care models at several network locations.

**Annual Report**

An annual report will be prepared at the end of each testing year of the program. The report will be completed and published for distribution within the first quarter of each subsequent year.

The annual report will be available on line and a copy be delivered to the Pilot Program Review Board, the Office of the Governor, the legislative oversight committee, the Office of the Auditor and Inspector, the Secretary of the U.S. Department of Veterans Affairs and the Oklahoma Congressional Delegation.
THE RECOMMENDATIONS

Recommendation 1:

That based on findings of the Oklahoma Veteran Pilot Program, the State of Oklahoma should assume management and control of services currently provided within the federally managed Veterans Choice Program.

Further, that state management of healthcare access and service delivery would be more cost effective and efficient when under local control and supervision; and,

That the President of the United States direct the Secretary of Veterans Affairs to:

1. Establish a distinct separation between the Oklahoma Veterans Pilot Program and the Veterans Choice Program for a testing period of three years; and,
2. Designate the State of Oklahoma as the official test site for a state managed veterans pilot program developed for improving healthcare access and service delivery to Oklahoma Veterans; and,
3. To allocate funds from the Veterans Choice Program as proposed by the Oklahoma Veterans Pilot Program.

Recommendation 2:

That the United States Department of Veterans Affairs allocate $250 million from the existing Veteran’s Choice Program to the State of Oklahoma to test a three-year pilot program designed to improve healthcare access, create a more efficient and cost-effective network of care and enhance the current federal VA healthcare system for all Oklahoma veterans.

Further, that the State of Oklahoma be designated the official testing location and that with said designation the U.S. Department of Veterans Affairs will:

1. Allocate funds to be dispersed over a three-year test period as follows:
   - Year 1: $100 million
   - Year 2: $75 million
   - Year 3: $75 million
2. That the pilot program be allowed substantial flexibility within existing rules, regulations and policies pertaining to healthcare access, services and reimbursement processes for providers participating in the pilot program in the State of Oklahoma.
3. That certain federal agencies with related health information on veterans participating in the pilot program be required to share information in a timely manner with participating healthcare providers to reduce duplication of services and maximize cost-efficiency.
That with said designation, the State of Oklahoma will:

1. Establish an accountability system to monitor the use of funds within the pilot program and submit an annual report to the appropriate federal agencies.
2. Create outcome measures to monitor the healthcare provider services, the accountability system used, the veteran population within the pilot program, the health information system established, the healthcare access network, the telehealth network and to include this information in an annual report.

Recommendation 3:
That the Oklahoma Veterans Pilot Program be attached as an independent program to the Oklahoma Department of Veterans Affairs and that the ODVA assume the oversight responsibility of the 3-year testing period.

Further, that the Executive Director of the ODVA assign a Program Manager to provide daily management and oversight of the Oklahoma Veterans Pilot Program.

Recommendation 4:
That the Program Model and Implementation Plan developed in this report be supported and accepted as recommendations for improving timely access, creating a network of transitional care and coordinating medical and behavioral healthcare needs outside the federal VA system.

Recommendation 5:
That the framework for developing outcome measures identified in this report be supported and accepted as recommendations for evaluating program success and creating long term system change.

Recommendation 6:
That the Oklahoma Veterans Pilot Program be directed to assist the VA Medical Centers with identifying obstacles to access and service delivery.

Further, that the VA Medical Centers be encouraged to support assistance from the Oklahoma Veterans Pilot Program with identifying obstacles to access and service delivery.

Recommendation 7:
That the planned outreach services identified and developed be supported and accepted as the primary method of contacting and informing the Oklahoma veterans community.

Recommendation 8:
That a statewide publicity campaign be executed to reach all Oklahoma veterans and encouraged to become a part of the Oklahoma Veterans Registry.
Recommendation 9:
That the Oklahoma Veterans Pilot Program be allowed to test the cost effectiveness and service delivery of fee for service versus coordinated or managed care during the testing period.

Recommendation 10:
That a shared health information system between the federal health exchange, the state system and private sector systems participating in the pilot program be encouraged.

Recommendation 11:
That reducing and streamlining application processes to service be required during the pilot program testing period.

Recommendation 12:
That efforts to enhance the use of healthcare professionals in rural Oklahoma be explored. Further, that the expansion of roles and authority to Physicians Assistants, Nurse Practitioners and Certified Counselors be required to improve healthcare coverage needs in rural Oklahoma.

Recommendation 13:
That efforts to increase healthcare services to female veterans be explored through the testing period of the Oklahoma Veterans Pilot Program.

Recommendation 14:
That the Oklahoma Veterans Pilot Program be allowed to explore the development of an additional insurance option for veterans not currently eligible for VA benefits.

Further, such an option would bring a lower cost monthly premium to a segment of veterans in the Reserves and National Guard. In addition, this option, if determined to be viable, would establish a revenue stream for the program following the test period.

Recommendation 15:
That the Governor of Oklahoma form a delegation to present the Oklahoma Veterans Pilot Program findings, recommendations and program implementation plan to the President of the United States and the Secretary of Veterans Affairs.
THE MEMBERS AND LEADERS OF THE OKLAHOMA VETERANS PILOT PROGRAM

We wish to recognize the many statewide members of the Oklahoma Veterans Pilot Program. These volunteer participants gave of themselves for the good of the program and demonstrated exemplary service on behalf of all Oklahoma Veterans.

Honorary Chairperson: Rita Aragon, MG (Ret)
Former Cabinet Secretary of Veterans Affairs

Special Advisor: Honorable George Nigh
Governor of Oklahoma (1979-1986)

Co-Chairperson: Myles Deering, MG (Ret)
Former Adjutant General, Oklahoma Military Department
Former Executive Director, Oklahoma Department of Veterans Affairs

Co-Chairperson: Mark Kinders, Ed.D.
Vice-President of Public Affairs
University of Central Oklahoma

Co-Chairperson: Karen Vahlberg, RN, BSN
CEO, LifeSpring Home Care

Program Coordinator: Pete Reed, MAJ (Ret)
Former Executive Director, Oklahoma Department of Veterans Affairs (1983-1986)

Membership
Robert McCaffree, MD, OU Health Sciences Center
Jeff Dismukes, Director of Communications, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)
COL Cynthia Tinkham, Oklahoma Military Department
MAJ Sharon McCarty, Oklahoma Military Department
AJ Griffin, Senator, Oklahoma State Senate
Claudia Griffith, Representative, Oklahoma House of Representatives
Chris Kannady, Representative, Oklahoma House of Representatives
Kerry Inhofe, BSN, Nurse Manager, U.S. Veterans Affairs, VA Community Care
Lamar Wilson, Transition Assistance Advisor, Oklahoma Military Department
Ellen Buettner, Attorney, ODMHSAS
Annette Mays, Director, OK Home Care and Hospice Association
Frank Simpson, Senator, Oklahoma Stat Senate
Steve Ramirez, MD, CMO Variety Care
Mike Crutcher, MD, CMO, Primary Care Network
Mark Morgan, Director, Muskogee VA Medical Center
Brent Wilborn, Director, OK Primary Care Association
Nico Gomez, Director, OK Association of Healthcare Providers
Nicole Miller, Legislative Liaison, Oklahoma Department of Veterans Affairs
Rob Arrington, Director, Claims/Benefits, Oklahoma Department of Veterans Affairs
John Wilson, Oklahoma Department of Veterans Affairs
Kerry Mucker, ODMHSAS
Mark Reynolds, ODMHSAS
Wade Vlosich, Director, Oklahoma City VA Medical Center
John Burden, U.S. Veterans Affairs
Teresa Croom, Systems of Care, ODMHSAS
Louis Wilham, BG, Assistant Adjutant General, Oklahoma Military Department
Harry Smith, Chaplain, LifeSpring HomeCare
Rep. George Young, House of Representatives
James Floyd, Principal Chief, Muscogee (Creek) Nation
Dr. Richard Allen, past policy analyst for the Cherokee Nation
Paul Merchant, CW5 (Ret), Oklahoma Military Department
Pete Peterson, Oklahoma Veterans Council
Scott Ellis, Oklahoma Veterans Council
Pat Hall, President, Majority Plus
Rodolfo Alvarez del Castillo, MD, Coordinated Care of Oklahoma
Joe Walker, MyHealth Access Network
Jennifer Hamilton, Veterans Exchange Coordinator, U.S. Veterans Affairs
Robert Swicord, MD, OU Health Science Center
Tabitha Narvaiz, Coordinator, Army One Source
Randle Lee, Oklahoma Alzheimer’s Association
Dennis Statham, CPA
Travis Branch, Humana Healthcare
Chris Radke, Diagnostics Laboratories of Oklahoma
John Miller, Attorney
Jessica Hammack, Oklahoma Military Department
Dr. Tracy Morris, Professor of Math/Statistics, University of Central Oklahoma
Dr. Nichole Kish, Optometrist
Steve Lewis, Attorney, Lewis Law Firm
Bobby Bramlett, Bramlett Insurance Agency
Chad Mathias, Retirement Living
Kris Brinson, Murray County Abstract
Kim Denisoff, Oklahoma City
Larry Click, Attorney
Mike Crews, Crews Insurance Agency
Kevin Statham, Department of Rehabilitative Services
Charles Danley, Director, Grand Lake Mental Health Center
Shane Faulkner, PIO, Oklahoma Department of Veterans Affairs
Terri White, Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services
Ed Pulido, MAJ (Ret), Senior Vice-President, Folds of Honor Foundation
Danna Fowble, Director, Force 50 Foundation
Jenny Schmitt, OANA
John Reid, Oklahoma Business Roundtable
Joel Kintsel, Deputy Director, Oklahoma Department of Veterans Affairs
Sarah Lane, Attorney, Oklahoma Department of Veterans Affairs
Steve Yarger, Comptroller, LifeSpring Home Care
Ginger Ramsey, Executive Assistant to the CEO, LifeSpring Home Care
Ginger Thomas, Business Development Manager, LifeSpring Home Care
Bob Vahlberg, Chief Marketing Officer, LifeSpring Home Care

**Congressional Liaisons**
Will McPherson, Assistant to Congressman Tom Cole
Ashley Wells, Assistant to Congressman Jim Bridenstine
William Barnes, Assistant to Congressman, Markwayne Mullin
Craig Smith, Assistant to Congressman Steve Russell
Allison Litterell, Assistant to Congressman Frank Lucas
Mike Yates, Assistant to Senator James Lankford
Brian Hackler, Assistant to Senator James Inhofe
THE ACKNOWLEDGEMENTS

The Oklahoma Veterans Pilot Program organization wishes to acknowledge the contributions of service and support of a program initiative to better serve the healthcare needs of all Oklahoma veterans.

SPECIAL OKLAHOMANS AND OKLAHOMA BUSINESSES:

Toby Keith, Country Music Artist Award Winner, Actor and Producer

Barry Switzer, former head football coach at the University of Oklahoma and head football coach with the Dallas Cowboys.

Steve Owens, Steve Owens Insurance Group and former Heisman Trophy winning tailback at the University of Oklahoma, who also played with the Detroit Lions.

Tinker Owens, Tinker Owens Insurance and former football wide receiver at the University of Oklahoma, who also played with the New Orleans Saints.

Career Tech
Gold Star Families
Grand Lake Mental Health Center
Harrison Henderson, PLLC
Level 4 Wealth Management
Brigadier General Paul W. Reed, Jr. (In memorium)
RumbleDrum
The Bramlett Agency
Trevor Randle Insurance
United Tissue Network
Valliance Bank
Pam Bloustine, Women Veterans of Oklahoma
Chesapeake Energy
David Griffis
Rusty Griffis
Lori Linney, City of Ardmore
Paige Peterson
Peter Luitweiler
Rep. Kevin Wallace, House of Representatives
Amy Brown, City of Tulsa
Bill Wince
Bill Brewster, former Congressman
East Central University
Patriot Ford, Purcell, OK
Blake and Statham, CPA’s
Veterans Corner
American Top Ten
Giulliano Gallupi, M.SC, fitness expert
Tracy Morris, Ph.D., Professor of UCO
Scotty Deatheridge
Richard Holmes, Attorney
Jacquie Baker
Phyllis Dorough Baker
Will Barnes
Jerry Baxter
Brandy Boggs
Westley Boggs
Brad Boles
Terry Boston
David Bowen
Juli Byrnes
Kevin Cantrell
Bob Cantrell
Natalie Charles
Markia Clifton
Eric Clifton
Scott Clifton
Jordon Cox
Veronica del Moral
Gentner Drummond
Auston Ellis
John Farris
Bob Ford
Stephanie Foster
Erica Fowble
Ginny Fowble
Noel Frederici
Niki Gorham
Duane Guynes
Kay Guynes
Steven Hall
Alyssa Harrison
Sonja Hatfield
Michael Hayes
Sara Hill
Dennis H. Hines
Alfred Hollis
Diane Jones
Gus Jones
Donna Kubowski
James Larsen
John L. Lehmann
Nadine Lewis
Ruth Livingston
Diane Loser

David Mantle
Marilyn Mantle
Joe Mathis
Annette Mays
Chris McKone
Mary Meeks
Paul M. Merchant
Ginger Meyers
Nicole Miller
Linder Miller
Mark Morgan
Richard Morgan
Dennis Morgan
Kelsey Mourant
Will Mullins
Karla Niemann
Paul Odom
Danny Oliver
Oren Lee Peters
Pete Peterson
Myron Pope
Coral Porch, Cmdr, Oklahoma VFW
Dee Porter
Emily Potter
Linda Powell
Ivenhoe Richey
Jonathan R. Rose
Paul Rosino
Mike Russell
Charles Selby
Eddy Shepherd
Scott Smith
Lloyd Smithson
Steven Snyder
Tracy Spencer
J.D. Spohn
Shanna S. Stallings
John Stewart
Ginger Thomas
Kate Tillotson
Scott Tripp
Todd Wade
Brad Ward
Darrell Watts
Catherin Webster
OKLAHOMA GENERALS

Ben Robinson, BG (Ret), USAF
Tony Strickland, MG (Ret), USA
K.C. McClain, MG (Ret) USAF
Richard Hefton, BG (Ret), OKARNG
Lee Levy, LTG (Ret), USAF
Tommy Franks, General (Ret), USA
Jerry Grizzle, MG (Ret), USA
Thomas Stafford, General, USAF and NASA Astronaut
Douglas Dollar, MG (Ret) OKARNG
Bradley Gambill, MG (Ret), USA
Roger Brady, General (Ret), USA

OKLAHOMA VETERANS ORGANIZATIONS

AMVets
American Legion
American Ex-POWs
Disabled American Veterans
Fleet Reserve Association
Marine Corps League
Military Officers Assn. Of America
Nat'l Assn. of Black Veterans
Oklahoma Women’s Veterans Organization
Paralyzed Veterans of America
Rolling Thunder Oklahoma Chapter 1
Special Forces Oklahoma Chapter 32-50
U.S. Sub. Veterans, Inc., USS OKC Base
Veterans of Foreign Wars
Viet Nam Veterans of America
SPECIAL RECOGNITION:

Special recognition is hereby made to the following entities for contributions of resources and in-kind services.

- The Oklahoma Department of Mental Health and Substance Abuse Services
- The Oklahoma Department of Veterans Affairs
- The Oklahoma Department of Rehabilitation Services
- The University of Central Oklahoma
- LifeSpring Home Care
- The Oklahoma Military Department
- Oklahoma Military Hall of Fame
- Cox Communications
- MTM Recognition
- Honoring America’s Warriors
- Folds of Honor Foundation
- Oklahoma Association for Home Care and Hospice
- Oklahoma Primary Care Association
- Oklahoma Veterans Council
SPECIAL TRIBUTE:

The Oklahoma Veterans Pilot Program wishes to pay tribute to Representative Claudia Griffith.

We lost Claudia during the writing of this report and want her family to know how much she will be missed. She was committed to this initiative and her contributions and recommendations are part of this report.

She was passionate about healthcare and especially the need to improve healthcare services to Oklahoma veterans. Her dedication to service and family was exemplary. Her desire to make the lives of Oklahomans better was special.

There will not be another Claudia Griffith. She was our colleague, our teammate and our friend. But most of all – Claudia was our inspiration.

Rep. Claudia Griffith receiving the Force 50 Foundation Distinguished Service Award from Governor Mary Fallin.
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Organizational Flow Chart
II. Veterans Leadership Team/Victor Company
OKLAHOMA VETERANS PILOT PROGRAM

VICTOR COMPANY MEMBERS & ORGANIZATIONS

AmVets
American Legion
American Ex-POWs
Disabled American Veterans (DAV)
Fleet Reserve Association
Marine Corps League
Military Officers Assn. Of America
Nat’l Assn. of Black Veterans
Oklahoma Womens’ Veterans Organization
Paralyzed Veterans of America
Mid-America Chapter
Rolling Thunder Oklahoma Chapter 1
Special Forces Oklahoma Chapter 32-50
U.S. Sub. Veterans, Inc., USS OKC Base
Veterans of Foreign Wars
Viet Nam Veterans of America
40&8
III. Governor Fallin Press Release
FOR IMMEDIATE RELEASE
March 27, 2017

Governor Mary Fallin Announces Outreach for Veterans Pilot Program

OKLAHOMA CITY – Governor Mary Fallin today announced efforts to inform Oklahoma veterans about the Oklahoma Veterans Pilot Program, a private/public initiative to develop a comprehensive health care access and delivery system for the state’s veterans.

A comprehensive outreach program will be spearheaded by the Force 50 Brigade and its two subgroups, Victory Company and the County Chairpersons Leadership Team.

“The Oklahoma Veterans Pilot Program is an important effort to identify best practices in healthcare delivery to ensure we offer the highest quality of care to our veterans,” said Fallin. “Our veterans have made incredible sacrifices for our freedoms, and the least we owe them is superior healthcare that is easily accessible for all. I applaud the formation of the Force 50 Brigade and its subgroups, Victor Company and the County Chairperson Leadership Team, to spread the word about this critical initiative.”

The governor made the announcement as hundreds of veterans gathered at the state Capitol to take part in the annual Veterans Appreciation Day activities.

The Oklahoma Veterans Pilot Program, which was launched in September, is a private/public effort to develop a comprehensive transitional system of care designed to deliver accessible quality healthcare to veterans statewide. The system will cover healthcare services in mental health, home health, nursing care, rehabilitative services, and coordinated access to physician services, laboratory services, pharmacy services and tele-health capability.

The Force 50 Brigade, which is the primary public awareness organization of the Oklahoma Veterans Pilot Program, will consist of 50 well-known Oklahoma entertainers, sports figures and professionals from the film and music industries, as well as two critical subgroups, the County Chairperson Leadership Team and Victor Company. Victor Company is the Veterans Leadership Team and will consist of veterans organizations and leaders within the veterans community. As the most integral part of this effort, it has been mobilized first, and
will be led by Pete Peterson and Scott Ellis, leaders of the Oklahoma Veterans Council.

“It is our hope that the outreach program being implemented under the Force 50 Brigade and led by the Oklahoma Veterans Leadership Team will encourage our Oklahoma veterans population to get involved with our efforts to improve healthcare opportunities to all veterans,” said Myles Deering, director of the Oklahoma Department of Veterans Affairs. “The role of the Oklahoma veterans service organizations will be to assist in gathering comments, survey data and assist in publicizing the program efforts to all Oklahoma veterans.”

“Pete Peterson and Scott Ellis bring proven leadership skills to this initiative and we are excited to have them on our team,” said Pete Reed, a former director of the Oklahoma Department of Veterans Affairs and coordinator of the Oklahoma Veterans Pilot Program. “The veterans service organizations that will be participating in the mission of Victor Company are critical to our success and we are deeply grateful for their support and guidance.”

The Victor Company members and organizations include:

- AmVets
- American Legion
- American Ex-POWs
- Disabled American Veterans (DAV)
- Fleet Reserve Association
- Marine Corps League
- Military Officers Assn. Of America
- Nat’l Assn. of Black Veterans
- Oklahoma Womens’ Veterans Organization
- Paralyzed Veterans of America
- Mid-America Chapter
- Rolling Thunder Oklahoma Chapter 1
- Special Forces Oklahoma Chapter 32-50
- U.S. Sub. Veterans, Inc., USS OKC Base
- Veterans of Foreign Wars
- Viet Nam Veterans of America

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IV. Website Message
To: All Veterans, Active and Retired Military Personnel, and their Qualifying Dependents

From: The Governor’s Oklahoma Veterans Pilot Program

Subject: Statewide Veterans Survey

Date: June 6, 2017-August 1, 2017

We need your input. Please go to:

www.okvetshealth.com or www.lifespringhomecare.com, then click the icon to complete the Statewide Veterans Survey.

Your participation is critical to our ability to effectively design a new healthcare access and delivery system in Oklahoma. Your participation will remain anonymous.

Thank you for participating.
V. Governor Fallin Press Release on Veterans Survey
   a. Veterans Survey/website announcement
   b. Veterans Survey/5 W announcement
   c. Veterans Survey/Special Advisor to the Oklahoma Veterans Pilot Program is Former Oklahoma Governor George Nigh
   d. Veterans Survey/Group Picture lead by Oklahoma Governor Mary Fallin
OFFICE OF GOVERNOR
MARY FALLIN

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Web: www.governor.ok.gov
Facebook: www.facebook.com/GovernorMaryFallin
Twitter: www.twitter.com/GovMaryFallin

FOR IMMEDIATE RELEASE
June 6, 2017

Governor Mary Fallin Announces Survey on Health Care Needs of Oklahoma Veterans

OKLAHOMA CITY – Governor Mary Fallin today announced a survey of health care needs among Oklahoma veterans. The “Take 10 Survey,” which will be conducted by the Oklahoma Veterans Pilot Program, is an effort to identify the most pressing health care needs among veterans, as well as obtaining additional general information that will assist in creating a new system of health care for Oklahoma veterans.

“I am especially pleased to announce this detailed survey effort, supported by our veterans’ organizations, business and health care leaders, education professionals, and members of the Oklahoma state Legislature, on the anniversary of D-Day,” said Fallin. “This day is a reminder of how much our men and women in uniform have sacrificed over the years. This is why we want to build a health care model that improves access to services, and creates a more cost-effective and
efficient system of care for our veterans. The participation of all Oklahoma veterans is critical to these efforts.”

The Oklahoma Veterans Pilot Program asks all veterans, military retirees, active Guard and reservists, and active-duty military to go to the pilot program website and take 10 minutes to fill out the “Take 10 Survey.” The website is www.okvetshealth.com.

“We encourage all Oklahoma veterans to visit our website (www.okvetshealth.com) and take 10 minutes to fill out the survey,” said Myles Deering, executive director of the Oklahoma Department of Veterans Affairs.

“This is a rare opportunity for members of our service organizations to play a significant role in shaping veterans’ health care for years to come,” said Pete Peterson, chairman of the Oklahoma Veterans Pilot Program’s Victor Company and the Oklahoma Veterans Council.

The survey will be available and active for six weeks, from June 6 to August 1. The University of Central Oklahoma (UCO) will then analyze the data, and it will be used by the Joint Task Force of the Oklahoma Veterans Pilot Program to finalize a comprehensive transitional system of care designed to deliver accessible quality health care to veterans statewide. This system will be recommended in November to the governor, state legislative leadership, and members of the Oklahoma congressional delegation.

“We are excited to be a partner in this effort to serve our veterans by managing the survey activity and analyzing the data collected on behalf of our Oklahoma veterans,” said Mark Kinders, vice president of public affairs at UCO.

“We hope the data collected will further our program efforts to better serve those who served with honor,” said Pete Reed, a former director of the Oklahoma Department of Veterans Affairs and coordinator of the Oklahoma Veterans Pilot Program.

###

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Oklahoma Veterans Pilot Program

The Oklahoma Veterans Survey

Visit www.okvetshealth.com and click the icon to take the survey.
OKLAHOMA VETERANS PILOT PROGRAM

WHAT: The Oklahoma Veterans Survey

WHO: ALL Veterans, Service Connected
Disabled Veterans, Active Duty Military,
Active Guard, Active Reserve and
Military Retirees

WHEN: June 6, 2017 - August 1, 2017

WHERE: Statewide

WHY: To assist in creating a Veterans-centered system of accessible healthcare that meets all levels of need to those who served with Honor.

How: Visit www.okvetshealth.com
VI. Senate Concurring Resolution 6

a. Picture of lead team on SCR 6
Resolution

ENROLLED SENATE
CONCURRENT
RESOLUTION NO. 6

By: Griffin, Simpson, Pittman, Allen, Bass, Bergstrom, Bice, Boggs, Brecheen, Brown, Dahm, Daniels, David, Dossett, Dugger, Fields, Floyd, Fry, Holt, Jech, Kidd, Leewright, Loveless, Marlatt, Matthews, McCortney, Newberry, Newhouse, Paxton, Pederson, Pemberton, Pugh, Quin, Rader, Schulz, Scott, Sharp, Shaw, Silk, Smalley, Sparks, Standridge, Stanislawski, Sykes, Thompson, Treat and Yen of the Senate

and

Griffith, Kannady and Young of the House

A Concurrent Resolution supporting the mission of the Oklahoma Veterans Pilot Program; encouraging Oklahomans to participate; and directing distribution.

WHEREAS, the Oklahoma Veterans Pilot Program has been created to develop a 21st Century healthcare delivery system for the Oklahoma veterans' community; and

WHEREAS, the healthcare delivery system will be part of a private/public partnership designed to improve timely access to services, the quality of care provided, improve efficiency and
create a cost savings to participating federal and state agencies; and

WHEREAS, the healthcare services will be designed as one seamless transitional system of care across Oklahoma; and

WHEREAS, the transitional system of care developed will be tested and placed into action with appropriate monitoring and outcome measures recorded; and

WHEREAS, the final healthcare product may be considered as a national model after the testing and action period; and

WHEREAS, this initiative is being supported by professionals in healthcare, the business and finance community, higher education professionals, community leaders and veterans from around the great state of Oklahoma.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE 1ST SESSION OF THE 56TH OKLAHOMA LEGISLATURE, THE HOUSE OF REPRESENTATIVES CONCURRING THEREIN:

THAT the Legislature supports the mission of the Oklahoma Veterans Pilot Program.

THAT the Legislature encourages all Oklahomans to participate appropriately in the program efforts to serve those who served with honor.

THAT a copy of this resolution be distributed to Governor Mary Fallin; ODVA Director, Myles Deering, MG (Ret), Co-Chairperson OK Veterans Pilot Program; UCO Vice President of Public Affairs, Mark Kinders, Ed.D., Co-Chairperson OK Veterans Pilot Program; Lifespring Home Care CEO, Karen Vahlberg, RN, BSN, Co-Chairperson OK Veterans Pilot Program; Pete Reed, Coordinator OK Veterans Pilot Program and Manager of Lifespring Veterans Program; and Mark Morgan, Task Force Chairperson and Director of the Muskogee V.A. Medical Center.
Adopted by the Senate the 24th day of April, 2017.

[Signature]
Presiding Officer of the Senate

Adopted by the House of Representatives the 9th day of May, 2017.

[Signature]
Presiding Officer of the House of Representatives

CERTIFICATION

STATE OF OKLAHOMA

) ss

COUNTY OF OKLAHOMA

I, Paul Ziriax, Secretary of the Senate of the State of Oklahoma, do hereby certify that the above and foregoing is a true and correct copy of Enrolled Senate Concurrent Resolution No. 6 as the same was adopted by the Senate and the House of Representatives of the 1st Session of the 56th Legislature of the State of Oklahoma, the original hereof being on file in the office of the Secretary of State of the State of Oklahoma.

WITNESS my hand at the State Capitol this 10th day of May, 2017.

[Signature]
Secretary of the Senate
VII. House Bill 1198 (Summary)
An Act

ENROLLED HOUSE
BILL NO. 1198

By: Hardin and McDugle of the House

and

Simpson of the Senate

An Act relating to veterans; requiring the Oklahoma Department of Veterans Affairs to create a veterans registry; requiring the registry contain certain information; authorizing the Department to promulgate rules; defining term; amending 29 O.S. 2011, Sections 4-110, as amended by Section 1, Chapter 286, O.S.L. 2013, 4-112, as last amended by Section 1, Chapter 165, O.S.L. 2015, 4-114, as amended by Section 1, Chapter 112, O.S.L. 2014 and 4-140 (29 O.S. Supp. 2016, Sections 4-110, 4-112 and 4-114), which relate to hunting and fishing licenses; requiring veteran registration for certain annual fishing license exemption; requiring veteran registration for certain annual hunting license exemptions; requiring veteran registration for certain lifetime license discount; requiring veteran registration for certain wildlife stamp requirement exemption; providing exceptions; directing the Oklahoma Wildlife Conservation Commission to promulgate necessary rules; amending Section 1, Chapter 261, O.S.L. 2013 (29 O.S. Supp. 2016, Section 5-203.2), which relates to restrictions on laser sighting devices; requiring veteran registration as a condition for certain exemption; directing the Oklahoma Wildlife Conservation Commission to promulgate necessary rules; amending Section 1, Chapter 45, O.S.L. 2015 (40 O.S. Supp. 2016, Section 801), which relates to the Voluntary Veterans' Preference Employment Policy Act; modifying definition; amending 47 O.S. 2011, Section 6-101, as last amended by Section 1 of Enrolled House Bill No. 1845 of the 1st Session of the 56th Oklahoma Legislature, which relates to driver licenses; requiring veteran registration for driver license renewal fee exemption; providing exception; amending
Section 1, Chapter 330, O.S.L. 2012, as last amended by Section 1, Chapter 113, O.S.L. 2014 (47 O.S. Supp. 2016, Section 6-124), which relates to veteran designations on licenses and identification cards; requiring veteran registration for veteran designation; providing exception; directing the Department to promulgate necessary rules; amending 68 O.S. 2011, Section 1357, as last amended by Section 18, Chapter 54, O.S.L. 2015 (68 O.S. Supp. 2016, Section 1357), which relates to sales tax exemption; requiring veteran registration for certain sales tax exemption; directing the Tax Commission to promulgate necessary rules; amending 68 O.S. 2011, Section 2105, as last amended by Section 1, Chapter 312, O.S.L. 2016 (68 O.S. Supp. 2016, Section 2105), which relates to vehicle excise tax exemptions; requiring certain veteran registration for vehicle excise tax exemption; providing exception; directing the Tax Commission to promulgate necessary rules; amending 72 O.S. 2011, Section 402, which relates to the Special Disabled Veterans Employment Act; modifying definition; providing for codification; and providing effective dates.

SUBJECT: Veterans

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 421 of Title 72, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Department of Veterans Affairs shall create and maintain a registry of all veterans in this state by January 1, 2020. The registry shall include the following information regarding the veteran:

1. Name;

2. Military ranking and branch of service;

ENR. H. B. NO. 1198
VIII. Senate Bill 1053
An Act

ENROLLED SENATE
BILL NO. 1053

By: Simpson of the Senate

and

Hardin of the House

An Act relating to the War Veterans Commission and the Department of Veterans Affairs; broadening the authority of the Department; authorizing the promulgation of certain rules; providing for codification; and providing an effective date.

SUBJECT: Department of Veterans Affairs operations

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 63.5a of Title 72, unless there is created a duplication in numbering, reads as follows:

A. The Department of Veterans Affairs is authorized to obtain certification through the Centers for Medicare and Medicaid Services and accept payments and reimbursements from Medicare and Medicaid programs for services provided through Oklahoma Veterans Centers.

B. The Oklahoma Veterans Commission is authorized to promulgate rules to implement the provisions of this section.

SECTION 2. This act shall become effective November 1, 2018.
Passed the Senate the 12th day of March, 2018.

Presiding Officer of the Senate

Passed the House of Representatives the 17th day of April, 2018.

Presiding Officer of the House of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this __________ day of _______________, 20____, at ____ o'clock ____ M.

By: ________________________________

Approved by the Governor of the State of Oklahoma this _______ day of _______________, 20____, at ____ o'clock ____ M.

Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _______ day of _______________, 20____, at ____ c'clock ____ M.

By: ________________________________
IX. Senate Bill 931
An Act

ENROLLED SENATE
BILL NO. 931

By: Simpson of the Senate

and

Hardin of the House

An Act relating to soldiers and sailors; providing authorization and procedure for the Oklahoma Department of Veterans Affairs to accept certain gifts; prohibiting preferential treatment under certain circumstances; providing for codification; and providing an effective date.

SUBJECT: Oklahoma Department of Veterans Affairs

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 440 of Title 72, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Department of Veterans Affairs may accept and receive any and all gifts, donations, devices, bequests, grants or contracts of any kind for money or property, either real or personal including but not limited to military memorabilia, artifacts or equipment, whether conditionally or unconditionally given.

B. The Department is directed, authorized and empowered to hold such funds or property outright or in trust, invest or sell the property, and to use the principal or interest or proceeds of sale for the benefit of current or future Veterans programs, facility construction, repair or improvements or departmental operations.
C. The Department shall utilize its best efforts to comply with the terms of any conditional gift, devise or bequest in fulfillment of the donor's stipulations and provisions of applicable laws. Any real or personal property donated with conditions which are at any time determined infeasible to meet or continue may be returned to the donor, or if the donor is no longer living, if a natural person, or no longer a legally organized entity, for organizations, then the property may be sold and the proceeds of the sale deposited in the Department's general fund or the property may be further donated in kind to a veterans' service organization.

D. No administrator shall provide any preferential consideration to a potential resident of any Oklahoma state veterans homes in the course of the application and admission process due to any prior or pledged gift, devise or bequest of any money or property given or donated by the potential veteran resident or immediate family member of the potential veteran resident.

SECTION 2. This act shall become effective November 1, 2018.
Passed the Senate the 5th day of March, 2018.

Presiding Officer of the Senate

Passed the House of Representatives the 19th day of April, 2018.

Presiding Officer of the House of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this ________________ day of ________________, 20____, at _____ o'clock _____ M.

By: __________________________

Approved by the Governor of the State of Oklahoma this ______ day of ________________, 20____, at _____ o'clock _____ M.

Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this ______ day of ________________, 20____, at _____ o'clock _____ M.

By: __________________________
X. Force 50 Foundation Brochure
   a. Certificate of Incorporation
Monetary Donations are accepted by mail, telephone, e-mail and online.

Memorial Donations: Honor a loved one with a donation in their name.

Legacy Gift: Make a planned gift, such as a bequest in a will, annuity, life insurance policy or endowment.

Caring Angel Donation: Recognize a special caregiver by making a donation in their honor.

Annual Fundraiser(s): Sponsor and/or participate in our fundraisers in honor of a loved one.

Gift Certificates to grocery stores, pharmacies, gas stations, restaurants, entertainment, can be used with those that request assistance from the Foundation.

Fundraising Events and Sponsorships are available.

Contact us for more information.
The Force 50 Foundation was born of the Oklahoma Veterans Pilot Program and is committed to serving those in need by directing funds to:

Improve the quality of life for terminally ill and/or home bound patients and their families through the provision of needed care or services, special wishes, and community education of hospice services.

Veterans and their dependents requiring care or services, special assistance, and community education of veterans' healthcare services in cooperation with the Oklahoma Department of Veteran Affairs.

Outreach services and public awareness programs designed to educate private and public-sector entities and individuals dedicated to serving the health needs of Oklahomans and the Oklahoma veterans' community in cooperation with the Oklahoma Department of Veteran Affairs.

“The Foundation's assistance came just in time for our family to get back on track.”

-Melanie Jasper, widow, Daniel Jasper, Foundation Recipient
OFFICE OF THE SECRETARY OF STATE

STATE OF OKLAHOMA

AMENDED NOT FOR PROFIT CERTIFICATE OF INCORPORATION

WHEREAS, the Amended Not For Profit Certificate of Incorporation of

FORCE 50 FOUNDATION, INC.

has been filed in the office of the Secretary of State as provided by the laws of the State of Oklahoma.

NOW THEREFORE, I, the undersigned, Secretary of State of the State of Oklahoma, by virtue of the powers vested in me by law, do hereby issue this certificate evidencing such filing.

IN TESTIMONY WHEREOF, I hereunto set my hand and cause to be affixed the Great Seal of the State of Oklahoma.

EFFECTIVE DATE: October 20, 2017

Filed in the city of Oklahoma City this 11th day of October, 2017.

[Signature]
Secretary of State
XI. Inaugural Force 50 Foundation Awards
Banquet Highlights
INAURGURAL VETERANS SERVICE AWARD
Silent Auction - $1250 raised
INAUGURAL VETERANS SERVICE AWARD
2018 Awards
OK Governor Mary Fallin (R) presents the 2018 Medal of Freedom to former Governor George Nigh (D) with assistance from MG Rita Aragon.
Former Governor George Nigh (D) presenting the George Nigh Lifetime Achievement Award. Accepting on behalf of General Tommy Franks was COL Michael Hayes.
INAURGURAL VETERANS SERVICE AWARD
2018 Honorees – Distinguished Service

**Legislative Category:**
State Senator A.J. Griffin
State Senator Frank Simpson
State Representative Chris Kannady
State Representative Josh West
State Representative Claudia Griffith
State Senator George Young

**Non-Legislative Category:**
Mr. Bob Bramlett
Scott Deatherage, Honoring America’s Warriors
Pam Blustine
Peter Luitweiler
Mark Morgan
Annette Mays
Nadine Lewis
Pete Peterson
INAURGURAL VETERANS SERVICE AWARD
2018 Honorees – Commendation

Dr. Mark Kinders, University of Central Oklahoma and Karen Vahlberg, LifeSpring Home Care receiving commendations for their work with the Force 50 Foundation and the Veterans Pilot Program
INAURGURAL VETERANS SERVICE AWARD
Corporation Service Award (Small and Large)

Patriot Ford, Purcell

Chesapeake Energy Corp, OKC
INAUGURAL VETERANS SERVICE AWARD
State Agency Support

Oklahoma Department of Mental Health and Substance Abuse Services
INAUGURAL VETERANS SERVICE AWARD
Not for Profit - Service Award (Small and Large)
INAUGURAL VETERANS SERVICE AWARD
Higher Education – Small and Large

East Central University, Ada

University of Central Oklahoma, Edmond
INAUGURAL VETERANS SERVICE AWARD
Health Care Service and Support Award

Oklahoma Primary Care Association
INAUGURAL VETERANS SERVICE AWARD
Oklahoma Medal of Freedom

Governor George Nigh
XII. Survey Instrument
Oklahoma Veterans Health Care Access Survey

Dear Oklahoma Veteran:

We need your help.

Governor Mary Fallin has empaneled a state-wide Task Force of Veterans health care professionals, Veterans advocates and state legislators to assess the condition of health care access for the state's 350,000 veterans. This Task Force may recommend Oklahoma and federal policy changes based on your answers so you will have the best access and quality of services offered in any state.

To guide our activities, the Task Force is seeking your input on your experiences and satisfaction with access to information about resources available to you, ease of access to health care providers, and your satisfaction with your experiences.

Please answer all questions that apply to you. We will only use the summary data from all of the collected surveys to guide our activities in adjusting policies or program. Therefore, you survey answers will be anonymous, and no one will know who you are. Thanks for your participation.

Task Force Co-Chairs

Major General (Retired) Myles Deering
Executive Director,
Oklahoma Department of Veterans Affairs

Dr. Mark Kinders, Ed. D.
Vice President for Public Affairs,
University of Central Oklahoma
U.S. Marine Corps, 1968-72
Q2 Finding Helpful Information

Q3 Please indicate all of the resources you used to learn about the services available for Veterans health care AND their helpfulness to you. Please check all that apply.
<table>
<thead>
<tr>
<th></th>
<th>Very Helpful</th>
<th>Somewhat Helpful</th>
<th>Uncertain</th>
<th>Somewhat Unhelpful</th>
<th>Very Unhelpful</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>talked to a veterans administration staff person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>used the veterans administration website</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>called the veterans administration help line</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>talked to an oklahoma department of veterans affairs staff member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>used the oklahoma department of veterans affairs website</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>used a tricare website</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>talked with a tricare health services representative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>used a veterans organization website</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>talked with a veterans organization representative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>talked to another veteran for advice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transition Assistance Adviser, OK National Guard Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>-----------------------------------------------------</td>
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<td>□</td>
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</tr>
</tbody>
</table>


Q4 Your health care experiences

Q5 What kind of health care is most important to you?
- Mental Health Care
- Primary Health Care
- Specialty Care
- Urgent Care
- Access to prescriptions
- Hospital care
- Home-based care (home health, hospice, palliative, home support services)

Q6 What factors are most important to you when choosing a health care provider?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td>Quality of care</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of appointments</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance to health care facility</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost to receive care</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider reputation or expertise</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customer service</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convenience</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage by my insurance company or VA</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship to provider</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting room wait times</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient/personal safety</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Family care needs</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In payer network</td>
<td>○</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>○</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q7 How often do you find it necessary to seek health care treatment AND for what purpose? Please check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Weekly</th>
<th>Every Few Weeks</th>
<th>1-3 Months</th>
<th>4-6 Months</th>
<th>7-9 Months</th>
<th>10-12 Months</th>
<th>More than 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Illness</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Acute Illness</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>Mental Health</td>
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<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Injury</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>IO Care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Q8 Do you use your Veterans Administration health services benefits?

○ Yes
○ No

Q9 If you do not use Veterans Administration health services benefits, why not?

Q10 How far are you willing to drive to receive health care treatment?

○ Less than 10 miles
○ 10-20 miles
○ 21-30 miles
○ 31-40 miles
○ 41-50 miles
○ More than 50 miles

Q11 How often have you accessed health care in the past 12 months?
Q12 Where did you receive health care treatment in the past 12 months? Please check all that apply.

- Doesn't apply
- Veterans Administration Hospital
- Indian Health Services
- My own physician (My private health insurance)
- My own physician (TRICARE)
- My own physician (Medicare/Medicaid)
- Military Health Care provider
- Veterans Choice Program
- Oklahoma Department of Mental Health
- Emergency Care
- Veterans Administration Satellite Clinic
- My home

Q13 If you scheduled a non-emergency medical treatment, how long did it take?

- 0-10 days
- 11-20 days
- 21-30 days
- 31-40 days
- 41-50 days
- More than 50 days

Q14 How satisfied are you with how long it took to receive treatment for a non-emergency treatment?

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
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<tr>
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<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>
Q15 Please tell us about your satisfaction with your access to health care. Please check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Very Satisfied</th>
<th>Satisfied</th>
<th>No opinion</th>
<th>Dissatisfied</th>
<th>Very Dissatisfied</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paperwork to access treatment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The quality of health care treatment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Scheduling follow-up appointments</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Obtaining prescriptions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Paperwork for insurance</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My out-of-pocket costs</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Q16 Your profile

Q17 What is your gender?

☐ Male
☐ Female

Q18 What military branch did you serve in? Please check all that apply.

☐ Army
☐ Navy
☐ Air Force
☐ Marines
☐ National Guard
☐ Air National Guard
☐ Reservist
☐ Coast Guard
☐ Merchant Marine

Q19 Are you a Veteran of: Please check all that apply.

☐ World War II
☐ Korea
☐ Vietnam
☐ Post-Vietnam (Grenada, Panama, other campaign up to Gulf War)
☐ Gulf War/Somalia
☐ Bosnia/Kosovo Campaigns
☐ Global War on Terrorism (Post 9/11 to include Iraq/Afghanistan)

Q20 Did you serve in a designated combat zone?

☐ Yes
☐ No

Q21 Do you have a service-connected disability?

☐ Yes
☐ No
☐ Pending

Q22 Please tell us your Town/City of residence:
Q23 Please tell us your Zip Code:

Q25 Including the current year, how many years were you on active duty?

☐ 0-3 years
☐ 4-7 years
☐ 8-11 years
☐ 12-15 years
☐ 16-19 years
☐ 20 years or more
☐ Retired from a Military branch
☐ Retired from the Oklahoma National Guard

Q24 What is your age?

☐ 19 or younger
☐ 20-29 years old
☐ 30-39 years old
☐ 40-49 years old
☐ 50-59 years old
☐ 60-69 years old
☐ 70 years or older

Q26 What is your annual income?

☐ Below $25,000
☐ Between $25,000 and $49,999
☐ Between $50,000 and $74,999
☐ Above $75,000

Q27 What is your marital status?

☐ Married
☐ Divorced
☐ Separated
☐ Engaged
☐ Single
☐ In a committed relationship
Q28 Please choose the race you most closely identify with. Please check all that apply.

☐ Caucasian
☐ Hispanic/Latino
☐ African-American
☐ Native American
☐ Asian
☐ Other: ______________________

Q29 Are there any additional comments you would like to make about your access to Veterans health care in Oklahoma?

______________________________

Q30 If you would like to receive a copy of the findings of this survey, please include your email address below.

______________________________

THANK YOU FOR TAKING THE SURVEY
XIII. Survey Analysis
<table>
<thead>
<tr>
<th>Table of Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Demographics</td>
<td>1</td>
</tr>
<tr>
<td>Health Care Resources</td>
<td>5</td>
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<tr>
<td>Factors when Choosing Health Care</td>
<td>8</td>
</tr>
<tr>
<td>Frequency of Health Care</td>
<td>11</td>
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<tr>
<td>Location of Health Care</td>
<td>14</td>
</tr>
<tr>
<td>Satisfaction with Access to Health Care</td>
<td>18</td>
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<tr>
<td>Additional Comments</td>
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</table>
SAMPLE DEMOGRAPHICS

In total, 4,170 individuals responded to the Take 10 survey. Ten responses were identified by Qualtrics to be spam, and 69 responses were submitted by individuals from outside of Oklahoma and bordering counties. Additionally, 915 responses were completely empty, and another 278 responses were submitted by individuals who clicked-through less than 50% of the survey. All of these responses were removed from the sample. This resulted in a final sample size of 2,898 responses, or 0.9% of the total veteran population in Oklahoma. Table 1 presents the raw demographics of the final sample compared to those of the population of veterans living in Oklahoma.

Table 1. Raw sample demographics

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Population*</th>
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</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2,191</td>
<td>88.0%</td>
</tr>
<tr>
<td>Female</td>
<td>300</td>
<td>12.0%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 30 years</td>
<td>115</td>
<td>4.1%</td>
</tr>
<tr>
<td>30-39 years</td>
<td>299</td>
<td>10.6%</td>
</tr>
<tr>
<td>40-49 years</td>
<td>501</td>
<td>17.7%</td>
</tr>
<tr>
<td>50-59 years</td>
<td>532</td>
<td>18.8%</td>
</tr>
<tr>
<td>60-69 years</td>
<td>796</td>
<td>28.1%</td>
</tr>
<tr>
<td>&gt; 69 years</td>
<td>587</td>
<td>20.7%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian/White only</td>
<td>2,260</td>
<td>83.6%</td>
</tr>
<tr>
<td>African American/Black only</td>
<td>96</td>
<td>3.6%</td>
</tr>
<tr>
<td>Native American/Alaska Native only</td>
<td>171</td>
<td>6.3%</td>
</tr>
<tr>
<td>Other/Two or More</td>
<td>175</td>
<td>6.5%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
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<tr>
<td>Hispanic</td>
<td>86</td>
<td>3.1%</td>
</tr>
<tr>
<td>Not Hispanic</td>
<td>2,675</td>
<td>96.9%</td>
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<tr>
<td><strong>Annual Income</strong></td>
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<td></td>
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<tr>
<td>&lt; $25,000</td>
<td>586</td>
<td>21.4%</td>
</tr>
<tr>
<td>$25,000-$49,999</td>
<td>952</td>
<td>34.8%</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>642</td>
<td>23.5%</td>
</tr>
<tr>
<td>&gt; $74,999</td>
<td>555</td>
<td>20.3%</td>
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<tr>
<td><strong>Marital Status</strong></td>
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<td></td>
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<tr>
<td>Married</td>
<td>2,039</td>
<td>72.4%</td>
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<tr>
<td>Divorced</td>
<td>316</td>
<td>11.2%</td>
</tr>
<tr>
<td>Separated</td>
<td>42</td>
<td>1.5%</td>
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<tr>
<td>Engaged</td>
<td>63</td>
<td>2.2%</td>
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<tr>
<td>Single</td>
<td>271</td>
<td>9.6%</td>
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<tr>
<td>In a committed relationship</td>
<td>85</td>
<td>3.0%</td>
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<tr>
<td>Location of Residence†</td>
<td>Sample</td>
<td>Population*</td>
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<tr>
<td>------------------------</td>
<td>--------</td>
<td>-------------</td>
</tr>
<tr>
<td>Urban</td>
<td>443</td>
<td>16.0%</td>
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<tr>
<td>Rural</td>
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<td>15.0%</td>
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<tr>
<td>Mixed</td>
<td>1,905</td>
<td>69.0%</td>
</tr>
<tr>
<td>War Era</td>
<td></td>
<td></td>
</tr>
<tr>
<td>World War II</td>
<td>20</td>
<td>0.8%</td>
</tr>
<tr>
<td>Korea</td>
<td>85</td>
<td>3.3%</td>
</tr>
<tr>
<td>Vietnam</td>
<td>1,062</td>
<td>41.2%</td>
</tr>
<tr>
<td>Post-Vietnam</td>
<td>443</td>
<td>17.2%</td>
</tr>
<tr>
<td>Gulf War</td>
<td>1,389</td>
<td>53.9%</td>
</tr>
<tr>
<td>Branch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Army</td>
<td>1,353</td>
<td>47.6%</td>
</tr>
<tr>
<td>Navy</td>
<td>488</td>
<td>17.2%</td>
</tr>
<tr>
<td>Air Force</td>
<td>664</td>
<td>23.4%</td>
</tr>
<tr>
<td>Marines</td>
<td>267</td>
<td>9.4%</td>
</tr>
<tr>
<td>National Guard</td>
<td>459</td>
<td>16.2%</td>
</tr>
<tr>
<td>Air National Guard</td>
<td>99</td>
<td>3.5%</td>
</tr>
<tr>
<td>Reservist</td>
<td>162</td>
<td>5.7%</td>
</tr>
<tr>
<td>Coast Guard</td>
<td>22</td>
<td>0.8%</td>
</tr>
<tr>
<td>Merchant Marine</td>
<td>4</td>
<td>0.1%</td>
</tr>
<tr>
<td>Combat Zone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1,577</td>
<td>55.7%</td>
</tr>
<tr>
<td>No</td>
<td>1,253</td>
<td>44.3%</td>
</tr>
<tr>
<td>Service-Connected Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1,885</td>
<td>66.5%</td>
</tr>
<tr>
<td>Pending</td>
<td>190</td>
<td>6.7%</td>
</tr>
<tr>
<td>No</td>
<td>760</td>
<td>26.8%</td>
</tr>
</tbody>
</table>


The Take 10 sample is significantly different from the population with respect to sex, age, race, location of residence, and war era \( (p < 0.001) \), but is not significantly different with respect to ethnicity \( (p = 0.754) \). Specifically, females, Vietnam veterans, post-Vietnam veterans, Gulf War veterans, Native Americans, and those aged 40-69 years old are significantly over-represented in the sample; whereas WWII veterans, Korean War veterans, African Americans, those from rural residences, and those aged 18-29 or 70 years and older are significantly under-represented. These cells are highlighted in Table 1.

Due to these differences, the sample was weighted with respect to age, race, and location of residence. War era was not used in the weighting process as it is highly correlated with age and
there is some overlap between the war eras, meaning a veteran may have served in more than one war. Sex was also eliminated from the weighting process since there are 497 (14%) missing responses to this item. Also, after analyzing text responses it was discovered that a potentially large number of surveys may have been completed by spouses of veterans rather than the veterans themselves. This could explain the large number of missing responses as the individuals may have been confused as to whether the question was asking for the veteran’s or the spouse’s sex. It could also explain why females are significantly over-represented in the sample. Figure 1 displays boxplots of the weights by age, race, and location of residence.

**Figure 1.** Boxplots of weights by age, race, and location of residence.

a. Age

![Boxplot of weights by age](image1)

b. Race

![Boxplot of weights by race](image2)
c. Location of residence

In the following analysis, weighted numbers are reported along with the weighted results of any statistical tests, unless indicated otherwise.
HEALTH CARE RESOURCES

According to respondents, the most used resources for learning about Veterans health care are other veterans (77%), VA staff (76%), and the VA website (73%). The least used resources are Transition Assistance Advisors (19%), TRICARE representatives (42%), and the TRICARE website (42%). Figure 2 displays the reported usage of all resources.

Figure 2. Reported usage of resources for learning about health care (n = 2,828)
Figure 3 displays the reported helpfulness of all resources. Respondents reported other veterans, other veterans organization representatives, and other veterans organization websites as the most helpful resources; and transition assistance advisors, the VA help line, and the ODVA website as the least helpful resources.

Figure 3. Reported helpfulness of resources for learning about health care \( (n = 2,828) \)
Sixty-four percent of respondents reported using VA health services benefits. Of those who reported not using these benefits, “difficulty getting appointments” was cited as the number one reason (35%), followed by “facilities too far away” (20%), and “using other health care” (14%). Figure 4 displays all reasons given for not using VA health services benefits. Bars shaded in gray represent the original choices on the Take 10 Survey for not using VA benefits. Bars shaded in blue represent the other responses written in by the respondents.

Figure 4. Reasons for not using VA health services benefits (unweighted) \( n = 1,063 \)
FACTORS WHEN CHOOSING HEALTH CARE

The most important type of health care was reported to be primary care (60%) and the least important was mental health care (7%). Figure 5 displays the most important type of health care with respect to sex, age, combat status, disability status, and whether or not VA benefits are used. In each plot, significant differences are circled.

There are differences between males and females with respect to the most important type of health care. Both males and females reported primary care as being the most important (61% and 55%, respectively). Males reported mental health care as the least important (7%); whereas females reported urgent/hospital/home care as the least important (6%). Females are significantly more likely than males to report mental health care as most important ($p < 0.001$).

There are differences between those aged 18-39 years and those 40 years and older with respect to the most important type of health care. Both age groups reported primary care as being the most important (57% and 60%, respectively). The younger age group reported access to prescriptions as the least important (2%); whereas the older age group reported mental health care as the least important (5%). The older age group is significantly more likely than the younger age group to report access to prescriptions as most important; and the younger age group is significantly more likely than the older age group to report mental health care as most important ($p < 0.001$).

There are differences between combat and non-combat veterans with respect to the most important type of health care. Both groups reported primary care as being the most important (60% and 60%, respectively). Combat veterans reported access to prescriptions as the least important (7%); whereas, non-combat veterans reported mental health care as the least important (4%). Non-combat veterans are significantly more likely than combat veterans to report access to prescriptions as most important; and combat veterans are significantly more likely than non-combat veterans to report mental health care as most important ($p < 0.001$).

There are differences between veterans with a service-connected disability or pending disability and those without a service-connected disability with respect to the most important type of health care. Both groups reported primary care as being the most important (58% and 64%, respectively). Veterans with a disability or pending disability reported urgent/hospital/home care as least important (8%); whereas those without a disability reported mental health care as least important (4%). Veterans with a disability or pending disability are significantly more likely than veterans with no disability to report specialty care and mental health care as most important. Veterans with no disability are significantly more likely than veterans with a disability or pending disability to report urgent/hospital/home care as most important ($p < 0.001$).

There are differences between veterans who use VA benefits and those who do not use VA benefits with respect to the most important type of health care. Both groups reported primary care as being the most important (58% and 64%, respectively). Veterans who use VA benefits reported urgent/hospital/home care as the least important (7%); and veterans who do not use VA benefits reported mental health care as the least important (6%). Veterans who use VA benefits are significantly more likely than veterans who do not use VA benefits to report specialty care as most important. Veterans who do not use VA benefits are significantly more likely than veterans who do use VA benefits to report urgent/hospital/home care as most important ($p < 0.001$).
Figure 5. Most important type of health care

a. Overall \( (n=2,848) \)

b. By sex \( (n=2,464) \)

c. By age \( (n=2,786) \)

d. By combat status \( (n=2,791) \)

e. By disability status \( (n=2,797) \)

e. By VA benefits \( (n=2,825) \)
The most important type of health care is also significantly related to race ($p < 0.001$) and income ($p < 0.001$). Specifically, Caucasian respondents are significantly more likely to report access to prescriptions as most important and significantly less likely to report mental health care as most important. African American respondents are significantly more likely to report primary health care as most important, and significantly less likely to report urgent/hospital/home care as most important. Those making more than $75,000 per year are significantly less likely to report mental health care as most important. The most important type of health care is not significantly related to ethnicity ($p = 0.327$) or location of residence ($p = 0.437$).

Figure 6 displays the most important factors when choosing a health care provider. The factors receiving the highest ratings are quality of care (90% rated most important), insurance coverage (86% rated most important), and provider reputation (76% most important). The factors receiving the lowest ratings are relationship to provider (48% most important), distance to facility (53% most important), and family care needs (54% most important).

**Figure 6.** Most important factors when choosing a health care provider ($n = 2,867$).
FREQUENCY OF HEALTH CARE

The number of times veterans accessed health care in the last 12 months is displayed in Figure 7. The median number of times was 3-4 and the most reported number of times was 5 or more.

Figure 7. Frequency of health care in the last 12 months (n = 2,723)

There is a significant difference in the frequency of health care with respect to sex (p = 0.008), disability status (p < 0.001), and whether VA benefits are used (p < 0.001). Specifically, females reported accessing health care more frequently than males. Those with a service connected disability reported accessing health care more frequently than those with no disability or a pending disability, and those who use VA benefits reported accessing health care more frequently than those who do not use VA benefits.

There is no significant difference in median frequency of health care with respect to location of residence (p = 0.296), combat status (p = 0.062), age (p = 0.210), annual income (p = 0.437), race (p = 0.476), or ethnicity (p = 0.106).
The reported frequencies of various types of health care are displayed in Figure 8. Sixty-nine percent of respondents reported seeking treatment for a chronic illness at least once a year; whereas only 32% reported seeking treatment for mental health at least once a year. These were the most and least sought treatments of the five categories on the Take 10 survey.

**Figure 8.** Frequency of health care treatment for various purposes (n = 2,814)

a. Chronic illness

b. Acute illness
c. Mental Health

![Bar chart showing frequency of mental health treatment.](chart)

- Weekly: 3.9%
- Every few weeks: 6.5%
- 1-3 months: 10.2%
- 4-6 months: 6.3%
- 7-9 months: 1.6%
- 10-12 months: 3.9%
- > 12 months: 27.3%
- Not at all: 40.4%

Frequency of Health Care Treatment for Mental Health

d. Injury

![Bar chart showing frequency of injury treatment.](chart)

- Weekly: 3.7%
- Every few weeks: 3.1%
- 1-3 months: 6.7%
- 4-6 months: 7.3%
- 7-9 months: 4.8%
- 10-12 months: 11.2%
- > 12 months: 22.0%
- Not at all: 41.3%

Frequency of Health Care Treatment for Injury

e. Inpatient/Outpatient care

![Bar chart showing frequency of inpatient/outpatient care.](chart)

- Weekly: 2.5%
- Every few weeks: 5.0%
- 1-3 months: 15.1%
- 4-6 months: 18.5%
- 7-9 months: 14.0%
- 10-12 months: 6.6%
- > 12 months: 10.2%
- Not at all: 29.1%

Frequency of Health Care Treatment for Inpatient/Outpatient Care
LOCATION OF HEALTH CARE

According to respondents, the most accessed locations for receiving health care in the last 12 months were a VA hospital (49%), a physician through private insurance (35%), or a physician through Medicare/Medicaid (26%). The least accessed locations were the Oklahoma Department of Mental Health (1%), Indian Health Services (3%), or the individual's own home (3%). Figure 9 displays the reported locations of receiving health care.

Figure 9. Locations for receiving health care in the last 12 months (n = 2,675)

- VA Hospital: 48.9%
- My Own Physician (Private Ins.): 34.7%
- My Own Physician (Medicare/Medicaid): 25.8%
- My Own Physician (TRICARE): 24.2%
- VA Satellite Clinic: 24.1%
- Emergency Care: 16.8%
- Veterans Choice Program: 16.0%
- Military Health Care Provider: 10.4%
- My Home: 3.0%
- Indian Health Services: 2.5%
- OK Department of Mental Health: 1.3%

Figure 10 displays the reported locations of receiving health care by urban, rural, and mixed locations of residence. The top two choices (VA hospital and a physician through private insurance) are the same for all three groups. The third most frequently used location for receiving health care is different for the three groups. For urban veterans, the third most used location for health care is a physician through Medicare/Medicaid (30%). For rural veterans, the third most used location for health care is a VA satellite clinic (30%). And, for veterans residing in mixed locations, the third most used location for health care is a physician through TRICARE (27%).
Figure 10. Locations for receiving health care in the last 12 months by location of residence

a. Urban residence (n = 412)

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA Hospital</td>
<td>54.7%</td>
</tr>
<tr>
<td>My Own Physician (Private Ins.)</td>
<td>32.7%</td>
</tr>
<tr>
<td>My Own Physician (Medicare/Medicaid)</td>
<td>29.9%</td>
</tr>
<tr>
<td>VA Satellite Clinic</td>
<td>25.4%</td>
</tr>
<tr>
<td>My Own Physician (TRICARE)</td>
<td>20.4%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>17.1%</td>
</tr>
<tr>
<td>Veterans Choice Program</td>
<td>13.8%</td>
</tr>
<tr>
<td>Military Health Care Provider</td>
<td>7.0%</td>
</tr>
<tr>
<td>My Home</td>
<td>3.9%</td>
</tr>
<tr>
<td>OK Department of Mental Health</td>
<td>2.9%</td>
</tr>
<tr>
<td>Indian Health Services</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

b. Rural residence (n = 383)

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA Hospital</td>
<td>54.4%</td>
</tr>
<tr>
<td>My Own Physician (Private Ins.)</td>
<td>32.9%</td>
</tr>
<tr>
<td>VA Satellite Clinic</td>
<td>29.6%</td>
</tr>
<tr>
<td>My Own Physician (Medicare/Medicaid)</td>
<td>23.1%</td>
</tr>
<tr>
<td>My Own Physician (TRICARE)</td>
<td>20.4%</td>
</tr>
<tr>
<td>Veterans Choice Program</td>
<td>19.7%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>17.0%</td>
</tr>
<tr>
<td>Military Health Care Provider</td>
<td>9.2%</td>
</tr>
<tr>
<td>My Home</td>
<td>4.0%</td>
</tr>
<tr>
<td>Indian Health Services</td>
<td>2.3%</td>
</tr>
<tr>
<td>OK Department of Mental Health</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

c. Mixed residence (n = 1,759)

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA Hospital</td>
<td>46.0%</td>
</tr>
<tr>
<td>My Own Physician (Private Ins.)</td>
<td>36.4%</td>
</tr>
<tr>
<td>My Own Physician (TRICARE)</td>
<td>26.7%</td>
</tr>
<tr>
<td>My Own Physician (Medicare/Medicaid)</td>
<td>25.3%</td>
</tr>
<tr>
<td>VA Satellite Clinic</td>
<td>22.7%</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>16.9%</td>
</tr>
<tr>
<td>Veterans Choice Program</td>
<td>15.9%</td>
</tr>
<tr>
<td>Military Health Care Provider</td>
<td>11.5%</td>
</tr>
<tr>
<td>Indian Health Services</td>
<td>2.7%</td>
</tr>
<tr>
<td>My Home</td>
<td>2.6%</td>
</tr>
<tr>
<td>OK Department of Mental Health</td>
<td>0.9%</td>
</tr>
</tbody>
</table>
Figure 11 displays the distance respondents are willing to drive to receive health care. The median acceptable distance was 21-30 miles and the most reported acceptable distance was 10-20 miles.

**Figure 11.** Acceptable driving distance to receive health care ($n = 2,867$)

There are significant differences in the median acceptable driving distance for health care with respect to whether VA benefits are used ($p < 0.001$), disability status ($p = 0.002$), age ($p = 0.013$), and race ($p < 0.001$). Specifically, those who use VA benefits are willing to drive further for health care than those who do not use VA benefits. Those with a disability or pending disability are willing to drive further for health care than those with no disability. Those 70 years and older are willing to drive further for health care than those under 70 years old. And, Native Americans are willing to drive further for health care than non-Native Americans.

There is also a significant difference in the median acceptable driving distance for health care with respect to location of residence ($p < 0.001$). Specifically, those living in rural locations are willing to drive significantly further for health care than those living in mixed locations, who are willing to drive significantly further than those living in urban locations. These results are displayed in Figure 12.
Figure 12. Acceptable driving distance to receive health care by location of residence
(\(n = 2,740\))

There were no significant differences in the median acceptable driving distance for health care with respect to sex (\(p = 0.314\)), combat status (\(p = 0.928\)), or annual income (\(p = 0.192\)).
Satisfaction with Access to Health Care

Figure 13 displays the respondents' satisfaction with various aspects of health care. Overall, the respondents seem to be satisfied with their access to health care, with more than 50% of respondents reporting being either satisfied or very satisfied with each aspect of health care. Respondents are most satisfied with obtaining prescriptions (77% satisfied or very satisfied) and least satisfied with time to treatment (55% satisfied or very satisfied).

Figure 13. Satisfaction with various aspects of health care (n = 2,720)

<table>
<thead>
<tr>
<th>Aspects</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtaining Prescriptions</td>
<td>15%</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>21%</td>
</tr>
<tr>
<td>Scheduling Follow-up Appointments</td>
<td>22%</td>
</tr>
<tr>
<td>Paperwork to Access Treatment</td>
<td>20%</td>
</tr>
<tr>
<td>Out-of-pocket Costs</td>
<td>25%</td>
</tr>
<tr>
<td>Paperwork for Insurance</td>
<td>16%</td>
</tr>
<tr>
<td>Time to Treatment</td>
<td>30%</td>
</tr>
</tbody>
</table>

Figure 14 displays the satisfaction among those who use VA benefits and those who do not. On average, those who use VA benefits are significantly less satisfied with time to treatment (p < 0.001), quality of care (p < 0.001), scheduling follow-up appointments (p < 0.001), and paperwork for insurance (p < 0.001); and significantly more satisfied with out-of-pocket costs (p = 0.001). There is no significant difference between those who use VA benefits and those who do not with respect to satisfaction with paperwork to access treatment (p = 0.259) and obtaining prescriptions (p = 0.283). The greatest difference between those who use VA benefits and those who do not is with satisfaction with time to treatment. Only 47% of those who use VA benefits reported being satisfied or very satisfied with time to treatment; compared to 72% of those who do not use VA benefits.
Figure 14. Satisfaction with various aspects of health care among veterans who use VA benefits and veterans who do not use VA benefits

a. Veterans who use VA benefits ($n = 1,770$)

- Time to Treatment: 36%
- Scheduling Follow-up Appointments: 27%
- Quality of Care: 25%
- Paperwork to Access Treatment: 21%
- Paperwork for Insurance: 15%
- Out-of-pocket Costs: 22%
- Obtaining Prescriptions: 17%

b. Veterans who do not use VA benefits ($n = 927$)

- Time to Treatment: 16%
- Scheduling Follow-up Appointments: 12%
- Quality of Care: 12%
- Paperwork to Access Treatment: 19%
- Paperwork for Insurance: 18%
- Out-of-pocket Costs: 28%
- Obtaining Prescriptions: 13%

* Indicates a statistically significant difference at the 0.05 level.
Figure 15 displays the satisfaction among veterans who served in a designated combat zone and veterans who did not. On average, veterans who served in a combat zone are significantly less satisfied with time to treatment ($p = 0.028$) and scheduling follow-up appointments ($p = 0.030$). Specifically, 54% of combat veterans reported being satisfied or very satisfied with time to treatment, compared to 57% of non-combat veterans. Similarly, 65% of combat veterans reported being satisfied or very satisfied with scheduling follow-up appointments, compared to 68% of non-combat veterans. These differences are large enough to be statistically significant, but they may not be practically significant. There are no significant differences between combat and non-combat veterans with respect to satisfaction with paperwork to access treatment ($p = 0.844$), quality of care ($p = 0.185$), obtaining prescriptions ($p = 0.192$), paperwork for insurance ($p = 0.467$), or out-of-pocket costs ($p = 0.368$).
Figure 15. Satisfaction with various aspects of health care among veterans who served in a designated combat zone and those who did not

a. Veterans who served in a designated combat zone \( (n = 1,511) \)

b. Veterans who did not serve in a designated combat zone \( (n = 1,161) \)

* Indicates a statistically significant difference at the 0.05 level.
**ADDITIONAL COMMENTS**

In all, 1,091 respondents provided additional comments at the end of the Take 10 survey. Those comments were tabulated according to key words and phrases resulting in the graph displayed in Figure 16.

**Figure 16.** Additional Comments (unweighted) (n = 1,091)
XIV. Survey Slide Presentation at the Interim Study Hearing on healthcare access.
Oklahoma Veterans Health Care Access Survey

October 4, 2017

Oklahoma House of Representatives Interim Hearing

Dr. Mark Kinders, Ed. D.
Vice President for Public Affairs
Co-Chair, Governor's Task Force

Dr. Tracy Morris, Ph. D.
Professor, Mathematics & Statistics
Co-Principal Investigator
Survey Major Theses

1. Is Information Easily Found on Health Care Services and Options?
2. Do Rural and Urban Veterans Have Equal Ease of Access to Health Care Services?
3. How Satisfied Are They With This Access?
4. Are Combat and Non-Combat Veterans Equally Satisfied with Access?
Survey Participation

- Employed standard survey research protocols of UCO
- Anonymous survey: respondents’ identities are protected
- Survey available online on the Web, by Mobile Phone, on Paper
- Thorough, pervasive publicity campaign
- Available from June – August
- 4,170 Veterans Opened the Survey
- 2,898 Usable Surveys Were Completed
- Degree of Confidence is 95% with a Margin of Error of +/-2%
- Survey sought Demographics profile by:
  - Age
  - Gender
  - Race
  - Service Era
  - Where Veterans live
Access to Information on Health Care Options
Health Services Information Sources

- Other Vet: 9% Very Helpful, 12% Somewhat Helpful, 21% Somewhat Unhelpful, 14% Very Unhelpful, 74% Uncertain
- Other Vets Org. Rep.: 12% Very Helpful, 15% Somewhat Helpful, 24% Somewhat Unhelpful, 14% Very Unhelpful, 64% Uncertain
- Other Vets Org. Website: 19% Very Helpful, 25% Somewhat Helpful, 25% Somewhat Unhelpful, 27% Very Unhelpful, 61% Uncertain
- VA Staff: 19% Very Helpful, 24% Somewhat Helpful, 24% Somewhat Unhelpful, 25% Very Unhelpful, 58% Uncertain
- VA Website: 21% Very Helpful, 25% Somewhat Helpful, 25% Somewhat Unhelpful, 27% Very Unhelpful, 56% Uncertain
- ODVA Staff: 21% Very Helpful, 24% Somewhat Helpful, 24% Somewhat Unhelpful, 25% Very Unhelpful, 48% Uncertain
- TRICARE Rep.: 19% Very Helpful, 24% Somewhat Helpful, 24% Somewhat Unhelpful, 25% Very Unhelpful, 55% Uncertain
- TRICARE Website: 19% Very Helpful, 25% Somewhat Helpful, 25% Somewhat Unhelpful, 27% Very Unhelpful, 48% Uncertain
- ODVA Website: 19% Very Helpful, 27% Somewhat Helpful, 27% Somewhat Unhelpful, 27% Very Unhelpful, 48% Uncertain
Services Sought

Top Purpose is Primary Care Treatment
Health Care Sought
(Last 12 Months)

- Primary Health Care: 60.2%
- Specialty Care: 14.8%
- Urgent/Hospital/Home Care: 8.9%
- Access to Prescriptions: 8.7%
- Mental Health Care: 7.4%
Female Vets & Mental Health

- Primary Health Care: 60.8% Male, 55.2% Female
- Specialty Care: 14.6% Male, 20.1% Female
- Urgent/Hospital/Home Care: 9.0% Male, 5.6% Female
- Access to Prescriptions: 8.7% Male, 6.6% Female
- Mental Health Care: 7.0% Male, 12.2% Female
Younger Vets & Mental Health

- Primary Health Care: 56.8% (18-39 years old), 60.4% (40 years or older)
- Specialty Care: 12.2% (18-39 years old), 15.5% (40 years or older)
- Urgent/Hospital/ Home Care: 9.7% (18-39 years old), 8.8% (40 years or older)
- Access to Prescriptions: 2.3% (18-39 years old), 10.1% (40 years or older)
- Mental Health Care: 19.0% (18-39 years old), 5.1% (40 years or older)

UNIVERSITY OF CENTRAL OKLAHOMA
Combat Status Differences

Primary Health Care
59.9%  60.2%

Specialty Care
14.2%  15.7%

Urgent Hospital/ Home Care
8.6%  8.6%

Access to Prescriptions
7.1%  9.9%

Mental Health Care
4.3%  11.0%

Combat Veteran
Non-combat Veteran

Percent
0  10  20  30  40  50  60  70
Top Factors for Choosing Provider

- Quality of Care: 90%
- Insurance Coverage: 86%
- Provider Reputation: 76%
- Customer Service: 73%
- Availability of Appointments: 73%
- Cost: 71%
- Patient Safety: 68%
- In Payer Network: 56%
- Convenience: 54%
- Wait Times: 54%
- Family-Care Needs: 53%
- Distance to Facility: 53%
- Relationship to Provider: 48%

[Bar chart showing percentage importance]
Annual Frequency of Visits

Frequency of Health Care in the Last 12 Months

- 0 times: 6.3%
- 1-2 times: 19.4%
- 3-4 times: 27.7%
- 5 or more times: 31.3%
- Monthly: 12.1%
- Weekly: 3.2%
Locations for Seeking Health Care
(Last 12 Months)

- VA Hospital: 48.9%
- My Own Physician (Private Ins.): 34.7%
- My Own Physician (Medicare/Medicaid): 25.8%
- My Own Physician (TRICARE): 24.2%
- VA Satellite Clinic: 24.1%
- Emergency Care: 16.8%
- Veterans Choice Program: 16.0%
Acceptable Driving Distances
Rural, Mixed, Urban Travel Differences

[Bar chart showing the percentage of acceptable driving distances for Urban, Mixed, and Rural areas for different mileage ranges.]
Reasons for Not Using VA

1. Too expensive
2. Difficulty with appointments
3. Facilities too far away
4. Need service not available
5. Don't know about eligibility
6. Concerns about quality
7. Using other healthcare
8. Use Medicare/Tricare
9. Services not needed
10. Difficulty with enrollment
11. Benefits denied/not eligible
12. Miscellaneous negative
13. Other

Category Frequency

- Too expensive: 351
- Difficulty with appointments: 204
- Facilities too far away: 147
- Need service not available: 133
- Don't know about eligibility: 115
- Concerns about quality: 94
- Using other healthcare: 77
- Use Medicare/Tricare: 68
- Services not needed: 67
- Difficulty with enrollment: 62
- Benefits denied/not eligible: 31
- Miscellaneous negative: 23
- Other: 23

Percentage Breakdown:

- Too expensive: 34.5%
- Difficulty with appointments: 20%
- Facilities too far away: 14.4%
- Need service not available: 13.1%
- Don't know about eligibility: 11.3%
- Concerns about quality: 9.2%
- Using other healthcare: 7.6%
- Use Medicare/Tricare: 6.7%
- Services not needed: 6.6%
- Difficulty with enrollment: 6.1%
- Benefits denied/not eligible: 3.1%
- Miscellaneous negative: 3%
- Other: 2.3%
Combat and Non-Combat Veteran Satisfaction with Access
Non-Combat Veteran Satisfaction
(Nearly Identical to Combat Vets)

- Obtaining Prescriptions: 14% Very Satisfied, 8% Satisfied, 9% No Opinion, 2% Dissatisfied, 77% Very Dissatisfied
- Quality of Care: 15% Very Satisfied, 8% Satisfied, 8% No Opinion, 12% Dissatisfied, 73% Very Dissatisfied
- Scheduling Follow-up Appointments: 20% Very Satisfied, 12% Satisfied, 18% No Opinion, 14% Dissatisfied, 68% Very Dissatisfied
- Paperwork to Access Treatment: 21% Very Satisfied, 18% Satisfied, 25% No Opinion, 14% Dissatisfied, 61% Very Dissatisfied
- Out-of-pocket Costs: 27% Very Satisfied, 14% Satisfied, 25% No Opinion, 14% Dissatisfied, 59% Very Dissatisfied
- Paperwork for Insurance: 16% Very Satisfied, 25% Satisfied, 15% No Opinion, 14% Dissatisfied, 59% Very Dissatisfied
- Time to Treatment: 28% Very Satisfied, 15% Satisfied, 12% No Opinion, 12% Dissatisfied, 57% Very Dissatisfied

UNIVERSITY OF CENTRAL OKLAHOMA
Overall Satisfaction with Access

<table>
<thead>
<tr>
<th>Service</th>
<th>Very Satisfied</th>
<th>Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtaining Prescriptions</td>
<td>8%</td>
<td>8%</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>Quality of Care</td>
<td>8%</td>
<td>12%</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>Scheduling Follow-up Appointments</td>
<td>12%</td>
<td>12%</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>Paperwork to Access Treatment</td>
<td>16%</td>
<td>27%</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket Costs</td>
<td>16%</td>
<td>27%</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Paperwork for Insurance</td>
<td>15%</td>
<td>15%</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>Time to Treatment</td>
<td>15%</td>
<td>15%</td>
<td>61%</td>
<td></td>
</tr>
</tbody>
</table>
Questions
XV. Veterans Demographic Data Sheet
Oklahoma Service Members/Former Service Members (SMFSM) Population Overview

Oklahoma has the 10th largest veteran population per capita\(^1\).

The total SMFSM population consists of 9% of the state’s overall population\(^2\).

**National Guard and Reserve** Total Force population is 28% of the state’s service member population\(^2\).

Nearly 1 out of 10 veterans in the state of Oklahoma are Women\(^1\).

There are 244,618 wartime veterans who make up 81% of the state’s veteran population\(^3\).

**Gulf War Era** (including Post 9/11) veterans are the largest war time veteran population accounting for 40%\(^3\).

Age 65 to 75 consist of 25% of the state’s veteran population. Ages 29 and under account for 6% of the state’s veteran Population\(^1\).

The two highest veteran populated counties are Oklahoma 18.70% and Tulsa 13.92% while the lowest veteran populated counties are Cimarron 0/04%; Harper 0.06%; and Harmon 0.06% \(^3\).

Veteran population by congressional districts starting with the highest; District 4-24.37%; District 2- 19.88%; District 3- 18.93%; District 5- (OKC) 18.76%; District 1- (Tulsa) 18.06%. \(^5\)

Veteran population based on race/ethnicity: White 81.2%; Black 7.6% Native 4.8%; Two or more races 5.1% and other 0.9%; Asian/Hawaiian/Pacific Islander 0.3%\(^6\).

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XVI. Program Budget
   a. Assumptions
## Program Budget

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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</thead>
<tbody>
<tr>
<td><strong>Annual funding</strong></td>
<td>$100,000,000.00</td>
<td>$75,000,000.00</td>
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<tr>
<td><strong>Rollover from prior year</strong></td>
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<td>$29,864,200.00</td>
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<tr>
<td><strong>Total funds available</strong></td>
<td>$100,000,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Program services (claim payments to participating network providers)</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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</thead>
<tbody>
<tr>
<td>$53,560,000.00</td>
<td>$70,560,000.00</td>
<td>$92,610,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Telehealth program</strong></th>
<th><strong>Year 1</strong></th>
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<th><strong>Year 3</strong></th>
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<tbody>
<tr>
<td>$720,000.00</td>
<td>$1,008,000.00</td>
<td>$1,411,200.00</td>
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<tr>
<td><strong>Total Program Service &amp; Telehealth Fees</strong></td>
<td><strong>Year 1</strong></td>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
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<tr>
<td>$54,270,000.00</td>
<td>$71,568,000.00</td>
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<table>
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<tr>
<th><strong>Gross remaining funds</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tr>
<td>$45,730,000.00</td>
<td>$39,102,800.00</td>
<td>$10,843,000.00</td>
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</table>

### Expenses

#### Mental health

<table>
<thead>
<tr>
<th><strong>Manager (1)</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$70,000.00</td>
<td>$70,000.00</td>
<td>$70,000.00</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Supervisor (1)</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$-</td>
<td>$45,000.00</td>
<td>$45,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Regional coordinator (4 @ 30K) + 1/year</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$120,000.00</td>
<td>$150,000.00</td>
<td>$180,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Total mental health</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tbody>
<tr>
<td>$190,000.00</td>
<td>$265,000.00</td>
<td>$295,000.00</td>
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#### Claims processing center

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<tr>
<th><strong>Manager (1)</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tbody>
<tr>
<td>$85,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Supervisor (1)</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tbody>
<tr>
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<td>$50,000.00</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Processing technician (6 @ 40K) + 1/year</strong></th>
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<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tbody>
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<td>$240,000.00</td>
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<td>$320,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Total claims processing center</strong></th>
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<th><strong>Year 2</strong></th>
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<tbody>
<tr>
<td>$325,000.00</td>
<td>$415,000.00</td>
<td>$455,000.00</td>
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</table>

#### Navigator program

- **Fixed fee - $150.00 / patient** $2,250,000.00 $3,150,000.00 $4,410,000.00
- **Indirect cost (10% of fixed fee)** $225,000.00 $315,000.00 $441,000.00

<table>
<thead>
<tr>
<th><strong>Total navigator program</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tr>
<td>$2,475,000.00</td>
<td>$3,465,000.00</td>
<td>$4,851,000.00</td>
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#### Health information system

<table>
<thead>
<tr>
<th><strong>Coordinator (1)</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tbody>
<tr>
<td>$80,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Assistant coordinator</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tbody>
<tr>
<td>$40,000.00</td>
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<td>$40,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Software &amp; support services</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$150,000.00</td>
<td>$125,000.00</td>
<td>$150,000.00</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Total health information system</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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</thead>
<tbody>
<tr>
<td>$230,000.00</td>
<td>$245,000.00</td>
<td>$270,000.00</td>
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#### Administrative costs

<table>
<thead>
<tr>
<th><strong>General administrative</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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</thead>
<tbody>
<tr>
<td>$125,000.00</td>
<td>$125,000.00</td>
<td>$125,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Payroll expenses</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$214,200.00</td>
<td>$273,600.00</td>
<td>$298,800.00</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Accounting/auditing</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000,000.00</td>
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<td>$1,000,000.00</td>
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<table>
<thead>
<tr>
<th><strong>UCO data analytics</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<td>$2,000,000.00</td>
<td>$2,000,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Marketing/ advertising</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tbody>
<tr>
<td>$1,500,000.00</td>
<td>$1,450,000.00</td>
<td>$1,400,000.00</td>
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<table>
<thead>
<tr>
<th><strong>Total administrative costs</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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<tr>
<td>$6,839,200.00</td>
<td>$4,848,600.00</td>
<td>$4,823,800.00</td>
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### Total Expense Per Year

<table>
<thead>
<tr>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
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</thead>
<tbody>
<tr>
<td>$10,059,200.00</td>
<td>$9,238,600.00</td>
<td>$10,694,800.00</td>
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<table>
<thead>
<tr>
<th><strong>EOY Net Balance</strong></th>
<th><strong>Year 1</strong></th>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
</tr>
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<tbody>
<tr>
<td>$35,670,800.00</td>
<td>$28,864,200.00</td>
<td>$148,200.00</td>
<td></td>
</tr>
</tbody>
</table>
Oklahoma Veterans Pilot Program

Budget Assumptions

1. The annual funding is based on program startup costs & program services for an estimated 65,400 veterans over 3 years.

2. Program Service Expenses are based on a volume of 15,000 veterans in the first year with an estimated 40% increase annually over the next (2) years. The average cost per patient is calculated using the 2017 average cost per patient of the CHAMPVA Program of $4,200.00 as a base with a projected savings of 15% in the 1st year, 20% in the 2nd year and 25% in the 3rd year. We expect these savings to be generated through the Pilot Program by providing a single transitional network of care, employing strategic partnering with various state agencies.

3. The Telehealth program is based on 2% of the total veterans assisted with an estimated annual cost of $2,400.00 / unit deployed and monitored.

4. The program general and administrative expense projection is based on $30,000,000.00 or 12% of the total $250,000,000.00 allocated by the Federal Government to the Oklahoma Veterans Pilot Program. These figures may vary due to the allocation changes to pay rates, cost of fees and number of patients served.

   a. The Mental Health expenses are based on the salary of a Mental Health Program Manager in Oklahoma. We anticipate adding a supervisor in the 2nd year to handle the increase in volume, as well as adding an additional regional coordinator in the 2nd and 3rd year.

   b. The Claims Processing Center expenses are based upon a medical billing manager salary in Oklahoma. We anticipate adding a billing supervisor in the 2nd year to handle the increased volume, as well as adding an additional processing technician in the 2nd and 3rd year.

   c. The Navigator Program expenses were quoted to us by the Oklahoma Department of Rehab Services, based on our current program model.

   d. The Health Information System expenses are based upon a coordinator's salary in Oklahoma. We anticipate adding an assistant in the 2nd year to handle the increased volume. The software expenses are expected to be higher during the 1st year to include initial setup costs of $50,000.00 with an increase of the base support and subscription fees in the 2nd and 3rd years, as additional partnerships are formed with other state agencies.

   e. The Payroll Costs is based on 36% of the gross payroll to cover the costs of benefits, vacation, payroll fees, insurance and taxes. This percentage was derived from the Bureau of Labor Statistics employer costs for the Midwest Region.

   f. The Accounting/Auditing expenses were quoted to us by an Oklahoma CPA/Auditor, based on our current program model.

   g. The UCO Data Analytics expenses were quoted to us by UCO, based on our current program model, they estimated an additional 2,000,000.00 in the first year to cover the initial setup.

   h. The marketing/advertising expenses were estimated by a private company with expertise in social and paid media, based on our current program model.

   i. The General Administrative costs include the remaining balance of the 12% expense projection.