J Community Health (2014) 39:990–996
DOI 10.1007/s10900-014-9846-6

ORIGINAL PAPER

Tribal Veterans Representative (TVR) Training Program: The Effect of Community Outreach Workers on American Indian and Alaska Native Veterans Access to and Utilization of the Veterans Health Administration

L. Jeanne Kaufmann · W. J. "Buck" Richardson Jr. · James Floyd · Jay Shore

Published online: 2 March 2014

Abstract American Indians and Alaska Natives serve at the highest rate of any US race or ethnic group, yet are the most underserved population of Veterans and do not take advantage of the Department of Veterans Affairs (VA) benefits and services. Barriers to seeking care include stigma, especially for mental health issues; distance to care; and lack of awareness of benefits and services they are entitled to receive. In response to this underutilization of the VA, an innovative program—the Tribal Veterans Representative (TVR) program—was developed within the VA to work with American Indians and Alaska Natives in rural and remote areas. The TVR goes through extensive training every year; is a volunteer, a Veteran and tribal community member who seeks out unenrolled Native Veterans, provides them with information on VA health care services and benefits, and assists them with enrollment paperwork. Being from the community they serve, these outreach workers are able to develop relationships and build rapport and trust with fellow Veterans. In place for over a decade in Montana, this program has enrolled a countless number of Veterans, benefiting not only the individual, but their family and the community as well. Also resulting from this program, are the implementation of Telemental Health Clinics treating Veterans with PTSD, a transportation program helping Veterans get to and from distant VA facilities, a Veteran Resource Center, and a Veteran Tribal Clinic. This program has successfully trained over 800 TVRs, expanded to other parts of the country and into remote areas of Alaska.

Keywords American Indian · Alaska Native · Veterans · Rural · Community outreach worker

L. J. Kaufmann (✉) · J. Shore
Veterans Rural Health Resource Center-Western Region, Native Domain, VA Office of Rural Health, UCD Mail Stop-F-800, 13055 East 17th Street, Aurora, CO 80045, USA
e-mail: jeanne.kaufmann@ucdenver.edu

W. J. "Buck" Richardson Jr.
VA Rocky Mountain Healthcare Network (VISN 19), Ft. Harrison, MT, USA

J. Floyd
Jack C. Montgomery VAMC (VISN 16), Muskogee, OK, USA

Introduction

American Indian and Alaska Native Veterans serve in the US armed forces at a higher rate than any other ethnicity and as a result, they suffer the highest consequences of PTSD, substance abuse, health problems and disabilities [1–6]. American Indians generally enlist to serve in the military for reasons attributed to traditional American Indian culture; the warrior tradition or to gain warrior status [1, 7]. Warriors are recognized as having physical, mental and spiritual strength and are honored and revered within American Indian society. Not only are they protecting and defending their homeland, they are gaining status within their communities. Volunteer rates for Native service members were considerable during the Vietnam era and to this day American Indians and Alaska Natives continue to serve in high numbers [8]. During wartime, more often than not, Natives had greater exposure to psychological trauma and were often positioned on the front lines in combat or in high combat areas [9]. It has been noted [1] that those who serve on the front lines are at greater risk of serious health issues and death. After returning home from combat, many Native Veterans suffer from PTSD and depression as well as substance and

alcohol abuse at rates higher than any other ethnic group [1, 10]. In addition, untreated mental illness, such as depression or PTSD, can result in self-medication with drugs or alcohol [10]. These disorders not only negatively impact the Veteran but can also have a devastating effect on their families and communities. Native communities are intricately linked and often tight knit, especially in rural and reservation areas. Lack of anonymity can be an issue in rural communities in general and is especially true for American Indian and Alaska Native communities. The lack of available mental health care professionals in rural and remote areas contributes to problems for those Native Veterans suffering from PTSD or depression to receive adequate mental health care or treatment [10].

Native Veterans face many barriers to care which can be compounded by cultural factors as well as the rurality of this population and because of these, many Native Veterans do not seek medical attention upon their discharge from military service. Barriers to care include stigma, especially for mental health issues; distance to care; and lack of awareness of the health services and benefits Native Veterans are entitled to receive [10, 11]. Despite eligibility for services and benefits through the Department of Veterans Affairs (VA), many Native Veterans are not enrolled or even aware of benefits for having served in the US armed forces. Of those Veterans who are enrolled in the Veterans Health Administration (VHA), Native Veterans have a higher percentage of service-connected disabilities [8]. According to the VA, a service-connected disability means that a Veterans disability is a result of injury or illness that was incurred or aggravated during active military service. Estimates for the number of Native Veterans who are enrolled in the VHA system are limited. These limitations are due to disparities in racial identification such as self-reporting, reporting as more than one race, or misreporting/non-reporting by VA staff based on subjective assumptions, resulting in inaccurate and incomplete data [12]. Best estimates from 2008 VHA datasets indicate that there are approximately 5,186,305 outpatient Veterans, of which approximately 169,000 endorsed American Indian or Alaska Native as their only race [9, 12]. Based on available VHA data, of these enrolled Veterans who are American Indian and Alaska Native Veterans seeking treatment, approximately 48 % are from rural and highly rural areas [12]. According to the American Community Survey 2006–2008 Census, the total number of United States Veterans residing in rural areas is 6,125,142 and the number of American Indian and Alaska Native Veterans who endorsed only one race was 63,901 [9]. Conflicting information makes it difficult to get an accurate assessment of the number of Veterans and the number of enrolled Veterans in rural areas, as well as those endorsing American Indian or Alaska Native descent.

There are a number of barriers to care for Native Veterans in rural and remote areas. Not only must they negotiate long distances to VA or other medical facilities with few transportation options [6, 12], but there are also weather related obstacles. Delays in care and access to care, may cause additional health problems, cause existing health conditions to deteriorate, and can lead to higher overall costs for medical care [9]. Native Veterans have the additional dilemma of which medical services to access. They can utilize VHA services, if available, or visit Indian Health Service (IHS) facilities or Tribal health care which may be closer to home, but which may not be able to provide specialized care. Information about Native Veterans accessing IHS or Tribal health is not systematically shared with the VHA. Lack of access, awareness, historical distrust of the federal government, and "red tape" of the application process has deterred many from utilizing the benefits of the VA [13, 14].

Additional barriers for Native Veterans accessing mental health care through the VHA, are based on their perception of the federal health care system. Studies have shown higher rates of PTSD and mental health disorders among American Indian and Alaska Native Veterans, however a number of these Veterans do not seek VHA health care services [2]. One community based study was conducted to determine what these barriers to accessing care were and resulted in a number of institutional issues [2]. From this study, the top five barriers identified by Native Veterans were that the VA system is difficult to use, there is no outreach to Native American Veterans, Native American Veterans lack resources to access the VA, Native American Veterans distrust the VA system, and there is no VA (facility) in the Native American Community. In addition, other issues of concern identified in the study were cultural insensitivity on behalf of the system and staff, poor communication, VA staffs' false ideas about Native Americans, and unfamiliarity or unawareness of needs of Native Americans [2].

Current literature shows that community based outreach is one way to reach a population (e.g., the elderly, pregnant teens, people living with AIDS and HIV, alcohol and substance abusers, the uninsured, etc.) previously proven inaccessible through traditional means and marketing. Studies demonstrate that community health outreach workers engaging in, going into or living in the communities, and connecting with the target population are successful in recruitment efforts and have increased enrollment in health care services [15]. This is especially true if the workers have a familiarity with and share the local language, values, beliefs, culture, social and economic characteristics. They often act as the bridge between the population they serve and the healthcare system [16–19]. Outreach requires that the worker earn the trust of the

target population and be recognized as a reliable source for information and services [18]. In addition, community based peer outreach is effective for reaching and accessing the hard-to-reach hidden population because they know who and where the target population is and how to connect with them since they have or had experienced the same issues and needs.

Effective outreach, enrollment and utilization of VHA services are problems for Native Veterans. There are a few models of access to care for Veteran populations in general, such as peer support groups for returning OEF/OIF Veterans as well as Vet Centers. None of these models, however, specifically target or actively seek out Native Veterans in rural communities to provide information on VA healthcare services and benefits.

In response to the needs of Native Veterans, coupled with the barriers and access issues faced by this population, the VA has developed a unique program. The Tribal Veterans Representative (TVR) training program is the solution developed to improve access to, and knowledge of, VA benefits and services for Native Veterans. In the following sections, a description of the development of the TVR program, its structure, processes and impacts, as well as examination of the specific model of treatment, outreach and engagement will be provided. In addition, lessons learned from this program and their implications for work with other underserved populations will be presented.

Background/Methods

The TVR training program was originally conceived by James Floyd, then Director of the Salt Lake City VA System, and W.J. "Buck" Richardson, Jr., the Minority Veterans Program Coordinator, Rocky Mountain Network, VISN 19, in 2001. During a 2 day Tribal Veterans meeting organized by then Adjutant General John "Gene" Prendergast in Montana in October of 2001, Native Veterans voiced frustration that they did not know about, or know how to, access VHA services. In response to that meeting and in addition to the Tribal Councils and members concerns, Floyd and Richardson travelled throughout rural Montana and Wyoming visiting American Indian reservations and speaking with Tribal Councils and Veterans about their needs and concerns regarding lack of (health care or VA) services available in their communities. The tribal communities expressed a need and desire to assist the VA to fill the gaps in education and outreach for Native Veterans.

It became apparent, based on the low numbers of enrolled American Indian Veterans and lack of access to health care services through the VA, that providing information and assistance in accessing the VA could benefit not only the Veteran, but their families and the communities as well. The solution, reached through these discussions was to develop a program to utilize peer outreach workers with connections and ties within these communities and who had knowledge of and were culturally sensitive to Native Veterans, in order to increase their access and knowledge of VA benefits and services. The TVR program was the result of these community discussions focused on how to assist tribes and Native Veterans in rural communities.

Tribal Veteran Representatives are outreach workers, volunteers who are not paid by the VA. They are appointed by their Tribal Councils and serve as points of contact for Veterans in their community and as liaisons between the Veteran and the VA. They are generally American Indian or Alaska Native Veterans who understand military and Native culture. Some TVRs are non-Veterans who are either married to Veterans or have a strong connection to Veterans and those serving in the military. They are family members or others who are intricately involved in and have knowledge of Veterans issues, however the majority of TVRs are Veterans themselves. They seek out and engage non-enrolled Native Veterans in their communities to encourage them to enroll in the VA and to seek medical attention if they are aware that the Veteran may need it. The TVR encourages them to enroll and helps them to understand the process, as well as walk them through the paperwork, thereby enabling the Native Veterans access to health care services and benefits.

The first TVR training occurred in the fall of 2002 and since then has taken place each Spring at Ft. Harrison in Helena, Montana. It provides "reference information and materials to facilitate their delivery of effective outreach, peer assistance and accurate information on VA benefits and services to Veterans" [20]. Ongoing annual training arose from the success of the initial training, interest by others in receiving the training, as well as the need to stay current on changing procedures, forms and benefits in the VA system.

The week long training on benefits and eligibility by VA staff provides the TVRs with various information on the VHA, Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA) which they then pass on to Native Veterans and their families in their home communities. They receive a Resource Directory Guide, DVD and a variety of forms and materials at the trainings. TVRs are equipped to provide the necessary forms and advice in enrolling the Vets into the VHA system, as well as how to access benefits and services including, claims benefits, healthcare enrollment, education benefits, home loan programs, death benefits and other benefit related issues [21].

The program also trains TVRs on outreach. These outreach goals and objectives are to, reach out to all Veterans,

find underserved Veterans, help families of Veterans, increase access to benefits and help improve the quality of life [21]. TVRs provide information on other health and community resources, assist in making appointments with providers, and help coordinate transportation to appointments. They lend credibility and provide sensitivity to the outreach effort in attempts to dispel the distrust Native Veterans have of the federal government and the VA.

Tribal Veterans Representatives are taught to conduct outreach in a variety of ways. They seek out Veterans in the community that they know or have heard about who have served time in the United States armed forces and who may need medical assistance. Outreach is not only conducted in Veterans homes, but they also go to town hall meetings, community events, Veterans meetings, community celebrations (e.g., Pow Wows), and Veterans benefits fairs [21].

The training is not limited to VA benefits and services or even Native Veterans. Organizers will facilitate the training on a wide range of topics that affect the Veterans, their families and their communities such as state and local resources, substance abuse issues, education and job opportunities, etc. Each year prior to the training, attendees are asked what they want to focus or receive information on so that the program may be curtailed to the needs and wants of the TVRs and their communities. One challenge of the TVR program is effectively tailoring to the needs of all the tribes and Nations represented at each training. Since there are numerous tribal Nations present and not all of the information fits the needs and wants of each culture or community, organizers respect the differences and adjust the curriculum accordingly.

Ongoing training is essential to provide existing TVRs with updated information on VA services and to connect with other TVRs. At the trainings, new TVRs are able to receive guidance and lessons learned from, and network with, existing TVRs. It is necessary for returning TVRs to remain up to date on changes within the VA and the training accomplishes that through the updated Resource Directory Guides and annual meetings. Adjustments to the trainings are made in order to stay current on the ever changing VA forms and procedures. In addition, ongoing support is provided to active TVRs through informational list serves, phone calls that include peer to peer support, events and trainings which include cultural education of VA staff, as well as connecting TVRs with VA benefits and systems experts to help with specific issues affecting a particular Native Veteran.

Enrollment in the TVR training program is generally informal. When the program is presented at meetings and conferences across the country, individuals and tribal communities often inquire about how they can register and participate in a training. The cost for travel to and lodging at the trainings is generally provided by the tribal communities and the Tribal Councils. The Resource Guide and training materials as well as a certificate of completion are provided by the VA.

Results

Since the first TVR meeting in the Fall of 2002, over 800 people have gone through the training. These numbers represent approximately 620 trainees in the lower 48 states and 180 in Alaska. There have been 13 TVR trainings to date (September 2013) in Montana, as well as four in Alaska, three in Oklahoma, three in South Dakota, two in Michigan and Georgia, and one each in Washington State, Idaho, Arizona and Minnesota. There are more trainings planned for Fiscal Year 2014 in Michigan, Alaska, North Carolina, Oklahoma and Idaho. The annual training takes place at Fort Harrison in Helena, Montana; however trainings occur in other states based on special requests. Annual trainings have also taken place in Alaska since 2010 and beginning in Michigan in 2013. To date, approximately 36 states including Alaska, US Territory America Samoa, and Alberta, Canada all have TVR representation.

Additionally, several projects and programs have arisen either directly from the TVR program or from the work of TVRs. For example, on the Blackfeet Indian Reservation, the Veterans Transportation System has been established to provide vans enabling Veterans access to the Ft. Harrison hospital in Helena, Montana. The vans run between the reservation and the VA hospital, allowing Veterans a way to get to appointments and receive services they might not otherwise have access to due to their lack of transportation, or barriers such as weather and long distances between the reservation and nearest VA hospital. Also, on the Blackfeet Indian Reservation, a Veterans Tribal Clinic offering basic primary health care was established to provide non-life threatening health care services to the Veterans in the community. On the Flathead Indian Reservation, a Veteran Resource Center was created to provide and assist Veterans in obtaining information and resources. There has also been an increase in resources coming into the local communities as a result of the increased number of enrolled Veterans receiving benefits from the VA.

In addition to providing enrollment and benefit information to help connect Native Veterans to VA services directly, the TVRs in the Northern Plains communities who are aware of those suffering from PTSD or substance abuse issues, provide information and encourage Native Veteran(s) to seek help through the VA's American Indian Telemental Health Clinics [22]. These clinics utilize clinicians in Denver, Colorado and through telecommunications equipment counsel Veterans in rural and remote areas

with PTSD and substance abuse issues where no VA facilities are available. The clinics provide culturally appropriate care to those who may not seek or receive these types of services [6]. The TVR provides information on these clinics and if the Veteran is interested, will help get them enrolled in the VA in order to participate in these services. They play a critical role in enrolling Veterans, especially those who have not previously sought care, in these clinics and help to decrease the stigma of seeking mental health services. Additionally, by facilitating wider benefits and services for patients enrolled in these clinics, the TVR plays a major role in helping improve and support the overall health, functioning and provision of resources available to these patients. Currently, the Denver-based clinics have eight active sites serving 14 different tribes. Clinic data from 2002 to 2011 shows that approximately 970 clinics were held which saw 185 individual American Indian Veterans, 3,220 individual follow-ups were conducted and 440 group sessions were held for a total of 3,845 clinic sessions and 4,610 patient contacts. The TVRs were instrumental in engaging and facilitating Veterans in accessing these clinical services through the VA [22].

Discussion

The TVR program targets Native Veterans living in rural and highly rural areas. The use of TVRs in these communities is important given the nature of rural and Native communities. Kirchner et al. [10] state in their review that "Rural social networks are smaller, denser, and of greater duration than non-rural social networks and may be far more influential to persons living in rural areas where anonymity is difficult to achieve" [10]. Being from the community or living in the community, they have connections and know who to talk to and how to find Native Veterans. Being Veterans themselves, they have similar life experiences from serving in the armed forces and have a unique and specific understanding of and access to this underserved population. TVRs dispel some of the myths of access to the VA and can assist Veterans enrollment in and ability to access services.

Given issues of cultural sensitivity and distrust of government, Native Veterans are more likely to trust and build rapport with other members of their community who have also served in the armed forces, lending to their credibility [13]. The one-on-one contact and respect from someone who listens, cares and genuinely wants to help, makes a big difference. Some Veterans need assistance after "normal" working hours, some are homeless, have no transportation, or are struggling and a TVRs' flexibility is key to their role in providing assistance how and when a Veteran is in need.

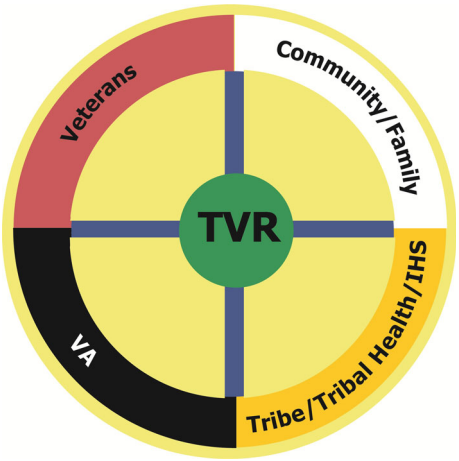

Fig. 1 The TVR Dream Catcher and how the TVR's represent and interact with different entities within and outside of their communities

Rural communities are intricately and highly connected. Community health and outreach workers who are from the community they serve, may have a better opportunity to create and develop relationships with the community and act as liaisons between health care providers and community members, as well as other organizations and entities who serve the community. They may also be better able to facilitate improvement in the health status and quality of life in rural communities and contribute to the delivery of health care in general [19]. TVRs, in their role as community outreach workers, interact on several levels. The TVR knows the community, is generally a Veteran and respected by community members, therefore they are able to foster trust and rapport and reduce barriers to VA enrollment for those in need of treatment. They are liaisons between the VHA, VBA, NCA and the Veteran, as well as State Veteran Organizations and tribal entities. Any information or services that are relayed to the Veteran, in turn get communicated and transferred on to family members and the community, including other Veterans, thereby affecting a larger number of people than solely that Veteran (Fig. 1).

Another outcome of the TVR program is its potential economic impact on tribal communities, which can be substantial. The TVR assists with Native Veterans enrollment into the VA system and as a result, helps to reduce the financial burden on local IHS clinics by reducing the use of services by Veterans so that more community members can access the IHS clinics. Congress budgeted $4.1 billion to the IHS in 2013, of which the per capita personal health care expenditure amounts to about $2,741 [23]. The IHS includes a system of 12 Area Offices and 168 IHS and tribally managed Service Units serving 566 federally recognized tribes; approximately 2.1 million American Indians and Alaska Natives [23]. Providing American Indian

and Alaska Native Veterans access to alternative clinics and services, subsequently frees up some of these expenditures, enabling additional tribal members to be served and access IHS health care services. Some Veterans that were using IHS or tribal health are now using VA services and alleviating those funds for other community members to utilize. The benefits paid by the VA to the Veteran, also infuses the local economies with money. In addition, with the implementation of the VA IHS National Reimbursement Agreement signed in December 2012, American Indian and Alaska Native Veterans will have increased access to health care services closer to home. As a result of the national agreement, the VA is able to reimburse the IHS for direct care services provided to eligible Native Veterans. The VA will reimburse at rates based on Medicare payment methodologies for inpatient and outpatient hospital services, freestanding clinic services, ambulatory surgical services, and outpatient pharmacy services.

The TVR training program has grown significantly over the past 11 years and continues to gain recognition as a model program within the Department of Veterans Affairs. Other programs are utilizing various aspects of it and incorporating them into their own outreach efforts to minority and rural Veteran communities proving its success and adaptability to other populations and communities. Not only has it affected the VHA through outreach and increased enrollment, but it has also provided hundreds of American Indian and Alaska Native Veterans with access to benefits and health care services they would not otherwise have known about or received. It has increased Veterans' quality of life and subsequently improved the lives of Veterans' family members and the communities in which they live by providing access to benefits and services they earned for their service.

Since 2002, this program continues to attract volunteers to serve in an outreach capacity within reservation communities. The intention to encourage and assist Native Veterans enrollment in VA in order for them to receive the benefits and health care services has been effective. This program appears to have had a major influence in these communities however, there is no conclusive data as to the overall impact this program has had on clinical outcomes or if it increases or improves benefits for Native Veterans. The implications are that this type of program could benefit other hard-to-reach populations within the VA. The issues surrounding unreliable numbers of Native Veterans, and ethnicity and racial data pertaining to American Indian and Alaska Natives, as well as statistics concerning TVRs and the number of Veterans enrolled in the VA as a result of the training program are limitations of moving forward to track these components.

The next step would be an evaluation component to track the number of Native Veterans enrolled as a direct result of the TVR program as well as how benefits are affected. For example, are there higher numbers of Native Veteran enrollees in the VA from reservations with TVR representation; and are services newly implemented and more prevalent on these reservations? An accurate assessment of these numbers would indicate support for the success of the program and increase its status as a model program which can be applied to various populations, not only to rural Native Veterans. Ideally, if a source of streamlined data were available that could more clearly identify who is Native and who is a Veteran, and define reservations as rural and remote areas, etc., then data can begin to be gathered or accumulated in a more regimented process thereby moving forward in defining successes and gaps of this program.

Despite the absence of this type of data gathering, outreach efforts onto American Indian reservations and in Alaska Native communities have increased Native Veterans' knowledge and awareness, as well as access to VA health care services and benefits. The success of the program can be evidenced by the continually increasing number of TVRs trained, indications that it is successfully enrolling Veterans, and the fact that other VISNs and departments within the VA are duplicating or modeling the concept/program and implementing similar trainings by sending outreach workers to various parts of the country to disseminate information, train representatives and enroll Veterans into the VA.

Conclusion

The TVRs, simply by living in and knowing the members of their community and being Veterans themselves, have a much better knowledge of who the Veterans are and a familiarity with the issues and barriers this population faces. Not only can this type of program be applied to the Native Veteran population, but it offers lessons and a potential model to other rural and Veteran populations. Utilizing community outreach workers familiar with a culture and the community, whatever that may be, is a key in gaining access to the underserved and hidden populations. By understanding and being able to relate to their struggles, provides outreach workers the support to build trust and rapport, and the ability to increase enrollment in the health care system, thereby increasing access to services and elevating the health status of the community.

The TVR program was developed to improve Native Veterans' and their families' access to and utilization of VHA benefits and health care services, and to developing and maintaining communication at the local level. The program and training are critical to address communication issues and reduce barriers to VHA services for American

Indian and Alaska Native Veterans in rural and remote areas where these are lacking. It is an innovative model that helps to identify and outreach to American Indian and Alaska Native Veterans and provide them with information on the VA and their entitled benefits.

Acknowledgments This research was funded by the Veterans Rural Health Resource Center—Western Region, Salt Lake City, Utah—Field Office for the Office of Rural Health. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs. This manuscript was reviewed by the Office of Rural Health, Department of Veterans Affairs, prior to submission.

References

1. Friedman, M. J., Ashcraft, M. L., Beals, J. L., et al. (1997). Matsunaga Vietnam Veterans Project, Vol. 1. White River Junction, VT: *National Center for Posttraumatic Stress Disorder and the National Center for American Indian and Alaska Mental Health Research*.
2. Westermeyer, J., Canive, J., Thuras, P., et al. (2002). Perceived barriers to VA mental health care among Upper Midwest American Indian veterans: Description and associations. *Medical Care, 40*(Suppl 1), 62–70.
3. Kramer, B. J., Wang, M., Jouldjian, S., Lee, M. L., Finke, B., & Saliba, D. (2009). Veterans Health Administration and Indian Health Service: Healthcare utilization by Indian Health Service enrollees. *Medical Care, 47*, 670–676.
4. Holiday, L., Bell, G., Klein, R. E., & Wells, M. R. (2006). *American Indian and Alaska Native Veterans: Lasting contributions*. Washington, DC: Department of Veterans Affairs, Office of Policy Assistant Secretary for Policy, Planning, and Preparedness.
5. Beals, J., Manson, S., Shore, J., et al. (2002). The prevalence of posttraumatic stress disorder among American Indian Vietnam veterans: Disparities and context. *Journal of Traumatic Stress, 15*(2), 89–97.
6. American Indian Telemental Health video. (2012). Department of Veterans Affairs, Office of Rural Health, Rural Health Resource Center-Western Region, Native Domain.
7. Native Americans and the US Military. Naval history and heritage. US Navy Web site. Accessed July 2013. http://www.history.navy.mil/index.html.
8. American Indian and Alaska Native Service members and Veterans. (2012, September). Department of Veterans Affairs.
9. Kaufman, C. E., Brooks, E., Kaufmann, L. J., et al. (2010). *Rural native veterans population report*. Department of Veterans Affairs, Office of Rural Health, Rural Health Resource Center-Western Region, Native Domain.
10. Kirchner, J. E., Farmer, M. S., Shue, V., et al. (2011). Partnering with communities to address mental health needs of rural veterans. *The Journal of Rural Health, 27*, 416–424.
11. Rost, K., Smith, G. R., & Taylor, J. L. (2008). Rural–urban differences in stigma and the use of care for depressive disorders. *The Journal of Rural Health, 9*, 57–62.
12. Kaufman, C. E., Brooks, E., Kaufmann, L. J., et al. (2013). Rural native veterans in the Veterans Health Administration: Characteristics and service utilization patterns. *The Journal of Rural Health, 29*(3), 304–310.
13. Tribal Veteran Representative Training Live Broadcast CD. (2006, November 15). Washington, DC: Department of Veterans Affairs Employee Education System (EES).
14. Welcome Home OEF/OIF Tribal Veteran Outreach Program CD. (2007, January). Washington, DC: Department of Veterans Affairs Employee Education System (EES).
15. Mack, M., Uken, R., & Powers, J. (2006). People improving the community's health: Community health workers as agents of change. *Journal of Health Care for the Poor and Underserved, 17*(1), 16–25.
16. Renault, V. (2012). Chapter 23. Modifying access, barriers, and opportunities. Section 6. Using outreach to increase access. Community Tool Box Web site. Accessed Dec 2012. http://ctb.ku.edu/en/tablecontents/sub_section_main_1876.aspx.
17. Glaun, K. (2009, May 11). How to conduct effective public benefits outreach to Native American populations. National Council on Aging Web site. Accessed Dec 2012. http://www.ncoa.org/enhance-economic-security/center-for-benefits/promising-practices/how-to-conduct-effective.html.
18. Needle, R. H., Burrows, D., Friedman, S., et al. (2004). *Evidence for action: Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*. Geneva: World Health Organization.
19. Community Health Workers Evidence-Based Models Toolbox. (2011, August). HRSA Office of Rural Health Policy. US Department of Health and Human Services, Health Resources and Services Administration.
20. Tribal Veteran Representative (TVR) Resource Guide. (2012). Washington, DC: Department of Veterans Affairs Employee Education System (EES).
21. Richardson, W. J. (2013). *Establishing effective outreach to veterans. Minority Veteran Outreach Program; Rocky Mountain Healthcare Network (VISN 19) Powerpoint presentation*. Department of Veterans Affairs, Office of Rural Health Web site. Accessed July 2013. http://www.ruralhealth.va.gov/education/wbnreeov/EstablishingEffectiveOutreachtoVeterans.pdf.
22. Shore, J., Kaufmann, L. J., Brooks, E., et al. (2012). Review of American Indian veteran telemental health. *Telemedicine and e-Health, 18*(2), 87–94.
23. IHS Year 2013 Profile Fact Sheet. (2013, January). Indian Health Service, Department of Health and Human Services (HHS) Web site. Accessed July 2013. http://www.ihs.gov/newsroom/factsheets/ihsyear2013profile/.