Working with Veterans Service Organizations

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BACKGROUND

Increasingly, medical researchers focusing on human subjects recognize the benefit of engaging with stakeholder groups in the course of carrying out their research. Such engagement can guide the researchers' choice of research topics to ensure that it addresses the problems that are most important to the communities being studied. By working with stakeholders during the conduct of the study, researchers can confirm that their methods are acceptable to community members; moreover, stakeholders can support outreach efforts, both for accruing subjects and for ensuring effective dissemination of results. The Veterans Healthcare Administration (VHA), part of the Department of Veterans Affairs (VA), is dedicated to the service of a clearly defined population – Veterans of the United States Military. As such, VHA researchers are readily able to identify the population that is most directly affected by their research efforts.

Veterans Service Organizations (VSO)

A wide range of organizations seek to support Veterans, often via attempting to influence or collaborate with VA. This support can take many forms; advocating for Veterans, providing services to Veterans, information sharing – e.g., advising Veterans how to access services to which they are entitled (esp. VA services), or purely emotional support. These organizations vary enormously: They can be local or national, for-profit businesses or charitable organizations, and Veteran or non-Veteran led.

In our efforts to ensure that our research is relevant for Veterans, and to leverage the peer support implicit in Veteran-led organizations whose mission is to serve Veterans, we have worked extensively with several such organizations. We will refer to these groups as Veterans Service Organizations (VSO) and define VSO as Veteran-led non-profit organizations whose

primary mission is to support Veterans. We will describe our experience both with national organizations and local organizations.

VSO history

In 1879 Congress chartered the first organization to represent Veterans in applying for benefits—the Navy Mutual Aid Association, but U.S. Military Veterans have banded together for mutual support since the country's founding. Indeed, one of the first financial crises in United States history was the demand from Continental Army regulars for payment for their years of service, which contributed to the formation of the First National Bank. The Grand Army of the Republic (GAR), made up of former Union soldiers following the Civil War, was both a social group (annual GAR encampments were enormously popular events for the members) and an advocacy organization, lobbying for pensions for injured Veterans, supporting voting rights for black Veterans, and campaigning for Republican candidates like Ulysses S. Grant. The GAR also presaged the patriotic displays led by modern VSO, establishing May 30th as Decoration Day, which eventually became Memorial Day. Finally, the organization into state level departments and local posts, which provided nearby social support for Veterans, was adopted by successor organizations such as the Veterans of Foreign Wars (VFW), formed in the aftermath of the Spanish American War.

While there are no direct successors of the GAR, the VSO that were initiated by Veterans of the Spanish American War (e.g., the VFW) or World War I (many, including the Disabled American Veterans and the American Legion) have persisted to the present day. The decision to maintain a large standing army in support of America's global presence led to the evolution of VSO that were not focused on a single conflict. While the Vietnam Veterans of America continue to be a "last man" organization that will dissolve with the death of the last Veteran of that war, many other VSO are open to a very broad membership. Some seek to serve Veterans with a specific

type of military experience (e.g., Military Chaplains Association of the USA), or Veterans from a distinct cultural group (e.g., Jewish American War Veterans, National Association of Black Veterans).

A number of VSO have received Congressional Charters, which are primarily honorific, but indicate that the group was sufficiently organized and motivated to seek and gain that recognition. Today there are 41 congressionally-chartered VSO ranging in size from fewer than 100 members (Congressional Medal of Honor Society) to more than 2 million (American Legion).(9) In addition, hundreds of other VSO are in existence. A partial list can be found on the VA's website: https://www.va.gov/vso/VSO-Directory.pdf.

VSO demographics

VSO activity peaked following World War II and the Korean conflict, when more than half of American men had served in the military, most during wartime. However, more recent cohorts of Veterans have been less likely to join VSO. Thus, VSO members tend to be older. Not unexpectedly, most members are male, reflecting the military makeup during that era. Moreover, the older and larger VSO (American Legion, VFW) had their membership growth during a period of widespread official and informal segregation, so that their members are disproportionately white. As would be expected with this older population, many have chronic diseases. Table 1 summarizes the demographic and clinical characteristics of the VSO members who participated in one of our projects.

VSO functions

A major function for some of today's VSO is representing Veterans in their claims for Veterans benefits. In addition to state government entities, 30 additional organizations are certified by VA to provide this service (https://www.va.gov/ogc/apps/accreditation/accredvso.asp). In addition to representing Veterans in benefits claims, VSO are potent political advocates for improved

Veterans benefits and support for active duty military personnel. Locally, VSO support youth activities, assist Veterans in need, make charitable donations, and participate in patriotic events, such as parades and military funerals. Many VSO members volunteer regularly at schools and hospitals, particularly VA hospitals, and participate in VSO sponsored blood drives.

VSO structure

As might be expected given the diversity of background, size, and current mission, the structure of VSO varies widely. We describe the structure of two very different organizations with which we have worked, the American Legion and Dryhootch of America, Inc.

The American Legion

The American Legion is the largest American VSO, with a membership of nearly 2 million. The Legion is hierarchically organized: Posts are organized into Districts which are organized into Departments (corresponding to states) which report to the national organization. The smallest unit is a post, which is organized by a group of members (Legionnaires) who meet regularly, typically monthly. These members generally live within a geographic region around the meeting location, though post catchment areas often overlap. This could be because a workplace (e.g., the Harley Davidson post) brought members together. Alternatively, personality conflicts within an existing post might cause a subset to split off, or Veterans with a shared identity – e.g., a post of police officers, or a post more accepting of African American Veterans – might form their own post.

Only the more engaged post members attend meetings regularly; among the posts participating in one project, mean meeting attendance was 21.7, while mean post membership was 208.5. Posts meet in a variety of venues, and their meeting places often display patriotic elements, such as American flags, a Veterans' memorial, or retired military equipment.

Each post is part of a District, which are geographically defined. In Wisconsin, the 400+ posts are organized in 12 Districts. Districts can facilitate collaboration among posts in a geographic area, but generally defer advocacy activities to the state level. In the Legion, the statewide organizational unit is the Department, as in “the Department of Wisconsin.” In large states, like California, it has been helpful to organize Districts into Areas, again with the idea of coordinating across posts and Districts within the Area. In addition to the 50 states, there are Departments serving the Legion posts in the District of Columbia, Puerto Rico, the Philippines, Mexico, and France. The Department in France serves 33 posts throughout Europe and the United Kingdom.

Within each organizational entity, there are elected leaders. The overall leader is a Commander, generally with one or more Vice-Commanders. The Adjutant typically manages the organization, while other officers include a Chaplain and Service Officer, the latter guiding efforts to help Veterans obtain the Veteran benefits to which they are entitled. At the Department and National level many of these individuals are paid professionals, although the Commander and Vice-Commanders are elected volunteers. Because these statewide and national leadership positions are very time consuming, they demand considerable personal dedication to the Legion, and some other source of income – many commanders are retired. The paid staff are generally responsible for ensuring that posts are functioning in accord with both Legion and civic guidelines – for example, they help ensure that individual posts attend to their responsibilities and limits as non-profit organizations.

While there is considerable overlap, Department and National leaders head most Legion advocacy activities, while post and District leaders carry out “boots on the ground” social and volunteer activities – for example, supporting Scouting organizations, providing honor guards at funerals for Veterans, or sponsoring the training of a service animal for a disabled Veteran.

Multiple posts within a District might contribute to organize and staff volunteer services at a VA Medical Center in their region. Large programs like American Legion Baseball require national, statewide, and local coordination. All levels of the organization have major roles in patriotic or memorial activities like Veterans and Memorial Day observances.

Dryhootch of America, Inc.

In marked contrast to the highly structured American Legion are single location VSO like Dryhootch of America, Inc (Dryhootch). In 2007, several primarily Vietnam era Veterans in southeastern Wisconsin formed Dryhootch to advocate for fellow Veterans, with a specific emphasis on the mental health needs of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans. At its outset, the primary aims of Dryhootch were to provide a peer-to-peer support system, as opposed to traditional clinical mental healthcare, and to facilitate reintegration into civilian life, totally apart from any named mental health issue. The founding Veterans initial approach included creating an acceptable headquarters for socialization and support among Veterans, including those who did not qualify for VA services, in unused structures on the grounds of the local VA Medical Center. This evolved into the creation of a retail coffee shop run by and for Veterans, which would also support an extended network of Veteran families and encourage Veteran interactions within the larger community.

The website explains that “hootch” is military jargon for a hut or safe place to sleep during combat. The term “dry” denotes the organization’s mission to provide a social gathering place for Veterans that is free of drugs and alcohol – a source of problems for Veterans of all eras. As such, the concept behind “Dryhootch” was a desire to establish a café-like environment dedicated to “helping Veterans who survived the war, survive the peace.” Dryhootch currently operates two Veteran-run coffee houses in Milwaukee. It has collaborated with other Veteran led or Veteran friendly organizations to develop other supports for Veterans. It is not a

membership organization but does use volunteer peer leaders in addition to paid staff to deliver support to Veterans with various mental health or reintegration needs. Veteran serving organizations with similar missions in other locations are loosely affiliated but there is no organizational link. There is an overseeing board, as required for its non-profit status, but operational decisions are centralized among the leadership, with the founder retaining the final say around organizational decisions.

EXEMPLAR PARTNERED ACTIVITIES AND LESSONS LEARNED

POsts Working for vetERans health (POWER) – Project 1 of 5

Based on increasing literature attention, a VA HSRD researcher (JW) thought that peer support might be an effective adjunct to clinical care, and reached out to VSO affiliated service officers at the Milwaukee VA to suggest that peer support delivered within VSO posts might improve Veterans' self-management skills, particularly around cardiovascular risk reduction. Simultaneously, we reached out to individual post commanders, requesting a chance to present to post members about health improvement and blood pressure (BP) control. We visited 7 local posts, presenting a brief, 5-minute overview of the importance of self-management for BP control, addressing questions and asking for thoughts on how best to help Veterans with hypertension control. We also measured blood pressures with a portable device, recording results without individual identifiers beyond age. Questions from post members covered a wide range of medical conditions, eligibility for VA benefits, and ways to improve VA healthcare, but there were no suggestions for how best to improve hypertension control, though several post members endorsed the importance of peer support.

One VSO officer, the statewide Service Officer for the VFW, viewed this program as a potential way to increase the value that the organization would bring to its members. He introduced JW to

the elected statewide leaders who agreed to provide a letter supporting the idea, emphasizing that participation would be a decision for each post commander.

The state level endorsement, the demonstrated receptivity of the initial posts, and the poor BP control documented at the visits (and in the literature) led to foundation funding to pilot this at 15 VFW posts. While approaching VFW posts for this project, two Veterans attending the VFW meeting where JW presented suggested that their Legion post might be interested, which led to the inclusion of 13 VFW and 2 Legion posts in POWER. Once committed, all of the posts continued to deliver the intervention throughout the planned 12 month intervention, except one VFW post where the commander, who was also the sole peer supporter at that post, developed family issues that made him unable to continue. However, data collection continued at that post.

POWER – Lessons Learned

1) The VA is a known quantity in the Veteran community. Unlike other academic outreach to community partners, the Veterans were very accepting of outreach – indeed, one group asked why we had not been doing this earlier.
2) Facetime is important. Going to the post facility on their schedule was simple and established that this was a partnership in which they shared authority.
3) These Veterans were deferential to medical authority and kind to guests. As opposed to “Community Based Participatory Research” in which the community partner helps define the agenda, these older Veterans seemed very deferential to the idea that JW brought to the meeting.
4) Veterans who belong to one VSO often belong to others. While very few Veterans attend VSO meetings, those who do may attend multiple meetings. It also makes it likely that one connection to the Veteran community can lead to other connections. Table 2 shows the VSO growth from one project to the next, often by word of mouth.

POWER II – Project 2 of 5

The visibility of POWER facilitated engagement with other VSO in Wisconsin, including the American Legion, the Vietnam Veterans of America (VVA), and the National Association of Black Veterans (NABVETS), which agreed to provide letters of support for a VA application for a more formal evaluation of the peer support intervention, including a clustered randomized trial to perform an evaluation. Each of the organizations provided letters of support for a successful grant application to conduct the trial (POWER II) and helped him to identify representatives for a Community Advisory Board (CAB).

Our approach to engaging posts was like that used in POWER. We mailed the post commander a letter introducing the project, noting state leadership support, and requesting a personal visit to the post. We followed up by telephone to schedule a visit by JW (70% of visits) or other study investigators. At the visit, the presenter distributed a one-page summary of the project, and talked about chronic disease self-management, the importance of peers in shaping behavior, and the requirements and incentives for participating.

The requirements included having two or more Veterans at each post serve as post representatives, responsible for helping us recruit eligible participants at their post, serve as peer leaders if their post was randomized to a peer led intervention, and be an ongoing point of contact. We enrolled eligible (i.e., hypertensive) post members in a study to evaluate the efficacy of the interventions. Our research assistants interacted with study participants four times over the course of the project (three times in person, one via phone). Meetings with study participants lasted 30-60 minutes, involved “hands-on” contact (BP checks), and provided valuable opportunities to converse and build trust. Though we did not interact directly with post members who were not in the hypertension study, we stressed to the post representatives and

peer leaders that presentations, handouts, equipment, etc. were intended for *everyone* at the post, not just those who enrolled in the study. We encouraged the sharing of POWER materials with family, friends, co-workers, and visitors to the post.

The CAB included representatives from our VSO partners and diverse community members, including the director of a city-wide health partnership, the president of a local medical society, a VA hospital administrator, and a leader from another fraternal organization. The PI and study coordinator met with the CAB on a quarterly basis to discuss engagement strategies, the peer leader training curriculum, and study progress.

POWER II – Lessons Learned

1) Recruitment within the VSO community is feasible. Across POWER and POWER II, we contacted 238 posts and visited 146. Most who declined visits reported that only a few post members attended meetings and did not think a visit was worth our time. Half (73) of the posts we visited joined either POWER or POWER II.
2) Veterans who signed up for key roles stayed engaged. We recruited 27 peer leaders for POWER; 21 of these original leaders completed the project. We recruited 58 peer leaders for POWER II; 56 completed the project. During POWER II, the attendance at training sessions averaged 86%. Trained study staff observed two post meetings at each POWER II post in the peer-led group. Data from these visits revealed that the planned presentations were made at 93% of posts, the scale was set out 57% of the time, blood pressure cuffs were set out 85% of the time, and health materials were displayed as designed 78% of the time. We think that requiring two peer leaders per post for POWER II improved adherence since both peers were engaged and supported one another. All posts completed data collection for both projects. The enthusiasm of the peer leaders is demonstrated by anecdotes collected by staff or comments like those shown in Table 3.

3) Once the post is in, the members are in. During enrollment, we estimated that about 1240 individuals regularly attended meetings at our participating posts. Based on their age, approximately 744 (60%) would have hypertension. Of this estimated number of eligible patients, 404 (54%) enrolled in the study, a remarkably high number. And our loss to follow-up was minimal: 379 (93.8%) of our original 404 participants provided data at 12 months, our primary endpoint. Of those lost, 13 had died, and 4 relocated.
4) Academic rules regarding research are viewed with some amusement by post members. For example, some peer leaders wanted to be sure that post members did not decline to participate in a project supported by the post, with the informed consent document viewed as a formality. To achieve uniform BP screening to identify eligibility, one peer leader insisted that members have their BP checked before they could get a beer.

Electric POWER – Project 3 of 5

We routinely present ongoing VA research to American Legion Departmental leadership and at the statewide convention. This has led to ongoing engagement. In response to a short turnaround pilot opportunity for funding of digital outreach, we proposed to use peer champions to enhance uptake of MyHealtheVet (MHV) in parts of Wisconsin that were a long way from VA Medical Centers. Departmental leadership provided assurance that they would work with us to identify posts that would participate, and that these posts would be willing to work with other Veterans. Our existing CAB from prior work endorsed the approach.

This project required the use of WiFi enabled laptops for communicating with the MHV website and demonstrating functionality. Since VA IT security software detracts substantially from functionality and makes the experience less comparable to using one's own software, we budgeted for the Legion to buy the hardware and software, as well as to provide stipends to peer leaders and participating posts. We also budgeted for a sophisticated Veteran user to

provide support for hardware malfunction and to help us with hardware selection. The Legion kept the hardware after the project was over.

We used a stepped wedge design in which the four laptops being used for demonstration were moved to four new posts every 4 months to demonstrate that the availability of peer led training led to increased familiarity with MHV and an increasing number of Veterans signing up as users.

Electric POWER – Lessons Learned

1) Many VSO members do not use VA Healthcare but are highly invested in it. We found that most of the Veteran members of these posts did not use VA healthcare. Although our educational efforts included a demonstration of how to seek health information online using both MHV and other reputable sources, we noted that VA-specific interventions were not personally relevant to many VSO members.
2) At the state level, the American Legion is a sophisticated organization and can complete VA required paperwork expeditiously. The subcontract required substantial paperwork – DUNS number, becoming a VA vendor, making the case that this should be a sole source contract – and the Legion was able to carry this out with little difficulty.
3) Legion Departmental leaders are very influential and knowledgeable. The experienced adjutant with whom we worked was able to identify posts with a history of successfully participating in other projects and could make the case with them in advance of our approach. Thus, all twelve of the posts that we approached for the project were willing and able to participate. The one that had difficulty with the project had been flagged as potentially problematic in advance.
4) Accumulated expertise – e.g., the existing CAB – is valuable. It is important to continue to stay engaged.

MOVE OUT – Project 4 of 5

Since the VA MOVE! program is highly effective for participants but has had a hard time getting people to participate regularly, we collaborated with our CAB to develop the MOVE OUT project, in which we would offer weight management activities at VSO posts. Based on feedback from the CAB, we focused on physical activity, since Veterans worry more about fitness than weight. In preparation for the application, Veterans who had dropped out of MOVE! – or who were eligible for MOVE! but did not participate – told us that barriers included inconvenient times and locations, and lack of access to facilities.

We identified fifteen posts scattered across our VA Medical Center's catchment area who were willing to serve as host sites for MOVE! education and activities, adapted for delivery by Veteran peers. We would educate these peers at regular meetings and they would then deliver the information to Veterans who came to their sites. Because of the importance of regular physical activity, we asked posts to provide at least weekly opportunities for physical activity but suggested more regular activity was beneficial. Most prospective peer leaders noted that they were already exercising more regularly than that, so they could do so, or could coordinate with their partner peers to have a range of options. Because these posts were distributed across the area, all Veterans would be within a few miles and less than 15 minutes travel from a participating site. In addition, the timing was outside the regular business hours of VA site MOVE! programming. Most of these Veterans would not be members of the host posts but would be meeting in a Veteran friendly environment. Moreover, it was hoped that this might stimulate more Veterans to join these posts. In addition, participants could request a highly discounted membership at one of several local YMCA branches. Because the participating posts were scattered across the area, we asked the peer leaders to attend bimonthly meetings at the VA, which all agreed was a central location, or at one of two posts which were more convenient for some members.

After funding, several posts dropped out because the prospect of tying up additional nights beyond their regularly scheduled post meetings was more daunting when it became reality. Other posts found that it was a large commitment considering that most participants would not be post members. Attendance by peer leaders was lower than it had been for POWER and POWER II.

During the implementation of the project, very few invited participants chose to attend the sessions at the host posts. When this pattern did not change despite regular delivery of informational newsletters, we made phone calls which suggested that although the times were no longer during business hours, they were still not convenient, and though the location was now nearby, it was still inconvenient to have to travel in order to exercise. While post peer leaders continued to deliver the planned exercise sessions, most of the people who attended were members of their own post, rather than the MOVE! eligible patients who had been invited as part of the study.

MOVE OUT – Lessons Learned

1) It may be asking too much to have people come to their post solely for the purpose of VA activities. It would be preferable to link the VA activity to an existing post activity. While we retained every one of 58 posts for POWER II, when almost all activities happened in the context of regular post meetings, we had substantial drop-out from MOVE OUT, which required meetings when there was no post activity.
2) Although VSO posts are a familiar environment to VSO members, they may not be an attraction for non-members, at least no more than other local venues.
3) Our Veteran CAB overestimated the influence of VSO on the Veteran community, perhaps because VSO members were over-represented on the CAB.

Dryhootch Peer Support Training – Project 5 of 5

In 2007, a VFW post commander who JW approached for POWER was also a board member for Dryhootch as it was being formed. He identified that the peer support advocated for hypertension self-management was like the peer support Dryhootch proposed to support the civilian reintegration of Veterans from OEF/OIF conflicts. As opposed to POWER, this was an area where JW had no clinical expertise, but where the Veteran partner had a clear vision of what they desired. They were also aware of a need for funding to support their work, and that POWER was being funded. The founder worked with JW to craft a funded grant application that proposed a needs assessment and a pilot effort to recruit and train individuals to provide peer support around reintegration issues.

This work led to purchasing a mobile food truck to do community coffee-based Veteran outreach and establishing a coffee shop qua peer support location in an area at some distance from the VA. Study team members contributed to demolishing and remodeling the facility, creating a sense of shared mission. Additional funding supported delivery of peer support to Veterans with dual diagnoses (substance use and another mental health condition), support for Veterans involved in the criminal justice system, and development of a training program for lay mental health peer supporters. There is ongoing development of a mobile app to support community-based peer supporters and their clients. These foundation and federal grants have totaled more than $3 million and continue to be an important contributor to the Dryhootch mission.

Dryhootch Peer Support Training – Lessons Learned

1) When the idea comes from the VSO, they are more reliably committed to the project. While the Legion has been an incredible partner, the academic team clearly leads the

project and ensures task completion. Dryhootch pushes for additional projects both from their need for funding, and because this is the only reason their organization exists.

2) Small organizations like Dryhootch may lack infrastructure. They are less reliable than the Legion regarding things like tracking hours or submitting invoices for reimbursement.
3) VA/academic investigators have resources and knowledge that can be very helpful, even if they lack expertise in the specific problem (or problems) they are asked to solve.

CONCLUSION

Our academic team pioneered the use of VA/VSO partnerships for community-based, peer-supported health promotion programs and associated studies of effectiveness. The bullets below summarize our “cross-project” lessons learned.

- It is important to understand the VSO with which you hope to work. For example, it is important that you make initial inquiries at a level consistent with organizational culture and rules. Additionally, you need to understand whether the way you hope to work with the organization is consistent with its goals.
- It is important to choose study staff members who are approachable, friendly, committed to the project and responsive to the needs and concerns of participants. The VSO community has substantial internal lines of communication. We continue to hear about prior staff members who have left Veterans with fond memories.
- The post leadership must be committed to the implementation of the project, especially as it relates to the peer leaders having adequate time to present.
- Post leadership support is necessary but not sufficient. Key post members (in our case, peer leaders) must be personally interested in the project. When post commanders “appointed” members to the role, performance suffered.

- When delivering health information to posts, presenters should use techniques that actively engage the audience. When using devices or props such as computers, pedometers, or blood pressure cuffs, be sure they are durable and functional; it is hard to make Veterans forget past equipment failures.
- Veterans, particularly those engaged in Veteran support activities, know each other. This is helpful for referrals, but also makes it hard to erase a bad reputation. Integrity, credibility, and a commitment to relationships that go beyond the funding cycle are essential for anyone looking to work with VSO.
- Ongoing engagement is vital. Highly engaged members of the academic team need to stay engage. As JW, the senior member of our group, took on other duties, the ability to spend time in the field became constrained. Even in stable organizations such as the Legion, when turnover of leaders occurs, relationships need to be re-established, which takes time. KE, ZF, LP and KH have developed relationships where JW is only peripherally involved; these relationships benefit all academic team members.
- Including MF, an early Veteran leader of Dryhootch, in the academic team has opened up additional contacts. He has spent considerable time as a paid consultant through various academic practices, which has allowed him to make an academic impact on behalf of Veterans, particularly within VA, but also more broadly. His arms-length distance from VA/MCW has allowed him more flexibility in outreach than would have been possible for VA employees or MCW faculty.

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TABLES

TABLE 1.		
Baseline Demographics of Study Participants in the POWER Program		
	POWER (pilot), N=153	**POWER II (trial), N=404**
Age (mean, in years)	65.6	68.2
Gender (#/% male)	129 / 84.3%	353 / 87.4%
Race/ethnicity (#/% white)	146 / 95.4%	389 / 96.3%
Household income, percent at <$25K:	19.2%	14.4%
Household income, percent at $25K to <$35K:	14.4%	15.8%
Household income, percent at $35K to <$75K:	43.2%	35.9%
Household income, percent at $75K or more:	23.2%	15.8%
Employment status (#/% retired)	92 / 60.1%	278 / 68.8%
Formal years of education (#/% high school or more)	138 / 90.2%	377 / 93.3%
Hypertension (#/%)	117 / 76.5%	404 / 100%
Previous heart attack/myocardial infarction (#/%)	21 / 14.1%	65 / 16.1%
Angina, coronary heart disease, bypass surgery, angioplasty, stent placement (#/%)	35 / 23.3%	120 / 29.7%
Stroke (#/%)	6 / 4.0%	33 / 8.2%
Renal failure or kidney damage (#/%)	9 / 5.9%	24 / 5.9%
Diabetes mellitus (#/%)	44 / 28.8%	108 / 26.7%
Obesity (BMI>=30) (#/%)	65 / 42.5%	205 / 50.7%

TABLE 2.				
The POWER Program: Participating VSO and # of Posts				
VSO Name	**Posts in POWER (pilot)**	**Posts in POWER II (trial)**	**TOTAL POWER POSTS N=73**	**% per VSO of TOTAL POSTS**
American Legion	2	34	36	49.3%
Veterans of Foreign Wars (VFW)	13	11	24	32.8%
Vietnam Veterans of America (VVA)	0	5	5	6.8%
Benevolent and Protective Order of the Elks (ELKS)	0	2	2	2.7%
National Association of Black Veterans (NABVETS)	0	1	1	1.4%
American Veterans (AMVETS)	0	1	1	1.4%
Disabled American Veterans (DAV)	0	1	1	1.4%
Korean War Veterans (KWV)	0	1	1	1.4%
Jewish War Veterans (JWV)	0	1	1	1.4%
Marine Corps. League	0	1	1	1.4%

TABLE 3.
Examples of Peer Leader Activities that Went “Above and Beyond” the Requirements of the Program (Source: Self-Report and Observation)
Arranging to have guest speakers talk at the post about health-related topics
Doing independent research on a “hot topic” in health and sharing the findings with post members and the POWER staff
Writing health-related articles for the post newsletter
Setting up and maintaining a website dedicated to POWER topics
Starting a “walking group” with co-workers
Anecdotes from the Peer Leaders that Suggest a High Degree of Post Member and Community Engagement in POWER (Source: Written End-of-Program Evaluations)
“...following the exercise band training, a post member and his wife thanked me for my efforts and said that both he and his wife read all the handouts. His wife specifically said she enjoyed the exercise bands and uses them regularly.”
“People showed their medication cards, and talked about what questions they were going to ask their doctor.”
“One of the members started an exercise program. He really ‘went to town’ with his pedometer. He brought it in every month to tell people how many miles he walked.”
“My wife has lost 15 lbs. She exercises more and substitutes lower calorie food items for high calorie ones.”
“A fish fry customer was very happy with the information provided to the public via the Health Corner.”