

Rural Promising Practice Issue Brief: Connecting Older Veterans, Especially Rural, to Community or Veteran Eligible Resources (COVER to COVER)

Executive Summary

Nearly 10 million Veterans in the U.S. are age 65 years or older. Though many are eligible for benefits from the U.S. Department of Veterans Affairs (VA), many do not know or understand if they are eligible. Additionally, community resource counselors regularly work with Veterans, but they, too, may have limited understanding of VA benefits eligibility or the application process. The lack of familiarity among both Veterans and those who provide them with assistance is especially disadvantageous for vulnerable populations, such as:

- Veterans living in rural communities, who often face geographic and other barriers to access health care
- Older Veterans, who are more likely to have comorbid conditions (i.e., two or more health conditions at the same time)
- Veterans with chronic health conditions
- Veterans under financial strain or facing homelessness
- Home-bound Veterans

This model builds formal partnerships – and trust – among VA staff counselors, community agency staff, and the Veterans they serve. In the course of formal VA benefits trainings and building relationships, it bridges gaps in knowledge and helps to overcome previous communication barriers.

Connecting Older Veterans, Especially Rural, to Community or Veteran Eligible Resources (COVER to COVER) provides an access point to rural Veterans, caregivers and surviving spouses for extensive information on Veteran benefits, public programs, and private options. Aging and Disability Resource Centers (ADRC) or Area Agencies on Aging are trusted entities within rural communities. In many cases, Veterans call the ADRC for assistance with available public programs such as Medicaid, Medicare or utilities assistance. By partnering with VA and developing a deep understanding of VA benefits, ADRC staff can also provide detailed information about available resources for Veterans.

Pioneered at Utah's ADRC, this partnership creates a Veteran Benefits Specialist in-house at a local ADRC to educate Veterans about resources available to them, address Veterans' concerns about VA benefits, and provide real-time, accurate information. The Veteran Benefits Specialist, also called an options counselor, undergoes training with a VA partner to become an expert in VA programs. They are also well-versed about other federal, state and community resources such as Medicaid, the State Health Insurance Assistance Program, the Home Energy Assistance Target, and Medicare in order to share the most relevant information with Veterans.

This program improves services provided to Veterans and helps engage new populations who previously did not use VA services. It also empowers caregivers and surviving spouses who can benefit from a Veteran's enrollment in VA, thus strengthening families and communities as well as the individual Veteran.

Who Can Use This Rural Promising Practice?

All ADRCs, Area Agencies on Aging and Centers for Independent Living can use this partnership building model to expand their capabilities and better serve Veterans. In addition, all VA facilities seeking to build partnerships with community agencies can benefit from this strategy. This Rural Promising Practice can be initiated by either a local support agency or a VA facility. This includes, but is not limited to:

- Aging and Disability Resource Centers
- Area Agencies on Aging
- Centers for Independent Living
- Facilities of the Veteran Health Administration (VHA), including VA Medical Centers (VAMC) and Community Based Outpatient Clinics (CBOC)
- Geriatric and Patient Aligned Care Team Social Workers
- Regional and local representatives of the Veterans Benefits Administration (VBA)
- State Departments of Veterans Affairs

Subject Matter Experts

Jennifer Morgan, Program Manager, COVER to COVER

jen.morgan@utah.edu

(801) 582-1565 x4099

Bret Hicken, Geriatric Domain Lead, Veterans Rural Health Resource Center - Salt Lake City, Utah

bret.hicken@va.gov

(801) 582-1565 x2666



Need Addressed

Of the nearly 10 million Veterans in the United States who are 65 years of age or older, millions live in rural communities across the country. Though many Veterans are eligible for benefits from VA, many do not know about their options. For Veterans who reside in rural communities, learning about VA benefits can be especially challenging due to limited resources.

Anecdotal evidence suggests that many Veterans are hesitant to initiate what they fear will be a complicated application process. Additionally, many (especially aging Vietnam-era Veterans) encountered misinformation about their benefits at the time they returned from service, or developed health conditions related to their service later in life, never returning to VA for support. As such, some have no interaction with VA and instead rely on community geriatric resource centers to coordinate their health needs.

ADRCs are often the go-to resource for these Veterans. ADRCs are equipped to provide information and referrals, and specialize in options counseling to assist older adults and persons with disabilities to obtain long-term support.

Further reinforcing the barrier between older rural Veterans and VA was a lack of understanding of VA processes among community social workers and regional benefits coordinators who work outside the VA health system. In 2012, the Utah ADRC conducted a needs assessment of ADRC sites throughout the U.S. to evaluate typical needs of Veteran clientele and their experience to obtain services and benefits. More than 30 ADRCs participated in the survey. Approximately 95 percent of respondents reported that they usually or always asked clients about their Veteran status. However, their knowledge of VA benefits was generally poor—on average, 81 percent of ADRCs reported needing more information about VA resources. Respondents also expressed difficulty in finding information about VA services on their own. They overwhelmingly expressed interest in taking trainings about how to better navigate VA resources. These data formed the basis for an ongoing program between the VA Office of Rural Health and the Utah ADRC to provide extensive training on VA benefits to ADRC options counselors.

Through this model, rural Veterans have a new access point in the ADRC to learn about VA benefits and guide them through the application process within their trusted community network.

Veteran Success Story

An elderly couple living in rural Utah, each more than 90 years old, called the Utah Aging and Disability Resource Center to ask for assistance with their heating bill. Their counselor identified them as Veterans, and due to extensive training with VA experts, was able to educate and assist with their application process to enroll them in VA's health system for care. Now, both receive in-home services, greatly reducing their travel burden.

Implementation

The model can easily be implemented at other ADRCs through extensive training for current staff. Roll-out occurs in several steps: initiation, budgeting, training, implementation and evaluation.

Initiation

The decision to participate in this Rural Promising Practice requires willing partners from VA – VHA, VBA, or both – and community agencies. The first step is to identify a champion to help facilitate the approval process for implementation. A champion is required from each organization, and the champion's supervisor(s) must be willing to allow them to dedicate time to the process. These potential champions can be identified through traditional networking or basic online research once target partners are identified.

Budgeting

The partnership is built on existing infrastructures that are widely available in rural communities. Both VA and the Area Agency on Aging's infrastructure covers even the most remote counties. Additionally, State Offices of Veterans Affairs are required to have expansive coverage.

In practice, the champion of each organization will help arrange for appropriate early VA benefits training, and address early partnership barriers. Funding to compensate for effort of champions appears to be a key element. Often this might involve paying part of the salary of an individual in one of the partnering organizations.

Training

For more than 18 months, designated options counselors from Utah ADRCs received approximately 50-60 hours of highly-specialized VA benefits training. The same initial trainings should take place multiple times – at least three, and some as many as eight – to ensure that ADRC learners absorb the technical details described by VA experts. Ongoing training is also essential after the initial learning. This requires a time commitment from VA champions who serve as instructors. This duty is often shared across several VA staffers who opt to co-teach. This commitment must be clear from the beginning to ensure follow-through throughout the trainings.

Organizing trainings also became a key instrument for reaching out to various points of contact at local VA facilities, which helped grow the number of personal connections between staffs inside and outside of VA. It is integral that these trainings happen in-person, rather than remotely or online, to encourage the development of relationships between resource options counselors and VA administrators.

Training should take place in several phases, at first focusing on the basics of military culture, VA structure and VA terminology, and then moving on to the details of benefits eligibility and application.

Phase 1: Topics include military culture, learning VA language, how to obtain a DD Form 214 (Certificate of Release or Discharge from Active Duty), and how to locate local Veteran services representatives.

Phase 2: Core benefits training including disability compensation, pension, aid and attendance, burial, Veteran homes, Veteran health care enrollment, in-home health services, dependency indemnity compensation, Vet Centers, CBOCs, and Veteran Service Organizations.

Phase 3: Shadow local VA staff and representatives to see first-hand how the VA health and benefits systems operate.

Ongoing: Currently all community agency participants attend at least two days of training per year.

Many agencies sent multiple staff to VA benefits trainings to ensure maximum understanding throughout their office, with typical trainings hosting 20-40 attendees each. Invitations were extended to many community partners, including Medicaid representatives, 2-1-1 state helpline representatives, and New Mexico, Nevada, and Idaho ADRC staff. The positive response from these diverse agencies demonstrated a clear interest in learning more about the VA benefits process.

Implementation

Trained ADRC counselors use their up-to-date expertise of the VA system and benefits to support Veterans. All new clients are systematically asked about their military status. Additionally, some community agencies integrate their Veteran outreach with existing in-home visits, creating additional touch-points to discuss VA benefits. For instance, Salt Lake County clients receiving Meals on Wheels are now asked about their military status. Counselors provide information about the different programs available, and sit with the Veteran and their family to fill out applications paperwork. This unique and invaluable outreach from ADRCs provides entry points for Veterans who may not have reached directly to VA on their own.

Evaluation

Follow-up customer satisfaction surveys were conducted with Veterans who engaged with an ADRC Veteran Benefits Specialist and ultimately were referred to VA resources. The surveys provided insights into the strengths of the model and areas for potential expansion.

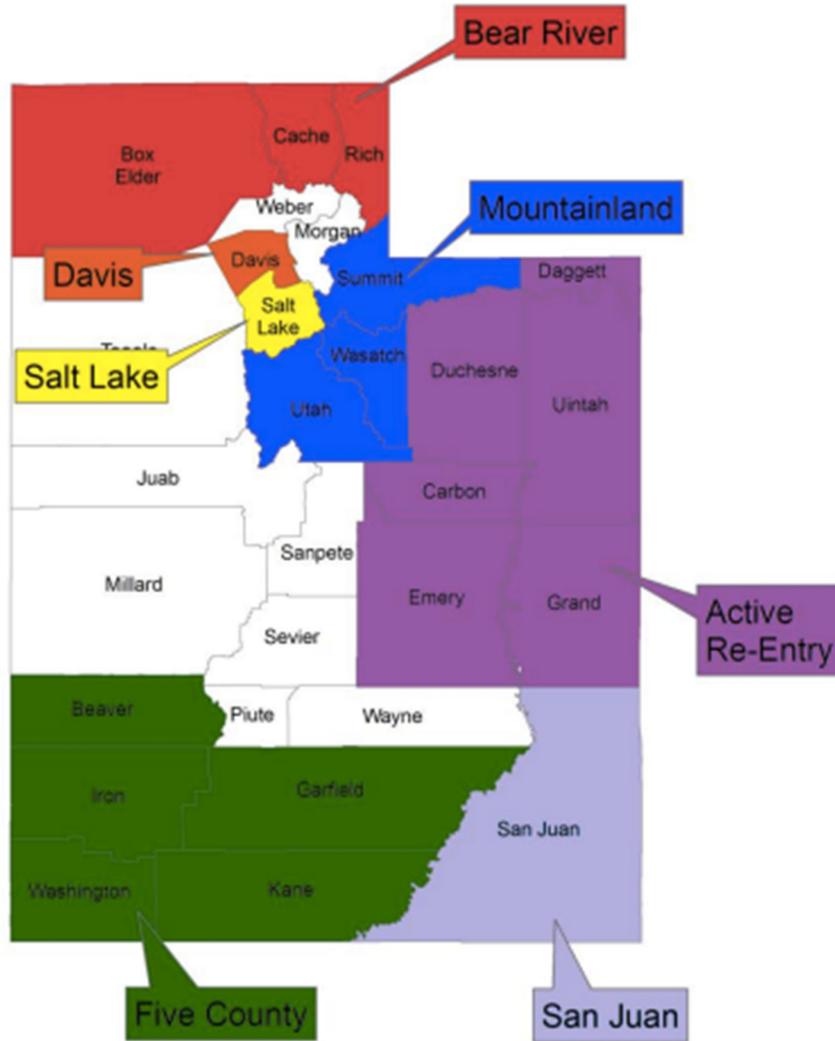


Figure 1. The colored counties demonstrate the broad range of Utah Aging and Disability Resource Centers that participate in the COVER to COVER program.

Promising Results

This model meets the following requirements for being selected as an ORH Rural Promising Practice:

Increased Access: This program embraces the no-wrong-door approach that is central to options counseling. COVER to COVER emphasizes access provision to rural Veterans in their own communities.

Fr April 1, 2013, to June 30, 2016, the program served more than 2,400 unique Veteran clients, facilitating more than 4,600 separate encounters. Of special note are the nearly 750 referrals made to assist Veterans who were previously not enrolled in the VA health system. The following data describe the demographics of Veterans who sought options counseling at five different agencies throughout Utah. Nearly half were age 80 years or older. Nearly as many caregivers and spouses call for support as do Veterans themselves.

ADRC Veteran Clients	Total*
Total Veterans	2,430
Total Encounters	4,634
Age 80+	1,102
Age 70-79	461
Age 60-69	387
Age 59 and younger	100
Deceased (client widow)	359
Service Era	
World War II	797
Korean Conflict	665
Vietnam War	692
Gulf War/Operation Enduring Freedom/ Operation Iraqi Freedom/ Operation New Dawn	56
Other	199
Caller Type	
Veteran	1,055
Caregiver or spouse	985
Widow of Veteran	369
Key VA Program Referrals (multiple may apply to a single Veteran)	
VA health care	1,168
Aid and attendance	929
VA in-home health services	710
Disability compensation	614
Pension	533
VA nursing home	421
Burial benefits	201

*Data represents fiscal year 2013 through third quarter fiscal year 2016

Evidence of Clinical Impact: More than 600 Veterans were enrolled in VA health care via COVER to COVER since the program's inception. Nearly 200 Veterans were referred for in-home services.

Office of Rural Health Rural Promising Practice Criteria

Increased Access: Measurable improvements in access to care and/or services. Examples include reduction in distance traveled to care, reduction in wait times, improved care coordination, and reduction in missed appointments.

Evidence of Clinical Impact: Positive results on outcomes of importance to rural Veterans based on evaluations conducted during the implementation of the program and at the end of the pilot period.

Customer Satisfaction: Increased patient, provider, partner, and/or caregiver satisfaction.

Return on Investment: Improvement in health system performance by 1) reducing the per capita costs of health care, and 2) improving or at least maintaining health outcomes, and/ or 3) positively impact the health care delivery system.

Operational Feasibility: Implementation is feasible and known barriers and facilitators of success could easily be shared across implementation sites.

Strong Partnerships and/or Working Relationships: Inclusion of VA and/or non-VA partners to maximize the efficacy of the intervention.

Customer Satisfaction: A formal plan for regular evaluation of patient satisfaction is a consistent element of this program. This involved calling a sample of Veterans and caregivers. In the first round of evaluation calls, out of a sample size of 70 people, 55 percent reported being aware of their referral to a VA service. More than half of clients reported that they already experienced positive changes as a result.

During the program, the ADRC continued to fine-tune the client satisfaction survey. Since the Veteran client population is older, issues with memory and the complexity of answer choices had to be addressed. Additionally, it was determined that surveying six to nine months after the encounter was not as effective as Veterans often did not clearly recall specific conversations. Currently, evaluators call Veterans and caregivers within one-month of their interaction with ADRC staff. However, this timeframe also poses a challenge as VA paperwork is often still being processed, making it difficult to gauge satisfaction with VA services. A protocol to assess satisfaction with the initial encounter and with subsequent services is in progress.

Return on Investment: In addition to the common mission of providing care and resources for rural Veterans, the financial incentives for participating are also significant. For a VAMC, additional previously non-enrolled Veterans can become vested, which positively impacts Veterans Equitable Resource



Allocation reimbursement. For the ADRCs, this partnership creates additional access to resources that may otherwise be non-existent or very limited. For state entities, such as a State Office of Veterans Affairs, participation promises delegation of limited state resources and increased federal involvement for rural Veterans. For instance, in Utah, the total disability and compensation to Veterans in the state increased 24 percent between fiscal years 2013 and 2014. Veterans are often able to access VA benefits immediately, rather than remaining on waiting lists for limited state resources and programs. This can lead to direct reductions in the cost of Medicaid and other state programs. Thus, diversity of the portfolio of programs available to rural Veterans has positive financial implications at many levels.

Operational Feasibility: So far, in addition to Utah, first-steps toward implementation have taken place in Colorado, Idaho, Nevada and Oregon. Representatives in Alabama, Kentucky, New Hampshire and Texas have expressed interested.

The program reinforces and expands work that already occurs, and creates synergies to allow this work to be done more efficiently. In this sense, this is not a “new program.” Partnerships empower participants by providing new knowledge, resources and relationships that help them to be more effective in their current work.

Strong Partnerships and/or Working Relationships: The heart of this program is a mutually beneficial partnership through the development of relationships that focus on the needs of individual Veterans and their families. The evolution of this program involved progressively adding more formal partners and deepening relationships.

Adoption Considerations

The following considerations represent findings noted from ADRC staff during the implementation and refinement of COVER to COVER.

- Each region and state should tailor COVER to COVER to their particular needs and strengths during implementation. The program lends itself to personalization at the site of implementation. For instance, established relationships with local Veteran Service Organizations could be integrated into the VA-state resource center partnership to further increase Veteran engagement.
- Additional referrals can increase the workload of existing VA and State Offices of Veterans Affairs staff.
- Participation in training must be coupled with both the ADRC counselor's and VA champion's commitment to support the resulting referrals with personal follow-through. Many VA health resources can be accessed quickly with the help of a willing VA partner (e.g. respite care). VA benefit decisions tend to take longer. Coupling increased access to both VA health and benefits provides "early wins" for the partnership that result in ongoing momentum.
- Achieving a common understanding about eligibility and content of VA resources reduces

misunderstandings about the appropriateness of referrals.

- VA staff members' willingness to provide their direct lines to multiple members of state resource center staff created invaluable direct connections.
- VA staff members are very often willing to provide training, sometimes the same training, multiple times.
- Partnering between VA services and administrations can be as important as partnering with outside agencies.
- CBOC staff may be less familiar with the full spectrum of VA benefits. Once trained, ADRC counselors may ask about VA benefits that are unfamiliar to VA staff.

Conclusion and Next Steps

Collaboration between the Utah ADRC and VA created a deepened understanding of both partners about the potential resources that can assist older rural Veterans.

As new sites begin to adopt this Rural Promising Practice, program administrators are working to identify key program elements that will allow successful expansion of the program to ADRCs in other states.

Available Resources

The leads of this Rural Promising Practice offer the following resource to aid in its implementation at other sites of care:

- Training agendas and materials (found on <http://www.utadrc.org/training.html>)

For more information on Rural Promising Practices, visit <http://www.ruralhealth.va.gov/providers/promisingpractices>.

Authors

Jennifer Morgan, MS Ed¹; Bret Hicken, PhD²; Randell Rupper, MD MPH³

¹ Utah Aging and Disability Resource Center

² Veterans Rural Health Resource Center – Salt Lake City, Utah

³ Salt Lake VA Geriatric Research Education and Clinical Center

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To Learn More

The U.S. Department of Veterans Affairs' (VA) Office of Rural Health (ORH) implements a targeted, solution-driven approach to increase access to care for the 3 million Veterans living in rural communities who rely on VA for health care. As VA's lead advocate for rural Veterans, ORH works to see that America's Veterans thrive in rural communities. To accomplish this, ORH leverages its resources to study, innovate and spread enterprise-wide initiatives through partnerships. To discuss implementing a Rural Promising Practice at your facility or to learn more, visit www.ruralhealth.va.gov or email rural.health.inquiry@va.gov.

VA



**U.S. Department
of Veterans Affairs**

References

1. National Center for Veterans Analysis and Statistics. Annual VetPop Survey, fiscal year 2014. Available from http://www.va.gov/vetdata/veteran_population.asp.