

COVER to COVER: Connecting Older Veterans (Especially Rural) to Community or Veteran-Eligible Resources

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A demonstration project trained community counselors to become veteran benefits specialists to improve access to benefits for veterans who are unaware of their eligibility.

According to the VA, 23% of veterans in the U.S., nearly 5.2 million individuals, live in rural areas.¹ The VHA serves more than 3 million rural veterans, and 56% of those enrolled in the VA system are aged ≥ 65 years.¹ Thus, aging veterans in rural areas constitute a substantial group who need support and assistance from the VA. Fortunately, the VA offers numerous benefits for veterans that support aging in place and improve quality of life through the VHA, Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA).

Despite the opportunities, many VA benefits go unclaimed. In some cases, veterans simply do not know these benefits exist.² In a 2010 VA re-

port, only 41% of veterans indicated that they understood their benefits “a lot” or “some.”² However, their understanding of specific benefits tended to be lower. For example, many veterans stated that they had “heard about” burial options at VA cemeteries (41.5%), but few understood specific benefits, such as cash burial allowances (10.6%).²

Many veterans also hold misperceptions about eligibility, which prevents them from applying. For example, some veterans believe that a high income or lack of combat ser-

vice disqualifies them from receiving VA benefits.³ Some veterans believe that others are more deserving of VA services, and they don’t want to “take a spot someone else needs.”³ Finally, some veterans hold negative attitudes about the VA, making them less likely to claim VA benefits, such as health care.⁴

For rural veterans, accessing benefits can be especially difficult, because most VA facilities that offer assistance are in urban centers.⁵ Though online access to benefit information is improving through

The VHA’s Geriatric Research Education and Clinical Centers (GRECCs) are designed for the advancement and integration of research, education, and clinical achievements in geriatrics and gerontology throughout the VA health care system. Each GRECC focuses on particular aspects of the care of aging veterans and is at the forefront of geriatric research and clinical care. For more information on the GRECC program, visit the website (<http://www1.va.gov/grecc/>). This column, which is contributed to by GRECC staff members, is coordinated and edited by Kenneth Shay, DDS, MS, director of geriatric programs for the VA Office of Geriatrics and Extended Care, VA Central Office, Washington, DC. Please send suggestions for future columns to Kenneth.Shay@va.gov.



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programs like My HealthVet and public facing websites, some older adults do not use computers, and Internet and mobile phone connectivity are often limited in rural communities.⁶ Nearly 43% of rural veterans do not have broadband Internet in their homes.¹ Moreover, the complexity of navigating benefits information via the Internet can be a frustrating and confusing process for older veterans.⁶

Accessing services and benefits in the community is similarly difficult. For more than 30 years, community organizations have noted the frustration that clients experienced with navigating a complex network of community providers who provide long-term services and supports (LTSS).^{7,8} In 2003, the Administration on Aging and the Centers for Medicare and Medicaid Services developed the Aging and Disability Resource Center (ADRC) program to promote a “no wrong door” approach for LTSS. Aging and Disability Resource Centers are a single point of entry into a network of community, state, and federal LTSS for older adults and individuals with disabilities.⁸ Options counselors at ADRCs provide information, counseling, and assistance with connecting to a vast network of programs such as Social Security, Medicaid, local transportation, Meals on Wheels, and housing assistance through a single office.

BACKGROUND

In 2012, VHA Office of Rural Health Resource (ORH) and Utah ADRC conducted a national survey of ADRC sites about their experiences working with veterans and found that 95% of ADRCs always or usually asked clients about their veteran status. The survey found that veteran clients present to ADRCs with diverse needs, many of which could be addressed through a VA benefit. However, the

majority (58%) of ADRC respondents reported that they had never attempted to help a veteran apply for VA benefits (unpublished data, 2012).

Respondents reported a limited understanding of VA benefits, infrequent contact with VA, and frustrations with the VA system. Although familiar with several sources for information about VA benefits (eg, toll-free number, websites, local VA facilities, etc), respondents generally found these sources unhelpful and insufficient for answering their questions. The only positive anecdotal comments that respondents made regarding VA were from those with personal relationships with employees at the VA who could help with veteran needs. Finally, all respondents reported a need for more information about VA benefits and to assist them with helping veteran clients.

Survey Response

In 2013, the ORH and the VA Salt Lake City Geriatric Research Education and Clinical Center (GRECC), under the sponsorship of the VA Office of Geriatrics and Extended Care (GEC), developed a collaborative demonstration with the Utah ADRC to address the needs identified in this survey. Connecting Older Veterans (Especially Rural) to Community or Veteran Eligible Resources (COVER to COVER) is a demonstration project designed to create a new access point for VA benefits for veterans living in rural areas. The pilot had 2 aims: (1) train ADRC options counselors as Veteran Benefits Specialists (VBSs); and (2) build relationships between the ADRCs and VA to facilitate information and referral.

Between 2013 and 2015, the demonstration was housed at the VA Salt Lake City Health Care System GRECC as part of the clinical dem-

onstration portfolio. The GRECC staff provided administrative support and mentorship for the developing partnerships. Subsequently, the demonstration was selected as a Promising Practice for enterprise-wide implementation. Both ORH and GEC coordinated opportunities for broad dissemination.

PROGRAM ELEMENTS

In Utah, 5 pilot ADRC agencies cover 19 counties, 14 of which are entirely rural. The remaining counties contain populations that are 20% to 49% urbanized (1 county), 50% to 80% urbanized (1 county), and 80% to 100% urbanized (3 counties). More than 95,000 veterans (12,857 in the 14 rural counties) live in the participating counties. The average income for veterans in all participating counties is \$36,699 for men and \$30,915 for women.⁹ Furthermore, about 53% of veterans in all these counties are aged > 65 years.⁹

For this pilot, each ADRC site assigned an existing options counselor as a dedicated VBS. Each VBS completed 80 to 100 hours of training in VA benefits. To facilitate the amount of training required to become experts, the ORH funded a portion of the salary for each VBS.

An outreach specialist at the VA Salt Lake City Regional Benefit Office, a geriatric social worker at the VA Salt Lake City Health Care System, and an outreach specialist at the Utah Department of Veterans and Military Affairs (UDVMA) were primary trainers for this pilot. Trainers provided 15 training sessions between February 2013 and September 2015, totaling 74 hours. The 5 designated VBSs attended all trainings, but meetings were opened to all ADRC staff and other community organizations; 115 individuals from Utah, Idaho, Nevada, New Mexico, and

Wyoming attended at least 1 training. In the first year and a half, trainings ranged from 1.5 to 4.5 hours and provided a general overview of benefits. As the value of these trainings increased among the ADRCs and other community providers, longer seminars were offered, the longest lasting 2 days, which provided in-depth training.

Training topics comprised the following 4 general categories:

- Core—VA structure, military culture
- VHA—health care, enrollment and eligibility, in-home services
- VBA—pension, aid and attendance, disability compensation, nursing home, dependency and indemnity compensation
- NCA burial benefits

In response to participant requests for training on other VA benefits, additional VA staff presented topics such as mental health, homelessness, telehealth, Vet Centers, and My HealthVet. Information on the Veterans Choice Program was incorporated into later trainings.

In addition to the training provided by COVER to COVER, the 5 ADRC VBSs completed the 25-hour Training Responsibility Involvement and Preparation of Claims (TRIP) online course. This coursework qualified them to take the examination to become certified veterans service officers.

With the information received in training, ADRC VBSs assist veteran clients and their families to learn about and apply for VA benefits. Veterans or family members contact the ADRC with a variety of needs, such as difficulty paying utilities, functional limitations, etc. All ADRC staff screen callers for veteran status and refer willing veterans or family members to the VBS who provides information about LTSS options and screens for eligibility for VA benefits.

Through these training events, VBSs also formed relationships with the VA trainers, resulting in the ability to refer to and coordinate with the VA on cases when needed. The VBSs often work closely with the UDVMA by helping veterans organize needed documents and coordinate with UDVMA staff to complete VA benefit claims. Furthermore, VBSs can help veterans navigate the VA system and advocate for their needs in coordination with the VA trainers.

The VBAs have described numerous positive outcomes from the COVER to COVER program. They universally report improved knowledge and confidence in assisting veteran clients. In many cases, simply identifying clients' veteran status in the normal ADRC intake protocol has placed them in touch with many veterans without any significant change in their workload. One specialist reported that COVER to COVER has improved the quality of services she can provide to veterans and that connecting veteran clients to VA frees public resources for other clients in need. Finally, they report that the trainings introduced them to key VA contacts and laid the groundwork for developing relationships with new partners. The following case is representative of the types of client experiences VBSs routinely describe.

CASE STUDY

“Larry,” a 94 year-old World War II veteran who had never applied for VA benefits, presented to a rural ADRC for assistance with paying his utility bills. Larry had numerous health issues, including early stage dementia. He relied on his 96-year-old wife, “Sandy,” to assist him with activities of daily living (ADLs) and instrumental activities of living (IADLs). However, Sandy also had

health problems that limited her ability to help. The couple wanted to stay in their home but worried they could not do it without help.

An ADRC staff member referred Larry and Sandy to the VBS, who helped the couple enroll in a community LTSS program called Aging Alternatives for in-home services. During this time, Sandy passed away, but the VBS continued to work with Larry and helped him apply for VA disability compensation, enroll in VHA health care, and connect to VA's Veteran Directed Home and Community Based Services (VDHCB) program for in-home services.

Larry received a 70% service-connected disability rating and started receiving monthly compensation from the VA. Although Larry wants to stay at home, the rating of 70% service connection allows VA to cover nursing home placement should it be needed. He established a VA primary care physician and uses VDHCBs to purchase in-home services. Since Larry receives in-home services from the VHA, he was discharged from the Aging Alternatives program. This allowed the ADRC to reallocate this resource to another person in need. Larry is still living at home.

FUTURE DIRECTIONS

This case study highlights the benefits for veterans of COVER to COVER program through its emphasis on productive relationships between VA and community partners. More extensive data collection related to veteran outcomes is ongoing and will be essential for sustaining the program locally and to support broader dissemination to other states. Ideally, expansion to other sites will include temporary pilot funding to offset the time needed to gain the knowledge

and skills to become a VBS and to provide consultation and training to other ADRC staff. Once the pilot funding ends, the ADRC staff would have the necessary knowledge, skills, and relationships to continue providing services to veterans. ●

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Disclaimer

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