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Healthcare Disparities in Rural Veterans

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Abstract

Veterans, as a population, tend to have higher levels of disability than the civilian population. The Veterans Affairs (VA), as an organization, is infamous for the bureaucratic challenges it presents to those seeking services. The complicated, confusing, and lengthy process of accessing care through the VA often presents a barrier in and of itself. Due to these and many other factors, veterans suffer from higher rates of disability, chronic illness, and mental illness compared to the general population. Rural veterans face additional barriers to healthcare based on their locale, including increased physical distance to care, and a shortage of general and specialty providers. The purpose of this project is to provide an educational intervention to veterans recently separated from the military and living in a rural setting regarding eligibility for healthcare benefits through the VA and the application process for said benefits. A pre and posttest was administered to evaluate improvements in veterans' understanding of these concepts, as well as a qualitative survey to determine the most useful piece of information presented. Results showed modest improvement in veterans' understanding of benefits and the application process, with evidence of successful process improvement though the project.

Keywords: Veterans, healthcare, rural, VA, benefits, education

Introduction

The challenge of increasing healthcare access to those with the greatest need is ongoing. The iron triangle of healthcare always applies: expanding access necessitates concessions of cost or quality, and vice-versa. Compounding this problem are the different needs of different communities; solutions applicable in some cases are ineffective or detrimental in others. One population with a particular set of challenges are veterans living in rural settings.

Broadly, a veteran is a former member of the armed services. According to the Veterans Administration (VA), anyone completing their full term of service and not given a dishonorable discharge may claim this title ("What is a veteran? The legal definition," n.d.). However, within military circles, the term “veteran” usually refers specifically to those who served in a combat zone during their military career. Similarly, “rural” may have different definitions depending on the context. The VA defines rurality according to geocode whereas the US Bureau of the Census defines rurality in relation to discreet population centers (Wallace et al., 2010). For the purposes of this paper, “veteran” and “rural” will be defined according to the VA. Rural veterans face barriers to accessing healthcare based on both their rural and veteran status, and as a result, they have poorer physical and mental health outcomes than both their urban and civilian counterparts. These poorer outcomes may result in not only healthcare disparities among veteran populations but may also exert a negative influence on local populations. To quote one study:

> If the veterans’ understanding of VA benefits is not clear prior to their entering or leaving military service, substantial numbers of veterans — many with significant untreated mental health issues — may remain untreated and will present a destabilizing force within their communities. (Ward et al., 2017, p. 674)

This leads to the question: in rural veterans, can increasing understanding about VA benefits increase access to and use of those benefits?

Background and Significance

Providing long-term medical care for veterans is a relatively new concept. As recently as the 19th century, service members who survived wounds on the battlefield had to rely on family, friends, or charity for care. The VA was originally designed to fill this gap, providing care for injuries sustained by veterans in combat. Despite now providing a much broader level of care, including most primary care functions, the VA healthcare system still primarily provides care for combat or service-related injuries. To receive specialized care, the VA requires documentation of a "Qualifying Event" connecting the veteran's injury or disability to their service ("About VA health benefits," 2020). Unfortunately, this connection is not always clear-cut. In general, a service member sustains a higher level of wear-and-tear during their service than most civilian occupations over an equivalent period. This often leads to increased level of musculoskeletal problems and pain diagnoses, not always related to a specific musculoskeletal injury (Ward et al., 2017). Without this documentation linking the medical concern to a specific event, veterans are often denied care despite the presence of a causal link between their service and their injury (Ward et al., 2017).

Additionally, documentation for injuries is not always available, sometimes for reasons outside the veterans' control. On one occasion, a fire in a VA warehouse destroyed archived service records, requiring those veterans affected to produce their own copies of medical documentation for service-related disability or go without care (Ward et al., 2017). On other occasions, veterans have been denied services because their records are too classified to access (Ward et al., 2017). Finally, the complicated, confusing, and lengthy process of accessing care

through the VA often presents a barrier in and of itself (Brooks et al., 2016). For these reasons, veterans often forego utilizing the VA healthcare system for injuries sustained during their time in service, leading to poorer health outcomes and greater rates of long-term disability.

Problem Statement

Service Members on deployment face the constant threat, and often reality, of enemy fire, and wounds sustained on the battlefield often require extensive and long-term care for proper recovery. The high levels of physicality required of service members results in high rates of chronic pain and musculoskeletal problems, resulting in higher levels of disability than same-age civilians (Ward et al., 2017) In addition to physical illness, veterans have a much higher rate of mental illness compared to the civilian population. Among veterans of the wars in Iraq and Afghanistan, 17.4% have depression, compared to 10.2% for the civilian population (Dittrich, et al., 2015). Due to these factors, veterans suffer from higher rates of disability, chronic illness, and mental illness compared to the general population (Buzza, et al., 2011; Lynch et al., 2011; Ward et al., 2017). Rural veterans face additional barriers to healthcare based on their rural status, including increased physical distance to care, and a shortage of general and specialty providers (Brooks et al., 2016; Buzza, et al., 2011; Kramer et al., 2017). The VA, while intended to assist veterans in managing long-term illness or injuries resulting from their military service, often fails to do so as many veterans forego utilizing VA benefits due to the challenges associated with applying for benefits (Ward et al., 2017).

Review of Literature

The fact that rural veterans have poor healthcare outcomes is not new; various VA and Armed Service affiliated organizations have been studying this problem for years. However, literature evaluating the challenges faced by rural veterans regarding their healthcare needs tends

to be more qualitative than quantitative. Demographic information is useful in categorizing veterans, but not for elucidating the reasons for poor healthcare outcomes. A significant portion of studies looking into this problem seek to identify barriers to healthcare for rural veterans through a focus group or individual interview format, combined with demographic and health status collection (Brooks et al., 2016; Buzza, et al., 2011; Hale-Gallardo et al., 2020; Kramer et al., 2017; LaCoursiere Zucchero et al., 2016; Stroupe et al., 2019; Ward et al., 2017). As a result, hard numbers are difficult to come by and most conclusions are based on common trends in responses identified in geographically diverse studies. The literature review describes challenges experienced by veteran populations, rural populations, and how the intersection of those two populations produces additional barriers to care. Finally, it describes how a lack of understanding of the VA healthcare system negatively affects veteran's healthcare outcomes.

Veteran Populations

The constant competition between offensive and defensive systems has resulted in increasing lethality in modern battlefields between peer or near-peer combatants. However, in recent conflicts involving US troops, enemy forces determined the disparity in firepower between us and them necessitated the adoption of asymmetric tactics, including widespread use of Improvised Explosive Devices (IEDs). The wounds service members receive from an IED are often catastrophic, including multiple amputations and extensive burns. In previous conflicts, most service members would not survive these injuries, but recent advances in ballistic protection, tourniquet application, and medical evacuation have produced a much higher survival (U S Department of Defense, 2016). However, such catastrophic wounds require extensive and long-term care for proper recovery. After the Gulf War, 44% of veterans serving in that conflict filed for a disability claim with the Department of Veterans Affairs, of which 87% were

approved (Dittrich, et al., 2015). Estimates of current conflicts suggest "a similar prevalence of claims and approval for those serving in the Afghanistan and Iraq wars, although more recent analyses of disabilities claims indicate that this might be a low estimate." (Dittrich, et al., 2015, p. 432). This means, despite an overall lower number of service members being involved in combat, a higher rate of service members suffer long-term injuries and illness in more recent conflicts, compared to those of previous generations.

In addition to their physical health, the nature of asymmetric warfare has produced strains on the mental health of veterans. Among veterans of the wars in Iraq and Afghanistan, 17.4% have depression, compared to 10.2% for the civilian population (Dittrich, et al., 2015). Notably, female veterans have rates of depression 87.9% higher than their male counterparts (Dittrich, et al., 2015). The reasons for this disparity are numerous, but primary among them are issues of sexual assault between service members (Brooks et al., 2016). Military service confers a 33% increased risk of suicide compared to the civilian population, increased to 77% if the veteran has been diagnosed with a mental health disorder (Dittrich, et al., 2015). For context on the scope of the problem, there is approximately one veteran suicide per day, based on data starting in 2001 (Lee, 2015).

Rural Populations

Residents of rural communities have a variety of barriers to obtaining healthcare, with lack of access as the most prominent. Lack of access results from many factors, the most significant of which is simply the distance between the patient and the provider. Numerous studies show rural stakeholders list travel distance as the biggest barrier to healthcare (Brooks et al., 2016; Buzza, et al., 2011; Kramer et al., 2017). The challenges of distance in rural settings are compounded by additional factors, such as the time required to travel to healthcare, the cost

associated with traveling, and the lack of community transit infrastructure (Buzza, et al., 2011). In addition, those living in rural communities typically have a lower socioeconomic status and greater levels of illness complexity than those living in urban communities, imparting a lower tolerance of healthcare, and associated travel, costs (Dittrich, et al., 2015). As a result, many residents of rural communities avoid seeking care until a situation becomes critical (Buzza, et al., 2011). Finally, there are fewer care providers in rural areas; incentivizing them to work in rural areas through increased salary or other financial benefits has not proven to be a successful long-term solution (Kramer et al., 2017; Ohl, et al., 2018). This provider deficit exacerbates the barriers presented by travel distance; fewer providers result in a lower density, necessitating increased travel distance, time, and cost. All these factors produce worse health outcomes in rural communities compared to urban communities.

Rural Veterans

A disproportionate number of veterans live in rural communities compared to their urban counterparts. While only 7.5% of military-age adults in the United States live in regions classified as rural, 11.8% of recruits from all branches are from these areas (Buzza, et al., 2011). Similarly, the highest concentrations of veterans from all branches are found in the most rural areas of the country (Buzza, et al., 2011). Finally, estimates from the VA about their user population state 41% live in rural areas (Wallace et al., 2010). This population must contend with challenges from the intersection of their rural and veteran status, some of which compound each other. For example, most VA hospitals and clinics are located in urban centers, and the lack of specialty services offered in many smaller clinics in rural communities exacerbates the issue of long-distance travel (Ward et al., 2017). Since only eight percent of veterans are women, they are relegated to a minority status, resulting in a lack of gynecological services except at the largest

VA facilities (Brooks et al., 2016). This again creates a barrier in the form of increased travel distance and cost.

Veterans face challenges reintegrating to civilian life, leading to higher rates of depression, anxiety, unemployment, and lower socioeconomic status (SES) compared to same-age civilians (Dittrich, et al., 2015). Veterans also experience a higher rate of physical disability than their civilian counterparts, including a higher rate of comorbidities and complex health issues (Buzza, et al., 2011; Lynch et al., 2011; Ward et al., 2017). According to one study: "Among the older population in 2008, only 8 percent had no chronic conditions, compared with 51 percent who had one or two, and 41 percent who had three or more chronic conditions (Ward et al., 2017, p. 666-667)." These all serve to exacerbate the challenges of travel distance and cost. Finally, veterans who are unfamiliar with how to access care through the VA end up relying on ER services, which exacerbates health problems and drives up costs to the community (Ward et al., 2017).

Lack of Understanding of VA Healthcare System

One factor that is consistently mentioned in studies on this topic is the lack of familiarity among veterans regarding their eligibility for benefits and navigation of the VA healthcare system. Veterans separating from the military, especially those returning from a combat zone, face a huge number of challenges involved in reintegration to civilian life. One study showed that 48% of veterans described difficulty in returning to social life, while 36% described difficulty in returning to family life (Dittrich, et al., 2015). The same study pointed out that 60% of veterans struggle to find a job related to their military skillset, resulting in a significant unemployment rate; in 2011 veterans of conflicts in Iraq and Afghanistan aged 18-24 were unemployed at a rate of 30.2%, compared to 16.1% unemployment of same-age civilians

(Dittrich, et al., 2015). The military, knowing this, has attempted to prepare veterans leaving the service, but the multitude of challenges has produced a “retirement to-do list” 54 items long ("Welcome to the military retiree transition center," 2012). Incorporated in this list is education regarding VA benefits and how to access them, which mostly gets lost in the noise. Veterans already separated from the military and wishing to use the VA healthcare system often struggle to understand the rules and regulations specifying which benefits they are eligible for (Brooks et al., 2016; Kramer et al., 2017; Stroupe et al., 2019; Ward et al., 2017) According to one study examining homelessness in veterans:

> Veterans don’t always know what they’re eligible for. It’s not printed out. You try to find out…I think if it’s hard for us, a veteran who might not be in the best of shape has to leap over hills and mountains, and it’s really tragic. I’m a veteran and I don’t even understand what people are eligible for. (LaCoursiere Zucchero et al., 2016, p. 4)

Better education about VA benefits and eligibility, therefore, can make a huge difference for veterans and their healthcare.

Project Purpose and Aims

The purpose of the project is to decrease the barriers to care faced by rural veterans, specifically the barrier presented by the complicated and unintuitive application process for VA benefits. This project seeks to explicitly affect the perceived barriers, self-efficacy, and cues to action factors, based on the Health Belief Model of behavioral change. The aims of this project are

1. To increase veteran understanding of the benefits available through the VA and how to access them via an educational intervention administered by phone.
2. To continually improve the educational intervention.

3. To feed information about knowledge gaps back to veterans' parent units.

Methods

The educational intervention consisted of individual conversations with veterans, conducted via phone, discussing the veterans service history and related potential military benefits. Included in the conversations was an assessment of their eligibility for VA benefits, the most common causes of claims, and specific veteran concerns. Additionally, a pre- and post-survey was conducted to evaluate the efficacy of the educational intervention. Variables within this test included the subject's current level of understanding, service history, health history, current disability rating, number of dependents, and household income. The project measured current understanding, with the service history variable under limited control through recruitment of subjects. Given the limited recruitment pool for this program, other variables were not controlled for to allow for a sufficient subject pool. The null hypothesis for the test is "This intervention will not change a veteran's understanding of the VA healthcare system." Costs associated with the program were minimal, as the infrastructure required involves a personal cell phone for communication and access to Microsoft Office tools for data recording and analysis.

Recruitment of Subjects

Due to an established relationship with the 898 Brigade Engineer Battalion (BEB), 81st Brigade Combat Team, this unit was the starting point for recruitment of subjects. Within Army National Guard units, Battalion Readiness Noncommissioned Officers (NCOs) manage the unit's duty roster and maintain records of recently separated personnel, including contact information. This makes them the obvious choice for a point-of-contact for the project. Recruitment consisted of contacting the Readiness NCO and requesting information on their recently discharged soldiers, followed by a filtering process based on Home of Record (HOR) information to

determine rural/urban living status. Veterans determined to live in a rural or highly rural area, as defined by the VA and based on the HOR zip code, were contacted to evaluate interest in program participation. Interviews were arranged with any veterans willing to participate.

National Guard soldiers differ from Active-Duty service members in several ways. First, members of the National Guard, when not on duty or activated, do not live in barracks and perform unit physical training daily as do Active-Duty soldiers, leading to an overall lower fitness level. However, National Guard soldiers must meet the same standards of physical fitness, both during physical fitness testing and during training exercises or deployments. This can lead to higher levels of injury when less-fit soldiers attempt to perform physically demanding tasks.

Second, Active-Duty soldiers receive medical care through military clinics or hospitals which share medical records with the VA, whereas National Guard soldiers typically receive care through a civilian healthcare provider. This means a National Guard soldier wishing to receive benefits must send records of care they received through a civilian provider to the VA for review, where the VA can simply search their own records for the medical history of Active-Duty soldiers.

Finally, Active-Duty soldiers transfer between units every two to three years, which often involves moving to a different state or country. National Guard soldiers typically belong to units within 50 miles of their HOR and may stay within that unit for the whole of their military career. As a result, Active-Duty units tend to be more multicultural and racially diverse, as members may come from a variety of geographic locations. National Guard units tend to be monocultural based on the location of the unit and any inherent lack racial or ethnic diversity within the home population. This may reduce the likelihood that results from this project can be generalizable to the wider veteran population.

However, many National Guard soldiers transition to the Guard following a period of Active-Duty service. Often, Active-Duty soldiers coming to the end of their contract may choose to reenlist with the National Guard to stay in a location they like, rather than continue to rotate between units around the country. As a result, many have experience with daily physical training and therefore lower instances of injury, have medical records within the military medical system, and have experience with diverse cultures from geographically disparate locations. Therefore, this recruitment design, while largely convenience-based, is nonetheless inclusive of the relevant population.

Data Collection

The educational intervention consisted of both open and close-ended questions. Open-ended questions included what barriers to healthcare the veteran has experienced, what healthcare needs they anticipate in their future, and how useful they find the information presented in the interview. Close-ended questions included veteran demographics, service history, and current health problems. Finally, there was a brief pre- and post-survey evaluating the veteran's levels of familiarity with VA benefits and comfort level navigating the VA healthcare system before and after the conversation. Format of questions for this survey followed the template: "I am aware of my eligibility for benefits within the VA healthcare system," followed by a five-point agree/disagree Likert scale, with higher numbers indicating more agreement. Qualitative data were collected using the question "What information was most useful to learn?"

Cultural Considerations

Veterans often feel most comfortable speaking to other veterans due to common bonds and shared hardship. Therefore, all interviews were conducted by someone who is themselves a

veteran, reducing one potential barrier to participation. Proficiency in English is required for military service, negating any concerns over language barriers.

Data Analysis

Quantitative data gathered via the pre- and post-test were tracked and graphed allowing for analysis through the duration of the project. Consistent trends in final scores and score improvement indicated a need for altering the intervention, creating a process improvement feedback loop. T-Tests serve to analyze the likelihood that the differences between two sets of data occurred due to random chance, while paired T-Tests analyze two data points taken from single subjects over time, as seen in the measurement of the dependent variable of this project. That the intervention would cause a decrease in a subject's understanding is unlikely, indicating that analysis of data in both the positive and negative direction is not useful. Therefore, a single-tailed, paired T-Test with a certainty value of 0.05 was the statistical tool chosen to analyze data and disprove the null hypothesis.

Responses to the question "What information was the most useful to learn" were used to identify critical information most useful to participants. Results were examined for similarities and then coded into discreet categories, with these codes then subjected to histological analysis to determine frequency distribution. Results were fed back to parent units as part of ongoing quality improvement.

Dissemination of Results

Soldier & Family Readiness Specialist (SFRS) work with veterans and their families to connect them with a wide variety of benefits and services, including those at the VA. Results of the project were shared with the SFRS within the 898 BEB to further their understanding of the

challenges faced by their stakeholders. Results were also shared with Battalion Readiness NCOs, enabling them to proactively address soldier concerns.

Review of Intervention

The educational intervention followed a standardized script. Possible participants were contacted via phone and a voicemail recorded if the subject did not answer. Subjects who received a voicemail were contacted a minimum of 48 hours later and second voicemail left if the subject again did not answer the call. Voicemails followed a script according to the Phone Call Script document (Appendix A). For participants contacted successfully and who consented to the intervention, the pretest was administered first to establish a baseline of understanding. The participant was then asked to describe their current understanding of VA healthcare benefits and the application process to avoid redundancy in the intervention. Depending on responses, the intervention may have moved forward in the process to avoid providing unnecessary education.

Assuming no prior knowledge, the participant was asked if they have spent any time in active duty, had been mobilized for federal service and if so, how long was their mobilization, and if they have a current disability rating. Based on this information, the Flowchart – VA Healthcare Benefits document (Appendix B) was used to determine the participant's likely priority group, and the participant informed. If the participant was eligible for healthcare benefits, the intervention moved on to describe what healthcare benefits are available to the participant, followed by a stepwise description of how to apply for them on the VA's website using the Flow of Intervention document (Appendix C). If the participant was ineligible for healthcare benefits due to their service history, the intervention moved on to describe disability benefits. The participant was asked to describe any service-connected illness or injuries for which they may apply for disability from the VA using the How to Apply for Disability

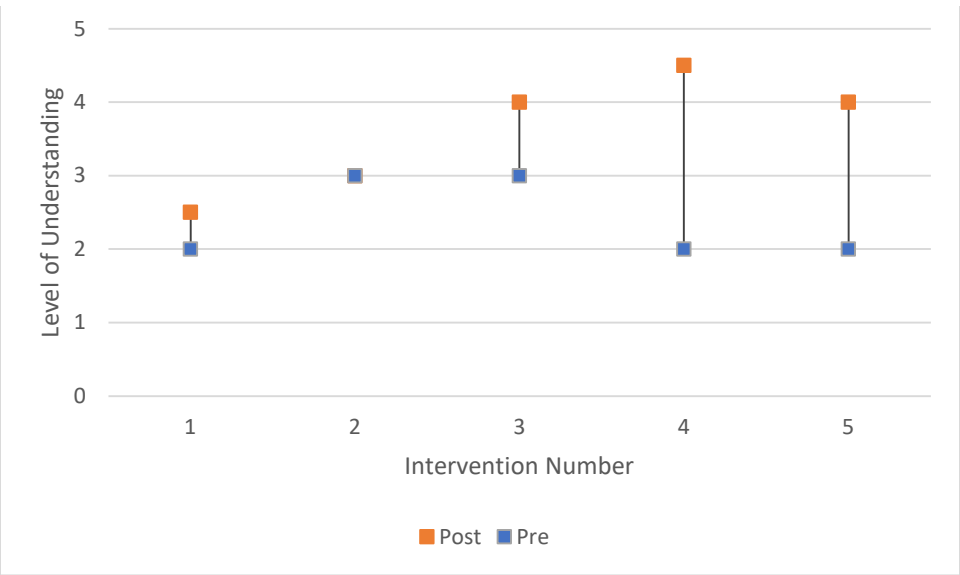
document (Appendix D). Finally, the intervention discussed disease subject to presumptive service connection and any healthcare problems the participant is currently experiencing that may qualify. The intervention closed with asking the participant to self-describe if they live in an urban or rural setting, the posttest, and the qualitative survey.

Results

During the recruitment process, HOR information for subjects was unavailable. As a result, instead of filtering subjects by rural status through HOR zip code, participants in the program were asked to self-describe if they lived in an urban or rural setting. While all data was analyzed, only data arising from participants self-describing as "rural" were included in results.

Figure 1

Pre and Posttest Results

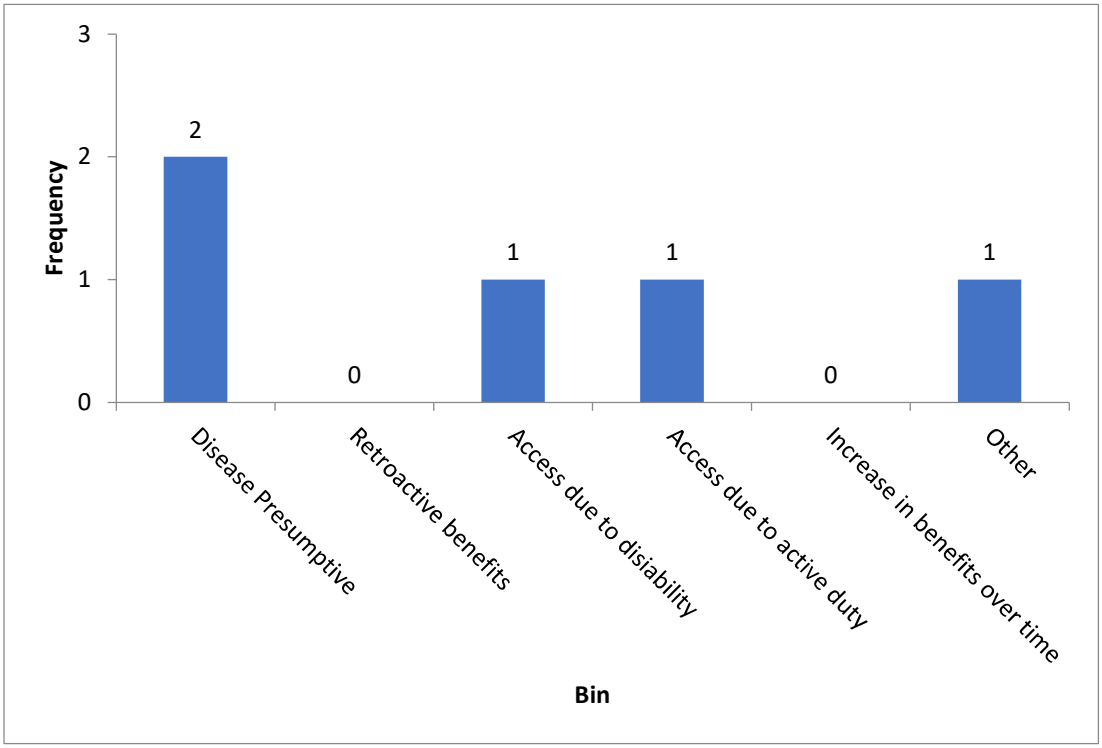


There were five participants in the educational intervention, all of whom completed the pretest, posttest, self-identification of urban/rural home of residence, and qualitative response. No pre-test results scored below two while post-test results varied between 2.5 and 4.5. Improvement between pre- and post-test results varied between 0 and 2.5. A paired, single-tailed T-Test of pre and posttest results shows p-value of 0.03.

Qualitative data was collected at the end of the intervention, by asking the participant "What information was the most useful to learn." Responses were coded into the following bins: disease presumptive, retroactive benefits, access due to disability, access due to active duty, increase in benefits over time, and one "other" code for responses too dissimilar to include with the rest. The histogram of coded responses shows disease presumptive as the most commonly cited as most useful information with 40% of responses, while access due to disability, access due to active duty, and other all accounting for an additional 20% each (Figure 2).

Figure 2

Qualitative Data Histogram: responses to "Most Important Information" presented



Discussion

Results of the survey varied, with a general trend toward increased final scores and increased improvement between pre-and post-test results seen over the course of the project. This

demonstrates the process improvement feedback loop designed into the intervention operated as intended. Overall, 80% of participants showed improvement in understanding, with the one outlier accounted for with additional context. The result showing no improvement involved a project participant who had extensive experience working within the VA healthcare system and for whom the intervention was not designed. Finally, the p-score of less than 0.5 appears to successfully disprove the null hypothesis, indicating the intervention changed participants' understanding of VA healthcare benefits. However, the small sample size is not sufficient to create a reliable statistical significance. While the results seem to indicate that a low cost and low effort intervention can affect a veterans' understanding of the VA health care system and the benefits for which they may be eligible, a larger and longer-term study would be needed to replicate and validate the results before making this assertion.

The results of the qualitative portion of the project indicate a significant lack of understanding on the part of veterans regarding fundamentals of the VA organization as a whole and what resources are available to veterans through that organization. Members of the National Guard are not automatically eligible for healthcare benefits through the VA, as a result the National Guard often fails to educate them, and many fail to educate themselves, about those benefits. However, multiple avenues exist for National Guard soldiers to access healthcare benefits, including through federal activation and/or being awarded a disability rating. The fact that a disability rating or time spent on active duty made a veteran eligible for healthcare benefits was rated as "most useful information" by a combined 40% of participants. This indicates that National Guard soldiers lack awareness of VA benefits for which they are eligible, and further suggests that many soldiers, lacking this awareness, do not make use of said benefits. This finding matches what was described in the literature, that many veterans don't know what

healthcare they're eligible for through the VA and therefore fail to make use of these resources, leading to poorer healthcare outcomes (Dittrich, et al., 2015; LaCoursiere Zucchero et al., 2016; Ward et al., 2017).

Similarly, the VA recognizes that many chronic conditions may result from military service without a classic qualifying event. Therefore, the VA developed the Disease Subject to Presumptive Service Connection category for disability benefits. This category allowing veterans suffering from a specific list of chronic conditions not necessarily a result of specific illness or injuries to still receive disability benefits for those conditions. Diagnoses included in this list are hypertension, diabetes, and peptic ulcers, all conditions commonly experienced by veterans. Knowledge of this category and the timeline within which a veteran may apply for benefits was rated as "most useful information" by 40% of participants. As a result, the linkage of access to healthcare to disability benefits, for which many veterans are eligible due to chronic conditions not necessarily linked to specific injuries or illnesses, is the information best suited to be disseminated back to participants' parent units.

Limitations

This project had several limitations. Most prominent is the lack of HOR addresses included in the list of potential participants. This nullified one portion of the inclusion criteria of the study, making determination of "rural" status prior to the intervention impossible. Asking the participants to self-identify rural status changed this inclusion criteria from an objective to a subjective criterion, potentially introducing confounding factors into the data set. This influenced another limitation of the study: the low sample size of only five participants. Such a small sample limits the validity of the p-value calculated from collected data and reduces the generalizability of results.

Another limitation was the necessary simplification of the complexity of VA healthcare benefits and eligibility into an intervention that could take place over a 15-minute phone call. The nature of this intervention precluded in-depth discussion of many types of benefits available and aspects of the application process due to time constraints. The results of the study, while encouraging, belie the fact that applying for benefits remains a complex and often unintuitive process and a 15-minute conversation is insufficient to fully communicate the details of the process or address any potential complications that may arise.

Finally, the scope of the project was limited only to discussing potential healthcare benefits and the application process to access them. The project did not address any follow-up with participants to determine if the intervention resulted in actual utilization of said benefits and/or healthcare improvements. This may be a topic for future study.

Conclusion and Implications for Practice

The Veterans Healthcare Administration can trace its roots to facilities founded in 1865 to provide medical care to service members wounded in the Civil War. Originally intended to provide relief only for acute injuries sustained in the line of duty, the VA is now one of the largest healthcare systems in the country and the third largest Executive branch agency, providing full healthcare services to both service members and their families. VA healthcare, when properly utilized, can provide significant benefits to service members in all aspects of their care. However, the application process for said benefits remains complicated and unintuitive, which often presents a sufficient barrier to prevent many of those eligible for benefits from attempting to apply.

This problem does not need to exist. This project demonstrated that improving access to VA healthcare through a simple educational intervention delivered by phone can be low-cost in

time, effort, and funding. Further, this project identified several key lessons regarding VA healthcare about which units are failing to educate their retiring service members. Improving education on these topics may significantly improve service members' future healthcare. Lessons from this project may also be applied to non-VA healthcare clinics who are eligible to treat veterans though community care programs. As previously stated, many rural veterans ignore the VA as a healthcare entity and often get their healthcare through the ER. This drives up costs for both the veteran and the healthcare provider and impedes implementation of preventative care for these individuals. Community care programs allow rural veterans to be seen by providers in their community if the closest VA healthcare facility is too far away for easy access; the VA pays for the visit and receives a copy of generated medical records. However, to receive care through the community care program, a veteran must first be enrolled in the overall VA healthcare system. Rural providers aware of this program can assist veterans in their communities to start the process of applying for healthcare through the VA, ultimately leading to the utilization of benefits through local providers. This can allow for dramatically improved access to healthcare for rural veterans as well as open up a new patient pool for rural providers.

The VA, both as an organization and as a healthcare system is often referred to as a "black box" through which no information passes. It doesn't have to be that way. By simply improving our educational interventions for veterans, we can provide them better healthcare. For our veterans, that seems like not too much to ask.

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Appendix A

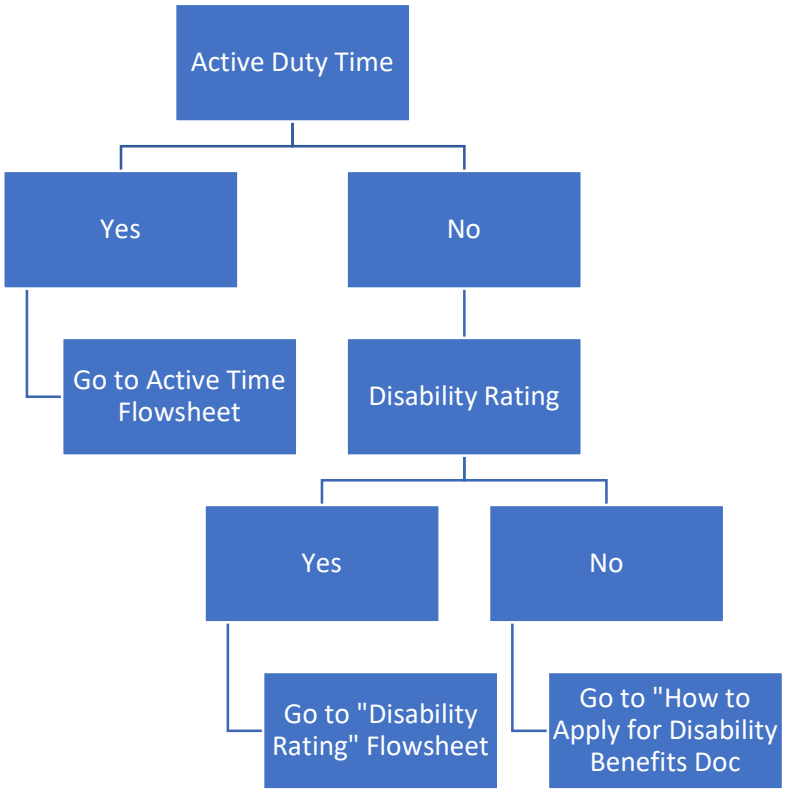
Phone Call Script.doc

Script for leaving voicemail on call attempt 1 and 2

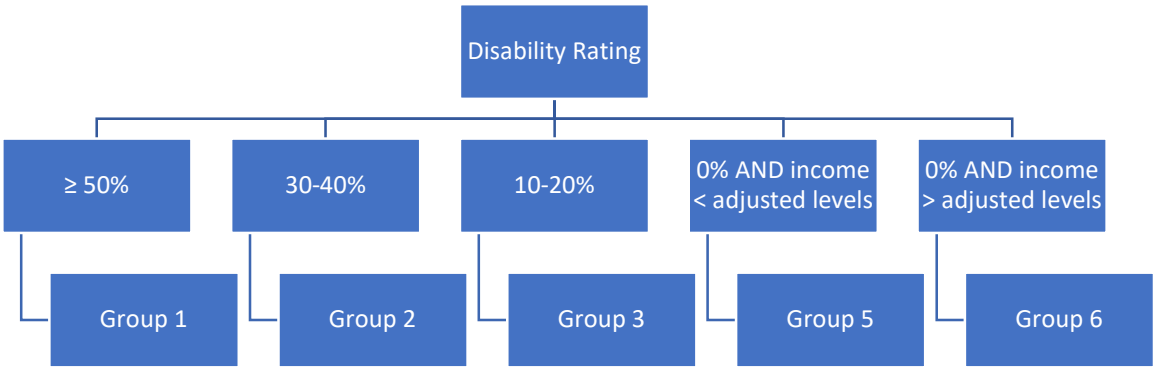
- Attempt 1
    - Hello, my name is SGT Johnson with the 898 BEB, I'm looking for (name). I'm working on a school project where I'm talking to people recently separated from the military about VA healthcare benefits, what you're eligible for, and how to apply for them. I won't be collecting any personal information and it should only take 15-20 minutes. If you'd give me a call back at 425-268-3587, I'd appreciate it. Thank you.
- Attempt 2
    - Hello, this is SGT Johnson again calling for (name). Like I said in my previous message, I'm working on a school project, and I'd like to set up a quick conversation about VA healthcare benefits and how to apply for them. Like I said before, I won't be collecting any personal information and the conversation should only last about 15 minutes. Please give me a call back at 425-268-3587 anytime.

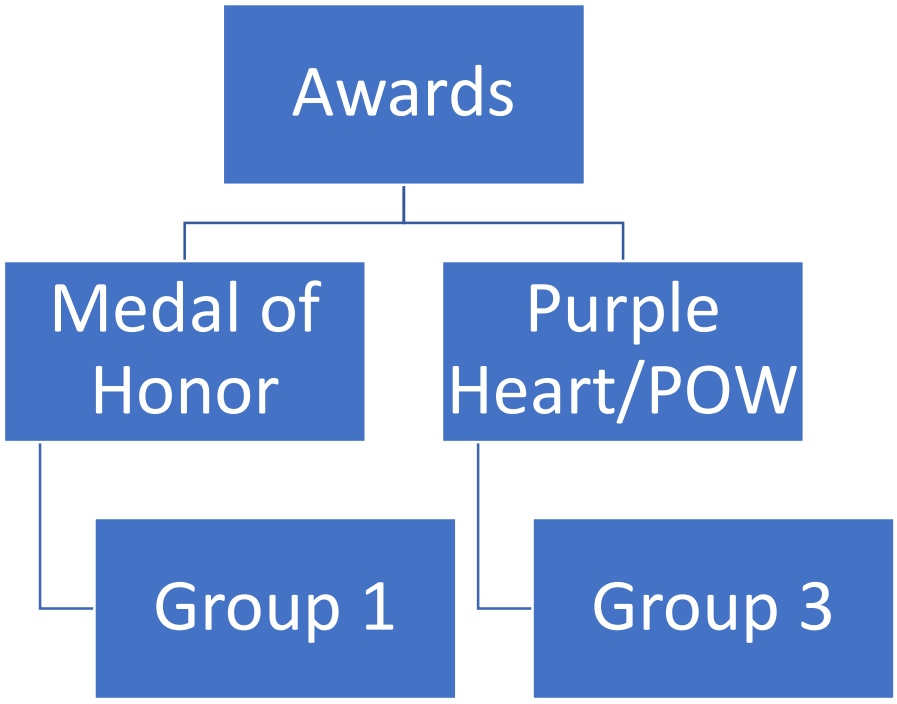
Appendix B

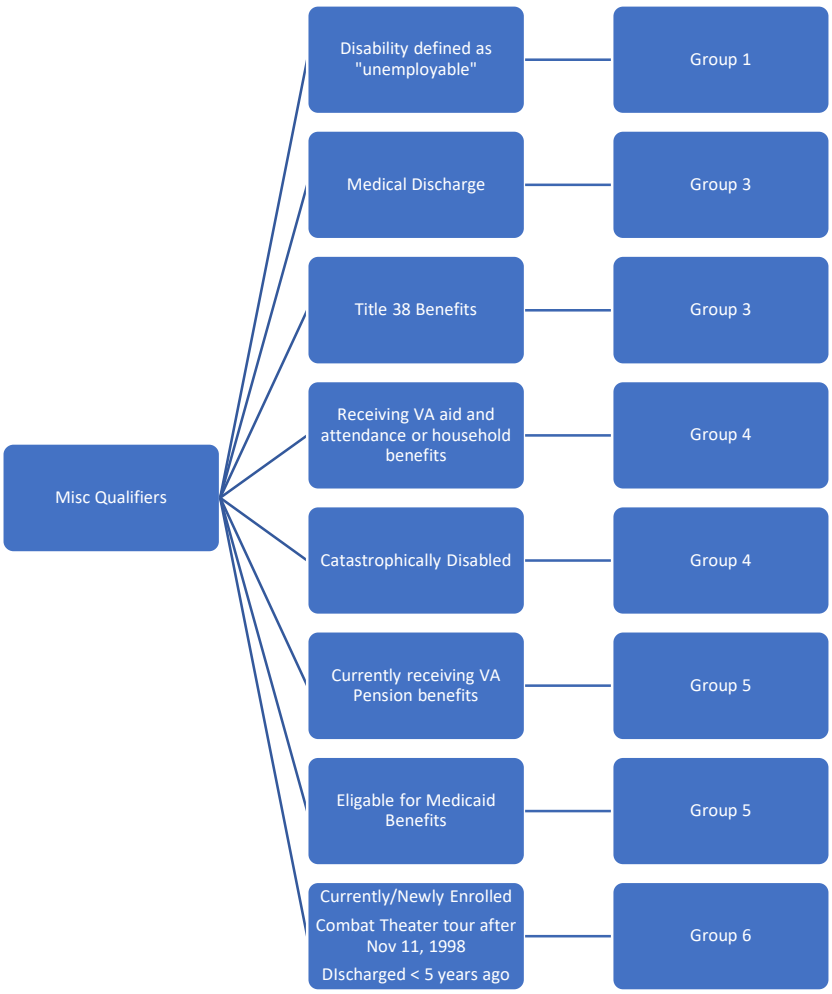
Intervention Flowchart.doc



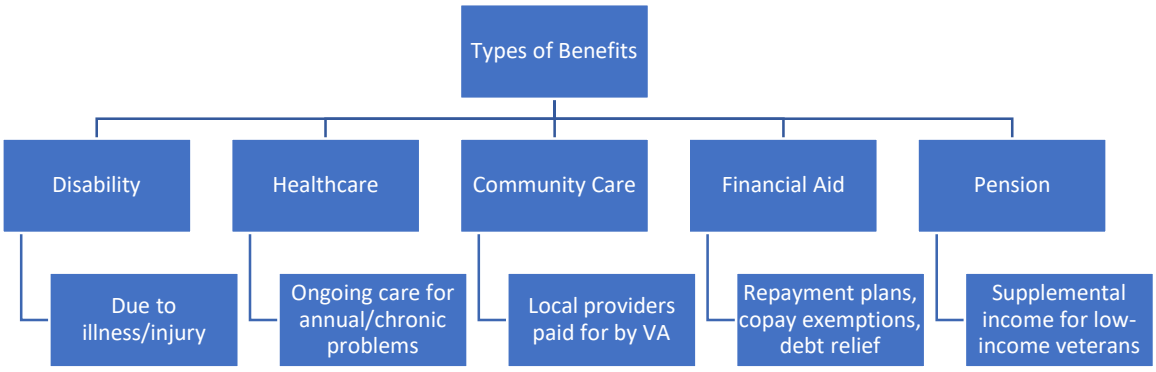
Active Duty Flowsheets

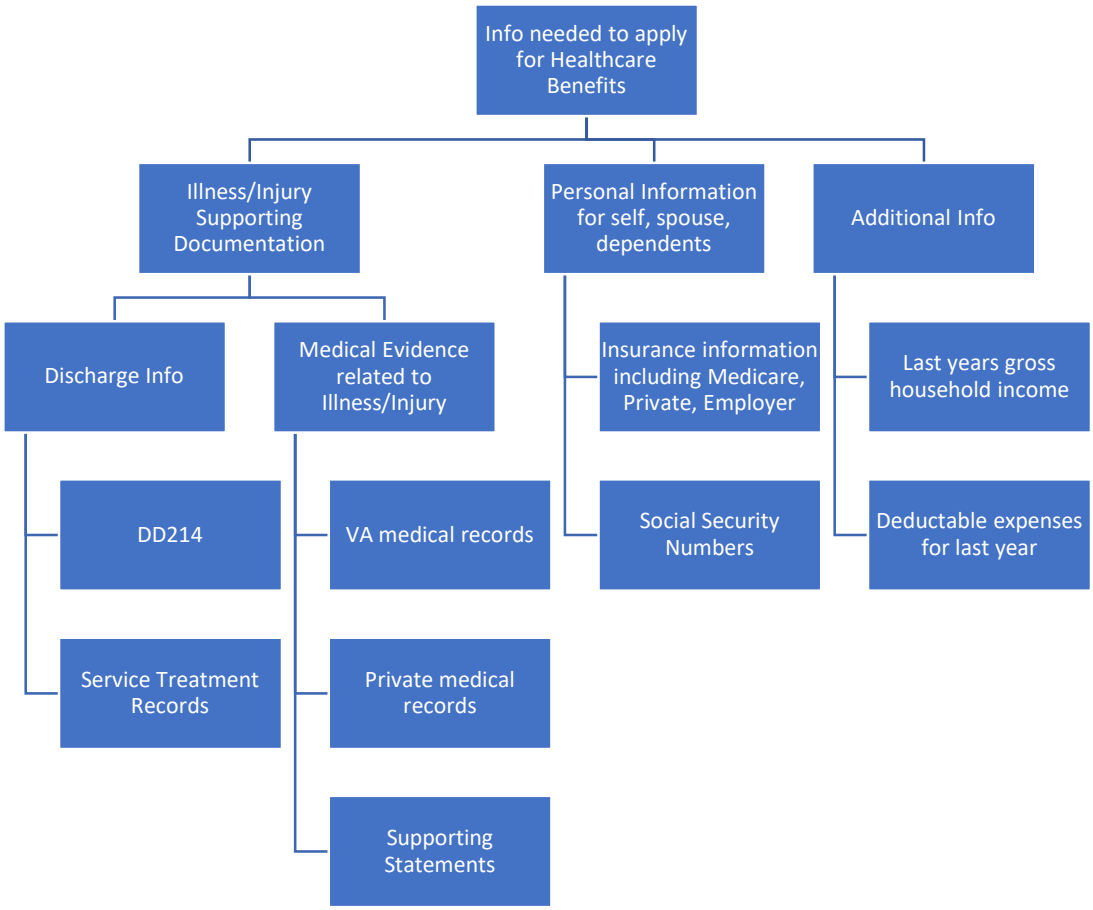





Misc Qualifiers
Disability defined as "unemployable"
Group 1
Medical Discharge
Group 3
Title 38 Benefits
Group 3
Receiving VA aid and attendance or household benefits
Group 4
Catastrophically Disabled
Group 4
Currently receiving VA Pension benefits
Group 5
Eligable for Medicaid Benefits
Group 5
Currently/Newly Enrolled
Combat Theater tour after Nov 11, 1998
DIscharged < 5 years ago
Group 6

Benefits Flowsheets






Steps to File for benefits
1) Submit an "Intent to File" form
2) Collect required documentation (see above)
3) Fill out VA Form 21-526EZ
4) Submit form
Online: https://www.va.gov/disability/file-disability-claim-form-21-526ez/introduction
Mail: Department of Veterans Affairs Claims Intake Center PO Box 4444 Janesville, WI 53547-4444
Bring completed form to local office
5) Approx 1 week wait time
Receive a letter sent to your HOR within one week
If no letter, don't apply again, call: 877-222-8387 (TTY: 711)

Appendix C

Flow of Intervention.doc

Guide to the intervention, used in conjunction with flowcharts and other documents.

- **Describe benefits (why should they care)**
  - Healthcare Coverage
    - Basic Services
      - Preventative care i.e. annual physical
      - Health education i.e. nutrition
      - Immunizations
      - Inpatient services
        - Surgeries + acute care post-procedure
        - Dialysis
        - Some specialized surgical care
      - Urgent/Emergent services
      - **Mental Healthcare always covered**
        - PTSD, Military Sexual Trauma, depression, substance abuse
      - Prescriptions, including from non-VA provider (must meet all requirements)
    - Other
      - Tests i.e. blood work, XR, ultrasound, etc.
      - Therapy and/or rehabilitation
      - Beneficiary travel benefits (payment for travel related to treatment)
        - https://www.va.gov/health-care/get-reimbursed-for-travel-pay/
      - Veterans Transportation Service (help getting to and from apts)
        - https://www.va.gov/healthbenefits/vtp/veterans_transportation_service.asp
      - Vision
        - Routine eye exams and preventative tests
        - Sometimes glasses and/or other services
        - https://www.va.gov/health-care/about-va-health-benefits/vision-care/
      - Dental
        - Sometimes
        - https://www.va.gov/health-care/about-va-health-benefits/dental-care/
- **What benefits you get depends on what priority group you belong to**
  - Do you have a disability rating?
    - Go to priority group flowchart
  - No active duty time or disability?
    - Go to how to apply for disability
  - Have disability and active duty time

        - Go to priority group flowchart
    - Already enrolled?
        - Look at additional benefits
        - Community Care
        - Financial Hardship
        - Pension
- **Disability Benefits**
    - Amount depends on % disabled, dependents
    - Having a disability rating makes you eligible for healthcare
        - Apply for one to get the other
    - Need an actual diagnosis, not just “pain”
    - Within one year: eligible for certain diagnoses automatically (see list)

Appendix D

How to Apply for Disability.doc

Guide to disability benefits and eligibility, used as a reference during the intervention

- Eligibility
    - Current illness or injury that affects mind/body AND served on active duty, active duty for training, or inactive duty training
    - While on duty became sick or injured due to service (Inservice Disability Claim)
    - Had an illness/injury prior to joining which was made worse by service (Preservice Disability Claim)
    - Disability related to service that didn't appear until after service ended (Post service Disability Claim)
    - **Note: claim must be for a specific illness or injury, not a "pain" diagnosis**
        - **I.e. must be for degenerative disc disease as shown on imaging, not "back pain"**
    - Common Disability Claims
        - Chronic (long-lasting) back pain resulting in a current diagnosed back disability
        - Breathing problems resulting from a current lung condition or lung disease
        - Severe hearing loss
        - Scar tissue
        - Loss of range of motion (problems moving your body)
        - Ulcers
        - Cancers caused by contact with toxic chemicals or other dangers
        - TBI
        - PTSD
        - Depression/Anxiety
    - Presumed disabilities
        - Chronic illness appearing one year after discharge
            - Must be at least 10% disabling
                - for example, you may submit a doctor's report showing that you're taking medicine for your high blood pressure
        - Illness caused by contact with contaminants
        - Illness caused by time spent as POW
        - Illnesses appearing more than one year after service
            - Hansen's Disease (3 years)
            - TB (3 years)
            - MS (7 years)
            - ALS (unlimited)
- How to file a claim
    - Have all the evidence and supporting documents
        - DD214
        - Service treatment records

        - Any medical evidence related to your illness or injury (like doctor's reports, X-rays, and medical test results)
            - Specific requirements depend on type of claim being filed (see below)
            - VA medical records and hospital records that relate to your claimed illnesses or injuries or that show your rated disability has gotten worse
            - Private medical records and hospital reports that relate to your claimed illnesses or injuries or that show your disability has gotten worse
            - Supporting statements you'd like to provide from family members, friends, clergy members, law enforcement personnel, or those you served with that can tell us more about your claimed condition and how and when it happened or how it got worse
        - Can take up to 1 year between starting the claim and providing all supporting documentation
            - Submit an "intent to file" form to start clock
            - Benefits granted will be retroactive to the date this form is filed
            - https://www.va.gov/resources/your-intent-to-file-a-va-claim/
    - Online: https://www.va.gov/disability/how-to-file-claim/
    - Mail completed **VA Form 21-526EZ** to
        - Department of Veterans Affairs
          Claims Intake Center
          PO Box 4444
          Janesville, WI 53547-4444
    - Bring completed application to local VA regional office
        - Locations: https://www.va.gov/find-locations/?facilityType=benefits
    - Help available through accredited representatives
        - https://www.va.gov/disability/get-help-filing-claim/
    - Average wait time: 155 days
    - Fully developed claim
        - Completed Application for Disability Compensation and Related Compensation Benefits (VA Form 21-526EZ) AND
        - All the evidence (supporting documents) you have—or can easily get—along with your claim AND
        - Certify that there's no more evidence we might need to decide your claim
        - Go to any VA medical exams required for us to decide your claim (VA will notify you if this is required)
- Benefits
    - Depends on % disability rating and number of dependents
        - Spouse/parent different than children
        - https://www.va.gov/disability/compensation-rates/veteran-rates/
- Types of claims and what you'll need
    - **Original Claim:** first claim you file for disability benefits
        - Evidence of a current physical or mental disability from a medical professional or a layperson AND

        - An event, injury, or disease that occurred during active-duty service AND
        - A link between the event, injury, or disease and the current physical or mental disability, usually medical records or opinions from health care providers
    - **Increased Claim:** asking for more benefits for a condition already determined to be service related that has gotten worse
        - Current evidence from a medical professional or a layperson showing your disability has gotten worse
    - **New Claim:** asking for added benefits or new benefits related to service-connected disability
        - Evidence of a current physical or mental disability from a medical professional or a layperson AND
        - An event, injury, or disease that occurred during active-duty service AND
        - A link between the event, injury, or disease and the current physical or mental disability, usually medical records or opinions from health care providers
    - **Secondary Service-Connected Claim:** new disability related to a disability that already exists
        - Evidence of the new physical or mental disability from a medical professional or a layperson AND
        - A link between the new disability and the disability already determined to be service connected, usually medical records or opinions
    - **Supplemental Claim:** providing new evidence to support a claim that was denied
        - New evidence that has not been previously reviewed related to the issue
    - https://www.va.gov/disability/how-to-file-claim/evidence-needed/
    - **PTSD**
        - A completed Statement in Support of Claim for Service Connection for Post-Traumatic Stress Disorder (VA Form 21-0781)
    - **PTSD based on personal assault**
        - A completed Statement in Support of Claim for Service Connection for Post-Traumatic Stress Disorder Secondary to Personal Assault (VA Form 21-0781a)
    - **Individual Unemployability**
        - Medical evidence that shows a service-connected disability prevents you from getting or keeping substantially gainful employment (work that brings in enough money to earn a livelihood). Odd jobs (marginal employment), don't count.
        - A completed Veteran's Application for Increased Compensation Based on Unemployability (VA Form 21-8940)
        - A completed Request for Employment Information in Connection with Claim for Disability Benefits (VA Form 21-4192), completed by your last employer
    - **VA Title 38 USC 1151 claims**
        - Need to submit evidence that shows at least one of the following led directly to added disability or to injury/disease getting worse
            - VA careless or negligence

        - VA medical or surgical treatment
        - A VA health exam
        - A VA vocational rehabilitation course (under 38 U.S.C. Chapter 31)
        - VA compensated work therapy (CWT)(under 38 U.S.C. 1718)
    - **Automobile allowance and adaptive equipment**
        - Loss, or permanent loss of use of 1 or both feet
        - Loss, or permanent loss of use of 1 or both hands
        - Permanent decrease in vision of both eyes
            - 20/200 vision or less in your better eye with glasses, or greater than 20/200 vision but with a visual field defect that has reduced your peripheral vision to 20 degrees or less in your better eye
        - A severe burn injury
        - ALS
        - Ankylosis in one or both hips (qualifies for adaptive-equipment grant only)
        - Application for Automobile or Other Conveyance and Adaptive Equipment (VA Form 21-4502)
    - **Seriously Disabled Child**
        - Need to submit medical evidence that shows the child became permanently disabled because of a physical or mental disability before their 18th birthday

Disease subject to presumptive service connection Highlights

- Arteriosclerosis
- Arthritis
- Calculi of the kidney, bladder, or gallbladder
- Cardiovascular-renal disease, including hypertension *
- Cirrhosis of the liver
- Diabetes mellitus
- Endocarditis (all valvular heart disease)
- Hodgkin's disease
- Leukemia
- SLE
- Myasthenia gravis
- ALS
- MS
- TB
- Tumors, malignant, or of the brain or spinal cord or peripheral nerves
- Ulcers, peptic (gastric or duodenal) *