ABSTRACT

AN IN-HOME VISTATION PROGRAM FOR HOMEBOUND OLDER ADULT VETERANS: A GRANT PROPOSAL

By

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The purpose of this project was to find a potential funding agency and create a grant for an in-home visitation program for homebound, older adult veterans. The goal of the program is to promote enriching relationships, increase levels of compassion by both parties, and decrease levels of depression/loneliness and/or social isolation among the older adult veteran population within Los Angeles County, California. The program will offer visitations by community college students and weekly activities addressing depressive symptoms while incorporating access to case management support for additional needs, such as medical and psychiatric referrals. The host agency for the program will be Home-Based Primary Care in the U.S. Department of Veteran Affairs. The Archstone Foundation was selected as the funding source for this grant. The actual submission and/or funding of this grant were not a requirement for the successful completion of the project.

AN IN-HOME VISITATION PROGRAM FOR HOMEBOUND OLDER ADULT VETERANS: A GRANT PROPOSAL

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I would first like to quote Gautama Buddha, "The secret of health for both mind and body is not to mourn for the past, nor to worry about the future, but to live the present moment wisely and earnestly." This experience and process could not have happened without dedication, mindfulness, and focus I have had in my graduate program. This focus and drive are in part fueled by the support of my family and loved ones who have cheered me on. Specifically, I would like to thank my parents who have supported and guided me through the stressful and difficult internship experiences and my mother who always kept me driven as a first-generation, Mexican-American, female college graduate. My siblings, especially my sister who would always have a smile on her face and cheer me up anyway she could.

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CHAPTER 1

INTRODUCTION

Scope of the Problem

It is expected that by 2030, more than 1 in 5 Americans will be a part of the older adult population (Qui et al., 2010). As a result of the baby boomer generation, those born between 1946 and 1964 will have a substantial impact on America. The baby boomers are characterized as having higher levels of education and lengthened life expectancy due to advances in modern medicine (Centers for Disease Control and Prevention [CDC], 2012). This rapid growth of older Americans places an unusually high demand on the health care system and age-related services (CDC, 2012). In 2010, out of the 38.9 million older adults, 9% were considered to be homebound and in need of extensive care (Qui et al., 2010).

Although aging is a unique and diverse experience, there are some common experiences each older adult faces. Over an adult's lifespan, it is normative to experience role transitions, loss of independence, and diminished societal networks, which include relatives and friends, as well as the deterioration of health including cognitive and physical losses (Rizzo & Toseland, 2008). Older adults have been found to have more symptoms of depression with suicide rates being the highest compared to other age groups (Rizzo & Toseland, 2008). With the growth of the older adult population, those considered homebound who require extensive care will also increase.

Homebound older adults are considered to be individuals 65 years and older who lack the ability of performing instrumental activities of daily living (IADLs). These IADLs include preparing food, dressing, bathing, using public transportation, maintaining their home, or taking medication in a timely manner (Graf, 2009). Impairments may range from mobility issues to illnesses that impact cognitive functioning, which prevent a person from leaving his or her home (Choi & McDougall, 2007). According to Smith and Hirdes (2009), IADLs are a significant predictor for social isolation.

The U.S. Department of Veteran Affairs, Division of Veterans Health Administration (VA) reported that of the 312.8 million veterans, there are about 3.88 million disabled veterans (n.d.b). About 24,257 of these disabled veterans are enrolled in the VA home-based primary care team (HBPC; Edes, 2010). The HBPC program specifically assists veterans struggling with complex, chronic, and disabling diseases, which impair their independence. The program provides primary care for an extended amount of time through an interdisciplinary team (IDT) who visits the homebound veterans in their residence.

As Americans age, about half of older adults 85-years-old and older will be dependent on one or more activities of daily living (ADLs). In comparison, 50% of the HBPC participants are dependent on two or more ADLs (Edes, 2010). In 2010, the VA combined both medical and mental health illnesses that were affecting HBPC veterans. Half of the top 10 diagnoses for homebound veterans were mental health illnesses; the top two included depression and substance use. Noting these complexities, the VA established mental health positions within the HBPC program across the nation (Edes, 2010). These statistics illustrate the importance of homebound older adults receiving

medical and social support services in order to successfully combat a combination of diseases and mental health illnesses.

Nicholson, Molony, Fennie, Shellman, and McCorkle (2010) have reported social isolation, a symptom of depression, among older adults being as prevalent as 43%. Medical and mobility complications, which further isolate this population, extend their likelihood of suffering from depression, social isolation, and other mental health disorders (Choi & McDougall, 2007). These detrimental complications can also result in risk of premature death and institutionalization (Choi & McDougall, 2007). If social isolation is combated early enough, a large number of issues this population faces may be averted.

Purpose of the Project

The purpose of this project was to design an in-home visitation program for homebound, older adult veterans age 65 and older. The program will be in collaboration with the Veterans Health Administration (VHA), a subcomponent of the VA. The Office of Geriatrics and Extended Care Services (GEC) within the VA are dedicated to empowering and promoting independence for older adult veterans. Veterans assisted through GEC receive home and community based services or long-term care within nursing home and residential settings.

Skilled Home Health Care is a part of GEC and targets homebound older adults or veterans that live far from a VA center. Some services include physical, occupation, or speech therapy along with home safety evaluations and education on managing finances. An associated program within GEC, Veteran-Directed Services administers skilled services, budget-management, and assistance with ADLs in consumer-directed system.

Although these services encompass a variety of common medical and mental health difficulties, there was not a program that incorporates in-home visitation designated to maintain and strengthen needed social and emotional support.

The program will benefit socially isolated, homebound older adult veterans by countering symptoms of depression and cultivating social relations within their community. In addition, the program is going to incorporate community college volunteers. This experience will then benefit volunteers through gaining knowledge, wisdom, and experience in aid clients they serve. An important feature within the program is for the veterans to experience an improvement within their quality of life, self-esteem, support system, so that they may enlighten a younger generation. The program's goals are to: (a) assist older adults in decreasing depressive symptoms, (b) reduce isolation, and (c) maintain healthy cognitive functioning by social interactions and a built relationship with community college volunteers.

Target Population

The population for this program is homebound older adult veterans, 65-years-old and older who suffer from depression and/or social isolation symptoms in Greater Los Angeles, California. Over 750,000 veterans are 65-years-old and older (VA, n.d.e). About half (323,431) of these older adult veterans live in Los Angeles County and have the VA, Greater Los Angeles Healthcare System (GLA) as a resource for their medical and overall health needs. Older adult veterans have been found to be at a higher risk for developing depression due to psychosocial stressors, trauma-induced events, and comorbid psychological and medical conditions (Burnett-Zeigler et al., 2012).

Exposure to negative events increases a veteran's likelihood of suffering from physical and mental ailments, such as traumatic brain injuries (TBIs), posttraumatic stress disorder (PTSD), depression, and anxiety (Byers & Yaffe, 2011). Traumatic and negative exposures affect a veteran's perceptions of loneliness, increases chronic physical conditions, and lowers physical and mental functioning later in life (Choi & McDougall, 2007; Harada et al., 2002). Veterans who continue to suffer from depression and social isolation in their mid-50s are more likely to develop dementia and experience ADL impairments (Byers & Yaffe, 2014).

Agency Description

The host agency will be GLA--one of the largest within the VA system (VA, n.d.c). GLA is within Veterans Integrated Service Network (VISN) 22 that is called the VA Desert Pacific Healthcare Network that serves veterans located in Southern California and Southern Nevada (VA, n.d.c). The VA GLA is made of three ambulatory care centers, specified inpatient hospitals, and 10 community based outpatient clinics (CBOCs; VA, n.d.c).

GLA specifically services residents within Los Angeles, Ventura, Kern, Santa Barbara, and San Luis Obispo (VA, n.d.c). The first VA was during the colonial period in 1636 (VA, n.d.d). The mission of the VA derives from President Lincoln's promise to attend to and care for veterans who have "borne the battle, and for his widow, and his orphan" (VA, n.d.d, para. 4). This mission is achieved by serving men and women who are honorably discharged. The VA is the largest health care system within America (VA, n.d.d). This department implements medical centers in a variety of ways throughout cities. Soldiers have the ability to access this system anywhere in the country. There are

main VA medical centers (VAMC), outpatient clinics (OPC), CBOCs, and VA community living centers (VA Nursing Home; VA, n.d.a).

The VHA assists with inpatient and outpatient health care, adult day care, nursing home care, and respite programs (VA, n.d.a). The VA contains a nationwide infrastructure with information from VA medical centers, research centers, outpatient clinics, and vet centers. Various services are provided by the VA, such as long-term care, veteran women's health clinics, treatment for mental illnesses and substance use, blind rehabilitation, and spinal cord injury (VA, n.d.a).

Cross-Cultural Relevance

In developing a program for older adult veterans, understanding of military culture and awareness of their vulnerability to mental illnesses should be considered. Due to veterans entering the military at an early age, an overwhelming number do not have a college degree (U.S. Census Bureau, 2012). Only about 26%, who are 25 years or older, have obtained a bachelor's degree. The majority of veterans, 92.3%, have a high school diploma (U.S. Census Bureau, 2012).

With a large number of veterans not having a higher level of education and being in high-risk situations, the chances of developing a mental health illness increase. Veterans were surveyed within 12 months of returning from deployment. It was discovered that veterans exposed to combat are at a higher risk for developing mental health disorders including depression and alcohol use disorder (Schultz, Glickman, & Eisen, 2014). Protective factors include higher education and a sense of social and familial support (Schultz et al., 2014).

As the baby-boomer population increases, veteran rates are also increasing (VA, n.d.b). This creates a higher demand for culturally competent programs, trainings, and volunteers to assist with mental health services for older adults (Choi & McDougall, 2007; Dohrenwend, Tuner, Turse, Lewis-Fernandez, & Yager, 2008). Veterans specifically may also be in need of additional support in accessing culturally competent services due to social isolation, being homebound, and whether or not their veteran ethnic identity has been positive or negative will impact their use of VA services (Bruce et al., 2002; Harada et al., 2002). Taking this into consideration, the program would have educated volunteers who are aware of the common needs of veterans.

Social Work Relevance

In order to serve older adult veterans correctly, it is essential for social workers to be considerate of veterans' culture and how it has affected their lives. According to the *NASW Code of Ethics*, the primary mission of social work is to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (National Association of Social Workers, 2014, para. 6). Older adults, especially homebound veterans who have potentially gone through traumatizing events in the military and are suffering from mental illnesses, are among the most vulnerable in society. It is social workers' priority and ethical responsibility to advocate social justice and change on behalf of older adult veterans through departments like the GEC.

Homebound older adult veterans are at a higher risk for mental and physical ailments, which suppresses their independence and instead forces them to become dependent on spouses or relatives for quality of life and care (Edes, 2010). Veterans who

are homebound can address these issues and challenges of comorbidity in mental and physical health through visitation programs that reinforce social support systems (Choi & McDougall, 2007). Veterans would then have an opportunity to build social relationships with the college-student volunteers who will also learn and recognize the older adult generation's value (Charlson et al., 2008). Furthermore, social workers will have an understanding regarding this necessity and assist with ensuring the actions would be done with respect and without discrimination.

Definition of Terms

For the purpose of this thesis project, the following terms are defined below:

Alcohol use/alcohol use disorder (AUD): The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*) classifies anyone who meets two of the 11 criteria within 12 months as having this substance use disorder. Criteria includes "craving, or a strong desire or urge to use alcohol" and "alcohol is often taken in larger amounts or over a longer period than was intended" (National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, 2013 "A Comparison Between DSM-IV and DSM-V").

Depression or major depressive disorder (MDD): A mood disorder that manifests in a variety of forms. Major depressive disorder, or major depression, is distinguished as "a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities" (National Institute of Mental Health, 2011, p. 2).

Homebound: Refers to adults who: (a) require assistance or a significant amount of assistance when leaving from their residence and (b) are physically immobile due to an illness or injury (Donelson et al., 2001).

Mental illness: "Collectively all diagnosable mental disorders" or "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning" (CDC, 2013, para. 3).

Older adults: Are individuals identified as 65 years of age or older (CDC, 2012, p. 1).

Posttraumatic stress disorder: Past traumatic experience in which the following areas are impacted: alteration in arousal and reactivity (hyper vigilance), adverse alterations to cognitive functioning, avoidant behavior, and intrusion (American Psychiatric Association, 2013).

Social isolation: Isolation refers to parse feelings of belonging, poor engagement or socializing, and minimal contact with others within the community (Nicholson, 2012).

Veterans: People who served in the U.S. armed forces and received a discharge in which they are eligible for VA benefits (Byers & Yaffe, 2014).

CHAPTER 2

LITERATURE REVIEW

Introduction

The purpose of this literature review is to examine the gravity of older adult veterans becoming homebound. Older adult veterans face an ample amount of physical and mental disabilities related to their service. Later in life they also become at risk for social isolation and becoming homebound. This chapter will discuss research that was found in order to demonstrate a need for and development of a volunteer program. The program will be designed to increase the quality of life for homebound older adult veterans. As the baby boomer generation continues to age, common symptoms of mental health illnesses, as well as effective healthy aging techniques that are available, will be addressed. Additional topics such as the prevalence of depression, protective coping factors, and healthy aging will demonstrate the necessity of this program.

Mental Illness among Older Adults

Mental illness is characterized as a disruption in a person's mood, cognitive functioning, thought-process, and feelings in relation to his or her society and daily activities (National Alliance of Mental Illness, n.d.). Mental illnesses, including major depression (MD) and alcohol use disorder (AUD), are prevalent in the older adult population (Volkert, Schulz, Harter, Woldarczyk, & Andreas, 2013). Although MD is found to be common among older adults, the prevalence rate of depressive symptoms

fluctuates anywhere from 4.5-37.4% (Schwarzbach, Luppa, Forstmeier, König, & Riedel-Heller, 2014). Research has shown adults affected by alcoholism, while being compared to the general population, are more likely to have a comorbid disorder that impacts their health and wellness (Volkert el al., 2013). When participants were questioned about their recent alcohol usage, the AUD prevalence rate was significantly low at 0.96%. The participants were also asked about their alcohol usage over time. Upon comparing the latest prevalence rates and rates of alcohol usage over time, their AUD rate dramatically increased to 11.71% (Volkert el al., 2013). AUD is the abnormal pattern of consuming alcohol leading to grim clinical impairments (Zeller, 2007).

Hasin, Stinson, Ogburn, and Grant (2007) found that a significant number of disabilities is correlated with AUD. Disability was defined as a presence of bodily pain, a diagnosis of mental illness, or a decrease in physical functions and vitality. To assess these disabilities, Short Form 12, version 2 (SF-12v2) was incorporated into the study. SF-12v2 determines the level of impairment within psychosocial functioning (Hasin et al., 2007). Participants with 50 points or less indicated a low score, which meant an individual had more disabilities. Alcohol dependency correlated with lower levels of social functioning. By becoming socially isolated, this harmed the individual's potential in developing and maintaining social relationships. Higher alcohol dependency was also positively associated with higher levels of experiencing mental health difficulties, such as mood and personality disorders (Hasin et al., 2007).

Men were at a greater risk of experiencing alcohol use and dependency than women experience. Men and women at the peak of their adulthood, between the ages of 30 and 64, had a higher possibility of lifetime abuse than any other age group. It was

noted that older adults were not discussed in regards to lifetime abuse considering they would have developed a dependency earlier in life (Hasin et al., 2007). Comorbidity rates were significantly correlated with drug use and personality disorders.

Alcohol use appears to be common in America with rates as high as 52% (Petrakis, 2014). Those who transition from heavy drinking to AUD are associated with an increase in health risk. It has been estimated that 17.6 million Americans suffer from AUD. In addition to mental and physical disabilities, mood and anxiety disorders have been associated with AUD (Petrakis, 2014).

Depression and Social Isolation

Depressive disorders have common symptoms, such as sadness, irritability, physical and cognitive changes that influence a person's daily functions (American Psychiatric Association, 2013). Differences among these disorders include lifespan of the symptoms, what induced the onset of the disorder, and timeframe (American Psychiatric Association, 2013). MD is the most common mental illness found in the older adult population. Although it is reported that depression in older adults has a higher increase in diagnosis, this is not analogous to symptoms diminishing or improving over time (Span, 2012).

According to Park and Unützer (2011), diagnosis of depression is difficult due to symptoms in adolescents and young adults being dissimilar when compared to older adult symptoms. Characteristics comprise of somatic, rather than emotional, dementia-like features that make it problematic to truly diagnose depression and cognitive impairments including memory loss and difficulty concentrating (Park & Unützer, 2011). As there are a number of symptoms older adults may exhibit, social isolation is crucial to monitor

since it leads to detrimental conditions, including death (Nicholson, 2012). Social isolation is defined as sparse feelings of belonging, poor engagement, lack of socializing, and minimal contact with others within the community (Nicholson, 2012).

The degree and duration of a person being socially isolated is a strong predictor of poor health (Coyle & Dugan, 2012). Social isolation becomes serious and taken into account for older adults since there are various transitional roles occurring simultaneously. About 29% of older adults who are not institutionalized live alone. This suggests that older adults are much more likely to suffer from social isolation and the adverse medical side effects (Coyle & Dugan, 2012).

Social isolation may increase as people age, but the perception of loneliness is what causes depressive symptoms (Coyle & Dugan, 2012). Loneliness is the feeling a person experiences when he or she deems the quantity or quality of a relationship(s) as being inadequate (Coyle & Dugan, 2012). The nature of being homebound is confinement and having sparse interaction with others, which is synonymous with social isolation (Charlson et al., 2008). Researchers have found that homebound older adults, while being compared to older adults in senior centers, had a significantly higher risk of eating alone, a lower support system, and were experiencing symptoms of depression (Choi & McDougall, 2007).

Mental Illness's Relationship to Homebound Older Adults

Medicare defines being homebound as a person who: (a) requires assistance or a significant amount of assistance when leaving from their residence and (b) is physically immobile due to an illness or injury (Donelson et al., 2001). In addition, there is an allowance for the person to leave his or her residence briefly (a) if in need of medical

care, (b) if the person is attending an adult day program, or (c) if in attendance to a religious service (Donelson et al., 2001).

The likelihood to suffer from a physical problem intensifies when a person ages. If the suffering continues and begins to interfere with daily activities, it is then transformed into a person becoming homebound (Qui et al., 2010). Homebound older adults have a higher rate of suffering from cardiovascular and musculoskeletal diseases than older adults who are not suffering from being homebound. Osteoarthritis that affects the musculoskeletal functions and limits movement is most seen in homebound older adults (Qui et al., 2010). This physical barrier upon a person creates a separation from society and causes a person's social relations, interactions, and functionality to deteriorate.

It has been discovered that homebound individuals suffer more from cognitive impairments, depression, and anxiety disorders than those who were not (Qui et al., 2010). The multiple health problems include circulator problems, dementia, and depression. It has been proven that there is a relation between mental health services and a person's physical abilities. Depression and other cognitive impairments, when treated, have been able to show significant enhancement on an individual's physical capabilities, which were thought to be deteriorating (Qui et al., 2010).

Depression is a major risk among the homebound population (Petkus, Gum, & Wetherell, 2013). As illustrated in a study conducted on 142 older adults, those eligible for in-home services through their primary care physicians had an elevated state of depression compared to those who were not seeking services. Out of those participating, cognitive impairments significantly elevated anxiety and depressive symptoms. Those

with present diagnosis of depression were 7 times more likely than non-depressive participants in having cognitive impairments as well (Petkus et al., 2013).

Risk Factors to Becoming Homebound

Various literature and research articles discuss multiple risk factors of becoming homebound as the general population ages. Physical and mental well-being is a topic that is repeated within each article. When physical and mental health declines, it has an effect on the higher risk of becoming homebound (DePalma et al., 2013). DePalma et al. (2013) evaluated hospital admissions and re-admissions among older adults and their correlation with ADLs functioning. The results show that 1 in 4 Medicare recipients that were hospitalized were sent home without resolving their newly discovered or existing ADL disabilities (DePalma et al., 2013). Evidence revealed that when new and untreated ADL limitations were compared, those with ADLs recently discovered were at a significantly higher risk for readmission than untreated ADL limitations (DePalma et al., 2013).

Alzheimer's, a form of dementia, causes memory loss due to physical changes within the brain (Plomin, DeFries, McClearn, & McGuffin, 2008). Alzheimer's is the most common form of dementia that affects brain function and has been found to increase risk for becoming homebound (Coyle & Dugan, 2012). Coyle and Dugan (2012) suggest that Alzheimer's and the risk of becoming homebound are correlated as a result of increased social isolation and perception of being lonely. Pairing social isolation and a decline of cognitive functioning, the chances of suicidal ideations increase as Alzheimer's progresses (Coyle & Dugan, 2012).

Choi and McDougall (2007) researched depression and its origination from chronic illness and social isolation within homebound older adults and the depressive symptoms compared in older adults participating in senior centers. Choi and McDougall invested a portion of their research discussing whether or not socioeconomic status, education levels, and the level of chronic health impairments correlated with the homebound older adult subgroup. Nearly 70% of homebound older adults stated they had difficulty meeting financial necessities each month. These financial strains negatively impacted their depressive symptoms (Choi & McDougall, 2007). Findings illustrate that lower levels of education are significant in whether or not an individual becomes homebound (Choi & McDougall, 2007). The subgroup, while being compared to non-Hispanic Whites and African Americans, had significantly lower levels of education.

Furthermore, chronic illnesses, perception of not enough familial or friend support, and financial stability impacted homebound older adults that were compared to older adults in senior centers (Choi & McDougall, 2007). Marital status and support were dramatically lower for homebound older adults, 8.7%, than nearly 30% in senior centers. These higher levels of support were also seen in religious services that were used effectively in lowering depressive symptoms for those in senior centers (Choi & McDougall, 2007). The coping strategy was not seen in homebound older adults. Only one third had reported attending services while 87% within the senior center subgroup stated they attended religious services multiple times within a month (Choi & McDougall, 2007).

A research program conducted in Austin was used to discover the issues and present medical problems that low-income, homebound older adults were facing. Choi, Marti, Bruce, and Kunik (2012) examined depressive symptom severity and the number of emergency room visits among low-income, homebound older adults participating in a telehealth problem-solving therapy. Of those participating, 67.7% visited the emergency room at least once within a 12-month span. Sixty one percent of the emergency room visitors made at least one revisit within a year.

Depressive symptoms played a role in the increase in emergency visits, which exacerbated somatic symptoms related to medical conditions the participants were combatting. It was noted that low-income homebound older adults are more vulnerable to financial hardships. Furthermore, these medical conditions, along with an increase in depressive symptoms, intensified the participants emergency visits (Choi et al., 2012). These reliable findings solidify the understanding that homebound older adults have an increased rate of medical comorbid ailments when compared to the general older adult population.

Compared to non-veterans, veterans diagnosed with PTSD have a higher risk of developing alcohol dependency. Further, veterans suffering from mental health issues are believed to lack coping skills that make them more susceptible to AUD (Petrakis, 2014). Research also demonstrates a significant correlation between alcohol use and MD (Hawkins, Grossbard, Benbow, Nacev, & Kivlahan, 2012).

Older Adult Veteran's High-Risk Vulnerabilities

As the risk for becoming homebound is more likely for the population of older adults with mental illnesses, veterans are at an even higher risk due to their vulnerability.

Almost six million veterans within the United States are provided primary medical care from the VHA (Bagalman, 2014). The VHA is a division within the Department of Veteran Affairs (VA) that assists veterans, dependents, and their survivors that dates back to the 1930s (U.S. Department of Veteran Affairs, n.d.).

Research has shown that although one-third of the veteran population is currently receiving medical treatment at the VHA facilities, one-third of the VHA patients, who have been diagnosed with depression, are not receiving any form of treatment (Burnett-Zeigler et al., 2012). Burnett-Zeigler et al. (2012) conducted a secondary analysis with data provided by the VA. This information depicted the type of services provided and pharmacy information for all VA veterans aged 50 years and older who were diagnosed with depression. Older adult veterans were found to be at a higher risk for developing depression due to distinctive life experiences, psychosocial stressors, traumatic events, and comorbid psychological and medical conditions (Burnett-Zeigler et al., 2012). Of those veterans who received treatment, the majority obtained antidepressants only.

Age differences were a factor contributing to whether or not a veteran received treatment. Veterans who were 50 – 64-years-old were at a higher likelihood of receiving only antidepressant treatments, psychotherapy sessions, or both while being compared to veterans older than 65-years-old. It was also found that veterans who were white, male, and married had a higher correlation with obtaining antidepressants and seeking mental health services than those veterans who were minorities, unmarried, and male. These results are in agreement with other studies stating that older adults have a higher prevalence rate for depression (Volkert et al., 2013).

Dohrenwend et al. (2008) sampled 248 male veterans diagnosed with PTSD from the Vietnam War. Of the participants, 94 were white, 70 were black, and 84 were Hispanic. The study illustrated an elevated diagnosis of PTSD for Hispanic and black veterans compared to white veterans. Hispanic veterans had higher diagnosis rates than both black and white veteran subgroups. Hispanic veterans were also noted to have an increase in war-zone stressors, lower rates of education, and entry into the military at a younger age. These factors contribute to the Hispanic veteran population being a high-risk population for developing PTSD and other comorbid mental and physical conditions (Dohrenwend et al., 2008).

As people go through life, significant events that have impacted a person affect how they engage in society (Harada et al., 2002). As a high-risk population, veterans may experience traumatic life stressors that will impact them as they age, thus veterans' engagement in society is affected. Information was gathered from 3,405 veterans located in Southern California and Southern Nevada. It was noted that combat veterans struggled in creating social relations throughout their lives and reported lower overall satisfaction and poorer health than non-combat veterans (Harada et al., 2002). The different experiences each veteran has had within their own ethnic group also impacts their military experience, thus shaping their veteran identity.

Hispanics were found to be the largest minority group to serve in combat (Harada et al., 2002). This detachment from society experienced by Hispanics has led to an increased perception of loneliness, thus resulting in an emphasis on Hispanic veterans to become homebound and suffer from chronic, physical conditions as they age (Harada et al., 2002; Choi & McDougall, 2007). Out of the three minority groups, black veterans

reported the lowest level of physical and mental functioning (Harada et al., 2002). These lower levels of functioning may deteriorate as these veterans age, which will impact their quality of life and ADLs (Smith & Hirdes, 2009). As a veteran's ADLs become impacted, there is a higher likelihood of a veteran becoming diagnosed with depression and having suicidal ideations (Chung, Chiou, & Chou, 2009).

Effective Interventions

Researchers have evaluated access to mental health services, social services and support, and psychotherapy in order to note the effectiveness of each intervention and its impact on homebound older adults (Karlin & Karel, 2013; Choi & McDougall, 2007; Qui et al., 2010; Charlson et al., 2008). Karlin and Karel (2013) evaluated the HBPC and the implementation of the full-time mental health provider. In recognition of mental health services not being met for homebound older adult veterans, the VA designed an additional resource within HBPC to assess and assist veterans with depression, anxiety, family stressors and coping with role transitions (Karlin & Karel, 2013). Findings demonstrated that 40% of the mental health providers' time was spent on one-on-one interactions with the veterans.

By the survey responses the researchers received, time that was spent with the veteran and interdisciplinary team demonstrated the older adults having access to a mental health therapist. HBPC program directors were given a survey. Out of 116 that filled out the survey, 101 directors reportedly stated having a mental health provider within the HBPC program (Karlin & Karel, 2013). One of the strongest indications of the mental health provider's impact on the program was the response from directors (Karlin & Karel, 2013). Program directors reported having the ability to identify and

notice mental health issues a veteran had and also assisted in the likelihood of them receiving the specific care they needed. Although the researchers did not discuss the veterans' perceptions of the program, it is proven that mental health providers are being utilized and their findings have contributed to other developments and current Medicare testing.

Similar to HBPC program implemented by the VA, Charlson et al. (2008) researched community-based services and their effect on newly diagnosed homebound older adults. Results demonstrated that newly homebound older adults experienced depressive symptoms that caused the individual's quality of life to decline rapidly. New homebound older adults were also noted as having little to no social support. Charlson et al. (2008) identified and measured social service support systems as having housekeeping, friendly visitation programs, and being a participant of the Meals on Wheels Program. While the study did not state ADLs returning for homebound older adults, it did demonstrate significant improvements in quality of life for individuals who participated in each social service support system.

Choi and McDougall (2007) compared 81 low-income, homebound older adults to 130 ambulatory older adults that were attending senior centers. A comparison was conducted to note any changes in depression risk, depression symptoms, and coping strategies. Researchers discovered that homebound older adults were at risk to exhibiting symptoms of depression (Choi & McDougall, 2007). Once coping resources such as exercise and engagement in social support systems were added, the effects of being homebound were no longer significant. Consequently, coping resources have a lower negative correlation to depression for homebound older adults. Furthermore, Choi and

McDougall (2007) discussed homebound older adults benefiting from additional support from an in-home visitor program where others can observe the older adult and provide a coping mechanism.

Chapter Summary

This chapter is a summary of the struggles and decline of quality of life aging adult veterans bear. In addition to having a higher risk for mental and physical ailments, veterans face another challenge when their limitations are affected. These limitations worsen or contribute to social isolation and depression. The vulnerabilities, risk, and challenges of suffering from a mental illness as a veteran were also discussed.

The relevant literature in this chapter demonstrates depression, social isolation, and risk of becoming homebound are related, as well as the importance of developing a visitation program. Research has illustrated the increase of the baby boomer generation, which furthers the necessity of a social service and volunteer program aimed at social isolation. With the demands and necessities of a program dedicated to healthy aging, funding for HBV may become a valuable resource to not only veterans, but also their community and loved one. The following chapter will highlight and explain a program dedicated for veterans and the funding options as the formation.

CHAPTER 3

METHODS

Introduction

This chapter will describe the methodology used to select a funding agency for the program. Details regarding the requirements needed from the funding source, the desired qualifications for the grant, and the variety of resources utilized will be described. The agency's requirements and those of the proposed program, along with selecting a funding source, will be explored.

Target Population

The target population of this in-home visitation program will be homebound older adult veterans that are suffering from social isolation and/or depressive symptoms in the Greater Los Angeles Area, California. According to the California Research Bureau, there are 1,757,283 male and 185,494 female veterans living in California (California Research Bureau [CRB], 2013). Of those veterans who are 65-years-old or older, 748,773 are male and 31,762 are female veterans. As one of the largest Veterans Integrated Service Networks (VISN), VISN 22 servicing Southern California and Southern Nevada care for 479,183 male and 19,544 female veterans 65-years-old and older. Most of these older adult veterans live in Southern California and 323,431 reside in Los Angeles County alone (VA, n.d.e).

The population of Los Angeles County is ethnically diverse. The representation is as follows: White (71.5%), Hispanic (48.3%), Asian (14.6%), and Black (9.2%; U.S.

Census Bureau, 2014). The city's population consists of both native-born and foreign-born (35.3%) individuals living in Los Angeles (U.S. Census Bureau, 2014). The female population in 2014 accounted for 50.7% of the total population in Los Angeles. Older adults who are 65 and older consist of 11.9% of the overall population (U.S. Census Bureau, 2014).

The population for this program will be taken from individuals through the VA, GLA and VA, Sepulveda network. The veterans encouraged to participate in the in-home visitor program will already have their primary physician and staff through the HBPC team. The older adults will have been screened through the use of the Mini-Mental Status Exam (MMSE) for screening of capacity of cognitive functions, depression symptoms using the Geriatric Depression Scale (GDS), and UCLA Loneliness Scale for perception of loneliness and the medical outcome survey (MOS) for social support. The screening tools used are instruments that will determine the risk for the development of depressive symptoms or current social isolation issues.

Identification of Funding Sources

The grant writer used the Internet in order to find funding options. The following search engines: Google, Yahoo, and Firefox, were used to locate websites for potential sources. The website Grants.gov was also used. The following keywords were included: *homebound adults, veteran, veterans, depression, social isolation, community, mental health, and prevention*.

Criteria for Selecting a Grant

The criteria used to direct the final funding source were: (a) how well both the funding source goals and the program's intent relate, (b) geographical locations outside

of the Los Angeles County area, (c) how extensive the funding is, (d) mission purpose, and (e) funding priorities. Past grants funded, application process, and organizations that received funding were also examined. At first, funding sources specifically for veterans were not appropriate for the proposed volunteer program. Therefore, the grant writer included older and aging adults. The following two funding sources were produced.

Ralph M. Parsons Foundation's priority is to improve and enhance the community through social impact and medical centers (Ralph M. Parsons Foundation, 2014). Although the purpose and mission were similar to the program's intent, the Foundation was not specific to nor did it emphasize supporting the older adult population. This left one funding agency, the Depression in Later-Life Initiative, funded by the Archstone Foundation.

Description of the Funding Foundation

The Archstone Foundation is a private, grant-making foundation formed in 1985. A few years later, the mission transformed to primarily assist and "contribute towards the preparation of society in meeting the needs of an aging population" (Archstone Foundation, 2015, para. 1). Currently, the foundation's primary focus is on: (a) adults aging in the community, (b) depression in later life, and (c) expansion of health care providers for the aging population. The Archstone Foundation (2015) has provided over 90 million dollars to fund 990 projects that will assist with this program's longevity in years ahead.

Grant Needs Assessment

In order to decide what kind of program is needed for homebound older adult veterans that will receive friendly visitations, various assessments were conducted. A

review of current literature to evaluate topics and any future improvements was completed. A year and two months of federal employment as a social work student intern have been completed in order to understand and note the services and programs given by the VAMC, particularly for older adult veterans. Through these methods, the demand for the implementation and funding of an in-home visitation program for homebound older adult veterans has been supported.

Grant Requirements

In order to receive funding, the foundation requests the grant writer to initially submit a letter of inquiry. Upon completion, the Archstone Foundation (2015) will determine whether or not a grant writer may continue the process and be invited to submit the proposal. The following seven steps summarize the requirements that need to be completed:

1. Submit Letter of Inquiry (LOI)
2. Submit full proposal by March 13, 2015, if invited to submit a Full Proposal
3. Host a site visit as part of the application process in April/May 2015
4. Attend three (3) in-person two-day meetings/trainings, and regular monthly training webinars; Two (2) in-person meetings will be held in Year One of the grant, one (1) in Northern and one (1) in Southern California; and one (1) in Year Two, in Southern California; Funding for travel should be included in the applying organizations' budgets. At least two individuals from each partnering organization should attend
5. Work with the AIMS Center at UW to explore revenue sources to support sustainability and/or continued development of the models of care developed within the partnership.

6. Work with the AIMS Center at UW and UC Davis to evaluate collaborative care community-engaged partnerships. Evaluation results will be shared with grantees and should be incorporated into the grantees' agency evaluation efforts and progress reports submitted to Archstone Foundation. As part of these efforts, the participating organization(s) will host an evaluation visit during the grant period, which may include on-site interviews with clinicians and leaders in the organization(s), as well as supplemental phone interviews before and/or after the evaluation visit.

7. Work with the University of Washington and University of California, Davis when preparing to submit information to their Institutional Review Boards (IRB) on the late-life depression interventions.

CHAPTER 4

PROPOSAL NARRATIVE

Department of Veteran Affairs Mission

The VA's mission is derived from President Lincoln's promise "to care for him who shall have borne the battle, and for his widow, and his orphan" through the service of honoring and caring for men and women who are veterans (U.S. Department of VA, Division of Veterans Health Administration, n.d.a, para. 1). This is achieved through the five core values: Integrity, Commitment, Advocacy, Respect, and Excellence that create the acronym "I CARE." Through "I CARE," veterans and their loved ones are able to witness the dedication and commitment the agency and employees have towards those they serve. The VA is the largest health care system within America. This department implements medical centers in a variety of ways throughout cities. Soldiers have the ability to access this system anywhere in the country.

In response to the growing number of older adult veterans, VA GLA is one of the five centers funded by the Hartfort and Archstone Foundations. With these funds, the Southern California Geriatric Social Work Education Consortium (GSWEC) provides the nation's first regional consortium that collaborates with five geriatric social work agencies and 12 prominent medical aging providers (U.S. Department of Veteran Affairs, Division of Veterans Health Administration, n.d.c). A variety of programs that assist older adult veterans includes but is not limited to: home based primary care, adult day health care, geriatric medicine, and the nursing home care unit.

Proposal Summary

Within the Home Based Visitation (HBV) program there will be a lead social worker whose primary mission is to provide veterans with a social contact that is just as valuable as the comprehensive, interdisciplinary primary team in HBPC. There is a positive perception about HBPC and veterans are receiving medical and behavioral attention that leads to a reduction in hospital readmissions, freedom of staying within the community, and overall cost being affordable (Cooper, Granadillo, & Stacey, 2007). Although these findings are leading to a better quality of life, there has not been research or statements regarding the veteran's social support and community resources expanding. Homebound veterans suffer from an array of chronic illnesses and functional limitations that result in social isolation and depressive symptoms increasing with perceived severe isolation and loneliness (Choi & McDougall, 2007). Therefore, the HBV's goal is to reduce the veteran's social isolation and depressive symptoms along with creating a better quality of life using college-level volunteer visitors and any referrals needed in the community.

Narrative

Program Description

This project's goal is to seek funding for the enhancement of current services that provide homebound older adults with medical and psychological assistance through the VA's HBPC team. The program will be provided and coordinated by VA GLA by way of a social work consult from other fellow-staff members working in the HBPC team. This consult, fulfilled by a college-level volunteer, will primarily serve as a social interaction that maintains social support and advocacy for the veteran. The HBV's goal

is to improve the lives of men and women veterans that may be suffering from depressive and/or social isolation symptoms. The program includes college-level volunteers that will take on a supportive visitor role while professionals manage the program.

Target Population

HBPC can improve and affect a veteran's quality of life and reduce health care cost (Stall, Nowaczynski, Sinha, 2014). Despite the increase in quality of care, depression and other mental health issues are not being explored or promoted at the same level of urgency (Choi, Wilson, Sirrianni, Marinucci, & Heagel, 2014). With that in mind, veterans with depression or social isolation symptoms will be included in this program in order to increase their social support and foundation within their communities.

Veterans who are 65 and older who have been previously screened, documented as having a clinical need for, and admitted into the HBPC program, may apply for HBV services. There will be a minimum of six veterans seen every three months. This equates to 24 veterans being served within a year. These veterans applying will be screened a second time in order to confirm they are appropriate based on their MMSE, GDS, UCLA Loneliness Scale, and MOS scores. Those that fall within the appropriate areas will be welcomed to participate. Veterans who do not have the desired criteria may still be seen by the social worker and given support services and referrals, if necessary.

Qualifications of Key Leaders

Along with volunteers assisting veterans, a clinician that is a Licensed Clinical Social Worker (LCSW) will be directing the HBV program. The LCSW director must have at least two years post-licensure experience with veterans, ability to coordinate and

supervise an Associate Clinical Social Worker (ASW) who has also worked with veterans, Master's in Social Work (MSW) graduate students, and community college-level volunteers. Along with supervision, the LCSW will be willing to work in an interdisciplinary format within the HBPC team. The program director will oversee the program and routinely assess whether the project objectives are satisfactory.

The social worker will directly interact and work with the MSW interns. The clinical social worker will be the full-time case manager. Their duties include therapy and developing training sessions for volunteers with MSW interns while coordinating any materials the program director may need. When MSW interns are not in their school programs or required to complete their internship hours, the social worker will take on the MSW interns' duties. The MSW students, who are interested in gerontology and have the proper clearance check with the VA and program director, will have the opportunity to co-facilitate the training sessions with the clinician and manage a caseload for the college-level volunteers.

Six college-level volunteers will be recruited at local community college events and universities. These students, once the relationship has been established with the community college, may service learning credit. A variety of flyers, advertisements, promotions, and outreach will be used to acquire a well-rounded volunteer group. There will also be the use of student clubs, departments in the human services, and on campus events to recruit Mission Hills Community College students. Requirements are as follows: at least 18-years-old, enrolled in a community college, provide their own transportation with the possibility of their college reimbursing mileage, those applying for the positions who are seeking a degree in social work, psychology, or sociology will

be prioritized, ability to express an interest in working with the gerontology population, and submit a background check through the VA. There will also be an initial four-hour training session followed by recurring sessions with a rotation of different topics on confidentiality and boundaries with veterans, responsibilities as a volunteer, self care and check-ins with the social worker, learning and preventing burnout, and ways to create a safe environment for veterans and themselves.

Volunteers will work with MSW students, clinicians, and the HBV's LCSW towards the goal of decreasing social isolation. Volunteers assigned veterans will have one-on-one appointments. In order to increase chances of a good relationship, volunteers will be screened prior to caseload assignments for similar interest. The caseload and amount will depend on the volunteer's availability and skills. The number of veterans per volunteer will not exceed two or three.

The volunteer may schedule his or her visits depending on the availability of the veteran. Timeframes will be between eight in the morning and four thirty in the afternoon, Monday through Friday. Volunteers must be available for three to four months. During this time, volunteers will be assigned to a specific veteran. Volunteers must be available at least once a week to provide emotional and social support.

Visits may include a number of activities such as working on projects, playing games, watching movies or listening to music. These activities will not include any IADLs that should be conducted by a caregiver. Prohibited activities include meal preparations, feedings, bathing, dressing, or any housekeeping. Volunteers will track their activities through a checklist provided by the clinicians. As the volunteers are under an LCSW, a clinician, and MSW interns, they must advocate for the older adult

veterans. Volunteers are mandated and will be trained to contact the social work staff immediately for any issues or concerns that arise.

Sustainability

Due to the nature of the VAMC system and VA, GLA, maintaining a caseload and funding will not be an issue. As the veteran population is on the rise, any potential clients will be referred to HBPC and then to HBV. The program director and social worker will ensure that social work consults are being fulfilled in a timely manner from other VA geriatric programs. Contact and relationships will also be established and maintained through other social workers in order to assist any new HBPC patients. The HBC program will be substantially funded and maintained through the VA for the entire two-year period.

Program Goals and Objectives

The overarching goal of HBV is to maintain and enhance a healthy aging process that decreases depressive symptoms and social isolation homebound older adult veterans experience. The management and maintenance of healthy aging will be through positive socialization received by community college volunteers, MSW students, clinician, and the HBPC services from VA, GLA. It is hoped that participation in this program will enhance the veteran's quality of life through an increase in community resources and decrease of depressive symptoms. By way of this program, other VAMC and VISNs have the possibility of replicating a visitation program in their service areas.

Goal 1: Implement HBV into the HBPC at the VA, Sepulveda in North Hills, California

Objective 1: Recruit and train employees in facilitating the program.

Expected training results: Employees, MSW students, and community college volunteers will go through a number of workshops, which upon completion must have an 85% or higher on their training exams, then they may begin to screen veterans into HBV. The director is required to complete any field trainings mandated by MSW students' universities or documentations that are necessary. The social worker will specialize in clinical social work with an emphasis in geriatric social worker. The social worker will complete consults, assessments, case management duties, and directly assist in maintaining and enhancing the veteran's quality of life.

The MSW students will directly assist volunteers and veterans. These interns will complete trainings or requirements their university, program director, and agency requires. Community college volunteers are expected to complete workshops the clinician and the MSW students co-facilitate throughout the year and must go through the volunteer training process at the VA.

Phase 1: Prior to the program's commencement, all employees and volunteers will be given trainings on proper engagement protocols and common barriers that homebound veterans experience. The social worker will be trained in any VA clinical documentations required, facilitate workshops for volunteers, and any resources that are common for the VA. The MSW students will be trained in case management and be given a resource binder that contains information on other VA programs and common referral sources veterans have access to. Additionally, the MSW students will learn how to conduct assessments, the proper documentation formatting, and handle a caseload as clinicians that will be supervised by the program director.

The program director, clinician, and MSW students will be trained in the use of each scale and exam in order to screen, assess, monitor, and evaluate symptoms of depression and social isolation. The scales will monitor and note any changes noted before or after participating in the program. Further, the collected data will be analyzed to evaluate if depression and quality of life increased or decreased in part by HBV.

Objective 2: Provide services and engage with HBPC veterans who have symptoms of depression.

Program Screening and Requirements: Veterans will be evaluated and screened for appropriateness through the use of the MMSE, GDS, UCLA Loneliness Scale, and the MOS. These scales will also be used for both the pre and post exams as collected data for evaluations.

Social Work Consults: In order to be successful in obtaining a proper caseload for HBV, social work consults will be used as referrals and an aspect of outreach. Within two weeks, 85% of clinically documented consults requested by the HBPC team will be completed. As this program is in combination with other VA programs for older adults, the number of consults referred outside of HBPC will be extended to four weeks with a completion rate of 80%.

Services Provided: The program will provide at least three months of weekly visitations by community-college volunteers for a minimum of an hour. Upon a three-month completion, veteran will graduate the program and be given an opportunity to request another visitor, hobbies, or community resources. If veteran declines any additional resources or visitations, the case mangers will document the decline of further resources.

Caseload Maintenance: The program director will organize and review the number of active participants every 3 months. The program must maintain at least six veterans or more each quarter.

Phase 2: Process for social work consults and referrals from other VA programs. In order to establish clientele, the MSW interns and clinician are responsible for contacting other VA programs. Referrals and outreach are possible through emails, the computerized patient record system (CPRS), fliers, emails to the social work department, phone calls, or in person. Once a proper amount of veterans have been established, the social worker will be responsible for ongoing referrals. Those MSW students expressing an interest in clinical social work will be trained and responsible for screening veterans. If consults are needed, the program director or social worker will be made available to assist MSW students.

Phase 3: Volunteers will begin to conduct weekly visitations with veteran to address depressive symptoms. Initially, clinicians will utilize the MMSW, GDS, UCLA Loneliness Scale, and the MOS as pre-test assessments. Volunteers will have access to any therapeutic methods to meet the veteran's mental health needs. Volunteers will have opportunities to consult with clinicians and the program director regarding evidence-based practices (EVP), resources, or activities the veterans may improve from. Clinicians and volunteers will collaborate and be responsible for maintaining individual treatment plans. Clinicians will continue to maintain the number of participants and enrollees, graduations and discharges from HBV. Clinicians will also be responsible to refer any veterans that do not meet the criteria for HBV to available community resources.

The clinician will initially meet bi-weekly with veterans ensuring their needs are being met. After the first month, MSW students may shadow and then assist the clinician in these meetings. If the veteran reports they do not need additional support than the volunteer, the meetings will be shortened or reduced. In the last quarter of the program, the clinician's role will shift from outreach to follow-ups. Follow-ups will be designed to re-assess veterans and provide additional resources.

Goal 2: Collect Data from HBV

Data Collection: The clinician who will be initially assessing the veteran will also document the data. Once 95% of all the scores from the MMSE, GDS, UCLA Loneliness Scale, and the MOS are recorded, the collection will be considered successful. Clinicians will make sure all assessments are being properly completed and report this information to the program director every three months.

Phase 4: Clinicians will document each encounter with a veteran. The first visit will include scores from the MMSE, GDS, UCLA Loneliness Scale, and the MOS. The program director will be responsible for the data once it has been collected and for its safekeeping. Veterans that graduate from the program will have a follow-up session scheduled during the last quarter of the program. During the follow-up appointments, clinicians will reassess veterans with the pre-test screening as post-test. Veterans who are still participating in the last quarter will not have to complete a follow-up appointment due to the limited amount of time left.

Goal 3: Analyze and Display HBV Findings Related to its Effectiveness

Objective 3: Create a brochure and present the information.

Success of the program: The program will be considered successful when the veteran's post-scores demonstrate a significant decrease from their pre-scores.

Brochure presentation and host evaluation visit: The brochures will be completed with purpose, goals, objectives, and findings that are presented to the program director and the associate chief of social work.

Objective 4: Perform an evaluation of the program.

In addition to the evaluations conducted by the VA, the Archstone Foundation requires a host evaluation visit by the Advancing Integrated Mental Health Solutions (AIMS) at University of Washington and University of California, Davis (UC Davis). The visit may include phone interviews or on-site interviews with the volunteers and staff of the program.

Phase 5: The program director will be responsible to collect all data, information, host evaluation visit, and brochures that will be used to submit for both University of Washington's and UC Davis's Institutional Review Boards (IRB) on the late-life depression intervention.

Timeline

Veterans participating in this program will not have a deadline or maximum amount of time allowed to be receiving services. Veterans will graduate the program once they are not having weekly visits by volunteers. Completion of the program will be deemed by the veteran and social workers involved in the patient's care. The minimum timeframe of participation is three months or 16-weekly visits. The timeframe will allow veterans to utilize resources available in HBV. Resources will include case management,

access to clinicians, resources and referrals, and growth through relationship-based therapy.

The program will run for 24 months including a month prior the start date for employees to be trained and a month after for data analysis and evaluation. The program start date is August 1, 2015. Employees will be paid bi-weekly beginning the first week of training. Assigned MSW students to HBV for case management and clinical work will receive training in the second week of August. The program director will begin recruitment in the second week of August with the clinician and MSW students continuing outreach by the end of the month. Initially the volunteers will be trained by the program director. The clinician will continue these trainings workshops in the fall.

Starting September 1, 2015, veterans will be assessed by clinicians so they find a proper match with a volunteer. Although the clinician and MSW interns will conduct these assessments and matches, the program director or social worker will be available to oversee the MSW interns when necessary. Starting the second week of September 2015, veterans will begin to receive visits by volunteers, social worker, and MSW students. These visitations will continue until June 30, 2016. July 2016 will be the assigned months for data collection and analysis. The evaluation of findings will be presented on or before July 31, 2016.

Program Evaluation

During the 22 months of direct service, bi-weekly meetings facilitated by the clinician will be conducted for the MSW students and volunteers. These two-hour meetings will serve as an informal data collection, such as observations and reports by veterans or veterans' family. Each case will be discussed, reviewed, and

evaluated. There will be opportunities for assistance or feedback the MSW interns or veteran's well-being will be available.

The program director and clinician will manage and co-lead the meetings. Collection of the informal data will be collected by the program director. If it is found that the meetings are too short for the agenda, an additional hour may be allocated for supervision and debriefment. The final program evaluation will be completed as Goal 3 outlines.

Budget Narrative

In order for the program to be sustained for 2 years, a budget of $316,531.60 is necessary. Staffing of the program will require two full time employees and three MSW students awarded a GSWEC stipend. The program director will be employees for $65,000 annually and the ASW will earn $53,000 annually. The program director position will require a LCSW title and the clinician must have obtained their ASW. The LCSW and clinical social worker must have their license or be in the process of completing the requirements. Additionally, both employees must be well experienced in order to supervise and train MSW students.

In order to serve the maximum amount of veterans, three interns will be required; all three interns must be enrolled in an accredited social work program, accepted into GSWEC, and pass any requirements by the VA. Each MSW student will be awarded $5,500 per year in a form of a stipend. Interns will be assessing and conducting any group trainings that are required by the ASW and LCSW. Both the LCSW and ASW will supervise and provide weekly supervision.

MSW students are required to complete a minimum of 16 hours weekly for 9 months. Since the academic requirements differ and require less amount of time than the program, a second set of MSW student will be necessary. The second group of interns will receive the same amount of training and information as the first.

Direct program costs will include funding for program supplies, training materials, computers, printers, outreach materials, and any additional resource the volunteers may need. In order to receive funds through the Archstone Foundation (2015), it is required that the LCSW and ASW attend three, 2-day trainings for the entire duration of the program. Two of these trainings will be required in the first year in Northern California and Southern California. The following year, the remaining training will be held in Southern California.

Expenses and travel compensation will be included in the program's cost. Expenses include per diem lodging rates, meals with included expenses, and estimated cost for transportation to and from trainings. Per diem rates were located using the zip code for VA, Sepulveda on the U.S. General Services Administration website (U.S. Department of General Services Administration [GSA], 2014).

Indirect Costs

Ten percent of the total program costs will be allocated for general administrative and facility expenses. Expenses will include audits, utility bills, and general use of VA facilities. A budget of $28,775.60 is necessary to maintain the program operating.

In Kind Resources

As community college volunteers and their relationships with veterans is the central focus of this program, a minimum of six volunteers is necessary; three volunteers

with a client each and the remaining three with two clients will meet the program's required veteran enrollment. Volunteers will conduct weekly visitations for a minimum of an hour. Transportation to and from the veteran's residence is not covered and must be discussed in the initial interview by the LCSW and ASW. The community college students must be enrolled part-time at a local college. A desire to work with the gerontology population must be demonstrated. Volunteers are only required to participate for three months but are allowed to remain for the duration of the program. A new set of volunteers will be trained each three months.

TABLE 1. Line-Item Budget

Expenses	
Salaries and Wages (Yearly)	
Program Director (LCSW)	$65,000
Clinical Staff (MSW, GS-9)	$53,000
Total Salaries with benefits (Yearly)	$118,000
Total Salaries with Benefits: 2-year program	$236,000
MSW Stipends (Yearly)	
Additional Social Work Clinician (MSW Intern)	$5,500
Additional Social Work Clinician (MSW Intern)	$5,500
Additional Social Work Clinician (MSW Intern)	$5,500
Total Stipends without benefits (Yearly)	$16,500
Total Stipends without benefits: 2-year program	$33,00
Direct Operating Costs (Yearly)	
Travel Expenses for 1 Person/Two-Day Training	
Per Diem Lodging Rate ($138/day)	$276
Per Diem Meals Including Expenses ($71/day)	$142
Transportation ($30/day)	$60
Airfare, when needed ($150)	$150
Total Travel Expenses for one, two-day training x2 employees	$628
Total Travel Expenses for three, two-day trainings: 2-year program	$1,256
Computers x5	$5,000
Program Supplies @$100/monthly	$1,200
Outreach Materials	$1,000
Printer	$800
Training Materials	$750
Total Direct Costs	$8,750
Total Direct Costs: 2-year program	$17,500
Indirect Administrative Cost	$28,775.60
In Kind Resources	
Community College Volunteers x6	-
Total Program Cost	$316,531.60

CHAPTER 5

LESSONS LEARNED

Grant Writing Process

The grant writer found a variety of information supporting access to mental health and peer-supported services for veterans. Supporting research from multiple databases for volunteer services was not as easy to find. The process of determining current assistance, lack in specific VA programs, and demonstration foundations that may support a proposed program was a tedious and complex process. Starting from personal observations in my internship experience at the VA, noting a lack of programs for socializing, creating an idea and conceptualizing each aspect of the program was challenging.

Finding a lack in resources is much simpler than finding a solution. Originally the grant writer had thought of screening for mental health workers as volunteers. This screen would have not worked due to the concept of volunteers providing service and time free of charge. The process of narrowing roles in HBV and the overall goal of the project were easier as the volunteer's role simplified. The difficulty was found in defining which veteran would be served, as the grant writer is extremely passionate about access of service to all veterans.

As time went on to conceptualize the grant writing process, the image of the program simplified. Grant writing is not a task taken lightly nor should it be accomplished within a short amount of time. The process of writing, crafting, and

presenting a paper of this scale can be overwhelming for a student. In order to simplify the project and manage my time, the grant writer divided chapters thus, these divisions created manageable internal deadlines.

Finding up to date relevant references and reviewing them was a side project the grant writer had not considered. Luckily, the grant writer has had some experience and knowledge in finding articles from undergraduate and graduate schoolwork. The resulting outlook on this project has allowed the grant writer to become appreciative for the online resources that are readily accessible. Also, this has allowed the grant writer to use organizational abilities and the knowledge learned in the MSW program.

Identification of a Funding Source

Finding multiple funding sources was easy. The difficulty lied in finding a grant that not only was compatible to my program, but also funded a federal agency. Using Internet search engines provided ample results that were not well suited or focused on a younger veteran age group. This was the most difficult aspect as the grant writer.

After multiple hours were spent on finding a source for funding, the grant writer decided to look up past VA collaborations with funding agencies. Websites designed to assist in matching grants with grant writers proved to be useless. There were many grants aimed at Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), but not older adult veterans. Fortunately, the Archstone Foundation (2015) not only discussed geriatric social work, but also funded and supported the community as well. After finding the right foundation, aligning both requirements for HBV and the funding foundation was the last task.

Social Work Implications

Social work acts as a broad umbrella that engages all communities. Social workers main focus is to empower and assistance undocumented immigrants, advocating for the lesbian, gay, bi-sexual, and transgendered (LGBT) community, or advocating for older adults. Equality and eliminating gender biases, leading rallies and movements in Long Beach's apartment community, or lobbying for higher quality of care for older adults, social workers and students are participating. Communities and individuals drive social work.

This enhancement and care comes directly from the *NASW Code of* Ethics, that states care and quality of life is vita for all communities, especially those experiencing oppression or vulnerability (National Association of Social Workers, 2014). The subpopulation of veterans is one small aspect that social work has focused on. Wars, conflicts, and national security in America impact social work and hopefully HBV alleviates these affects on veterans.

Many older adults will retire, move in with family members, or live alone. This population has the risk of becoming homebound, which includes all races, ethnicities, culture, etc. Veterans are a diverse population. Social work has the advantage of understanding, advocating, and caring or older adult and veteran needs. As the grant writer has seen at the VA, one minute you are working with a physical disabled veteran, then a homeless veteran whose family does not wish to support his drug use. Through this project, the grant writer has found valuable treatment models, supportive services, and volunteer roles that will impact a homebound older adult veteran.

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