Bridging the Gap

A Community-Embedded Rural Resource Navigator Model to Prevent Veteran Suicide

Rural access

Suicide prevention

Navigation + care continuity

VETERANS NAVIGATION NETWORK

Montana • Community-embedded • Peer-based
Trauma-informed • Rural access • Connection

Audience takeaway

How to adapt a hub-and-spoke rural navigator model that reaches veterans before, between, and after formal systems of care.

Mike McManus, VNN Program Manager
Senior Master Sergeant, USAF (retired)
County Veteran Service Officer (CA, retired)

1. Describe the structural barriers contributing to elevated suicide risk among rural veterans.

2. Explain how a community-embedded Resource Navigator model enhances continuity of care and suicide prevention outcomes.

3. Identify core training components (peer support, motivational interviewing, trauma-informed care, suicide prevention, NVLSP) required to deploy rural navigators effectively.

4. Apply principles of hub-and-spoke coordination to strengthen cross-system collaboration in rural regions.

5. Evaluate measurable indicators (VA utilization, engagement rates, satisfaction data) for assessing program effectiveness.

Why this matters in Montana

53.9

Montana veteran suicide rate per 100,000 in 2023

vs 35.2 nationally

40.1%

of veteran suicide decedents had recent VHA encounters in 2022

Meaning a majority did not

The design challenge

- Reach veterans before a crisis reaches formal care.
- Build trusted access points outside the clinic walls.
- Coordinate benefits, behavioral health, telehealth, and local supports as one pathway.

This is the gap the RRN model is built to close.

- Use data to frame the problem, but lead with a solution that communities can own.
- The presentation is not just about risk, it is about practical care continuity in places where systems are fragmented.

Structural barriers in rural veteran engagement

Why a standard clinic-centered pathway is often insufficient

Distance + transportation

Long travel times, sparse public transit, and weather amplify missed appointments and delayed help-seeking.

Workforce shortages

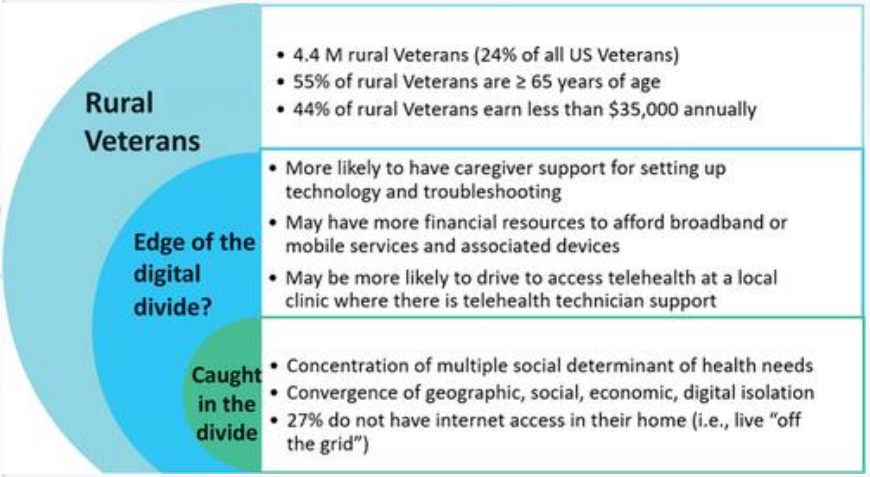
Behavioral health, case management, and specialty access are thin across frontier communities.

Broadband + telehealth gaps

Telehealth can help, but limited connectivity and digital confidence reduce its reach.

Trust + system complexity

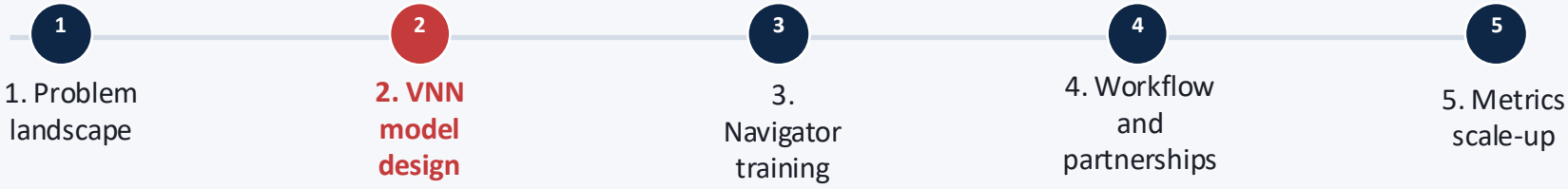
Veterans and families often do not know where to start—or do not trust that a system will stay with them.



The model response: put a trained, trusted human bridge in the community.

That person is the **Rural Resource Navigator**.

Roadmap for the session



Most of the time is spent on the middle of the pathway: This is how the model operates and how VNN can replicate it in your community.

- Hub and spoke model
- VNN based out of Billings as the hub with outreach to rural communities across Montana
- Looking at Great Falls, Helena & Missoula as other hubs using VNN employees or contract partners
- Miles City is the rural hub for southeastern MT
- MT Veteran Service Provider Network
- BHAC Veterans Subcommittee and network
- Local point of contact for healthcare, mental health support, benefits enrollment, peer mentorship, and resource navigation around social determinants of health. It is designed to improve access, reduce duplication, and make service delivery more efficient through coordinated partnerships, telehealth, transportation support, outreach, follow-up, and ongoing evaluation.

The VNN Rural Resource Navigator model

A community-embedded, peer-based, hub-and-spoke approach

Program intent

Deploy trained resource navigators in rural communities, starting in Miles City, to serve as a **central point of contact for veterans and families** across healthcare, behavioral health support, benefits enrollment, social determinants of health, and peer mentorship, volunteer opportunities, and events.

Community -embedded	Lives and works where veterans live.
Peer-based	Trust, credibility, and trauma-informed engagement.
Coordinated	Brings VA, state, tribal, nonprofit, and local systems into one pathway.

Initial community: Miles City

- Two navigators, peer mentors
- Long-term plan for additional rural placements.
- Virtual and in-person support.
- Program Support Specialist in the office
- Centralized service coordination and resource network and directory.

What the program is designed to accomplish

Access

Localized entry point

Reduce the burden of long-distance travel by giving veterans and families a consistent local contact.

Efficiency

Minimal duplication

Centralize care coordination so providers and partners are not solving the same problem in parallel.

Reach

Virtual + in-person

Use telehealth and assisted virtual access to extend scarce specialty resources.

Continuity

Follow-through

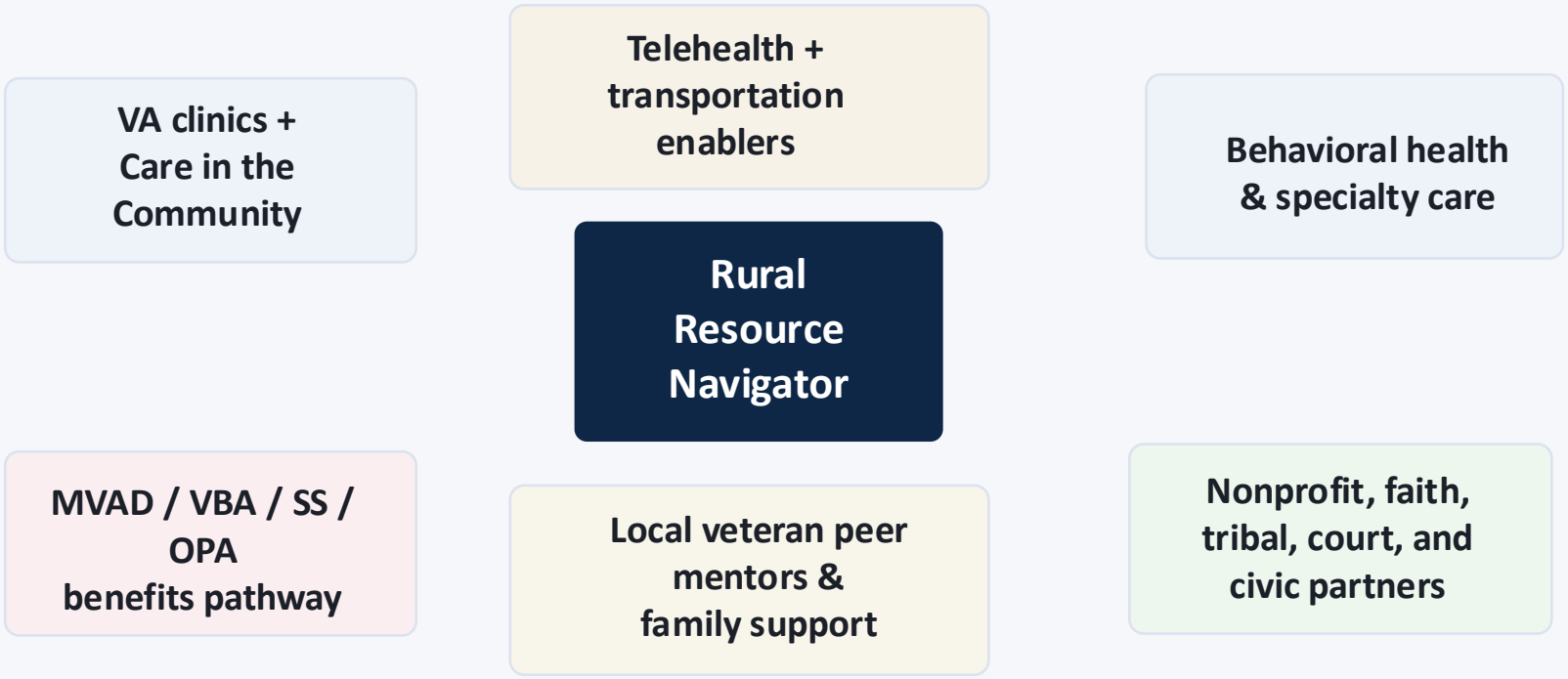
Stay with the veteran after referral so applications, appointments, and safety planning do not stall.

In practice, the RRN model is both a service-delivery model and a care-continuity model.

- It improves access to services.
- It optimizes use of scarce rural resources.
- It reduces the number of veterans who are left to navigate complex systems alone.

Hub-and-spoke care coordination and case management

The navigator sits at the center of relationships, not at the edge of them



The navigator does not replace partners; the navigator works with them to create a coherent pathway for the veteran.

What a Rural Resource Navigator actually does

Navigation + enrollment

- VA health care enrollment
- Benefits application support and follow-up
- Resource directory maintenance

Engagement + outreach

- Community meetings and workshops
- Marketing and awareness
- Identify veterans and families not yet connected

Direct support

- Virtual and in-person consultations
- Peer mentor coordination
- Connection & comradery
- Advocacy
- Transportation coordination when needed

Documentation + reporting

- Track services, referrals, and outcomes
- Quarterly reporting
- Continuous improvement feedback loops

Training and competency framework

Core training

Trauma-informed	WRAP-informed engagement, boundaries, safety, and trust-building
Motivational interviewing	Move from “I do not know where to start” to action and follow-through
Suicide prevention	QPR / SAVE, Mental Health First Aid, early identification, warm handoffs, and crisis de-escalation
Peer and family support	Understand rural veteran culture, isolation, and practical support needs
Claims, benefits education & connection	Know the process, documentation, and referral boundaries
Telehealth facilitation	Help veterans use virtual tools, appointments, and remote specialty access

Deployment principle

Train for consistent judgment in a complex environment—not for isolated tasks.

- Initial and ongoing training are built into the program plan.
- Competency includes knowledge of complex systems, when to engage, when to refer, and how to document and follow through.
- The role is strongest when peer credibility is paired with process discipline.
- Trust matters, but trust without process is not a scalable model.

Veteran journey: from first contact to continuity of care

1. Identify

Outreach event, partner referral, family concern, or self-referral

2. Engage

Establish trust, assess immediate needs, screen for risk, identify barriers

3. Connect

Enroll, schedule, refer, facilitate telehealth, coordinate transportation & care management

4. Follow through

Track goal completion, troubleshoot stalls, support paperwork and next steps

5. Sustain

Peer connection, check-ins, social supports, and re-engagement if needs change

The navigator stays involved after the referral. That single design choice is what converts a list of resources into continuity of care.

Three enablers that make the model practical in rural regions

Assisted telehealth

The navigator can equip veterans with devices, software access, and hands-on support so scarce specialists reach frontier communities more effectively.

Transportation coordination

Ride support and local coordination prevent distance and logistics from breaking the care pathway.

Peer mentor network

Volunteer peer mentors extend community connection, emotional support, and practical encouragement between formal touchpoints.

These enablers extend specialty care, reduce no-shows, and keep support visible between appointments.

Partnership ecosystem

Cross-system collaboration is a design requirement, not a side activity

Core stakeholder groups include

- Federal and state VA (benefits)
- VA health care & care in the community
- Area hospitals and Public Health Agencies
- Veteran organizations (AL, VFW, DAV)
- Peer mentors & other volunteers
- Faith-based, nonprofit, tribal, justice, and civic organizations
- Action for Eastern Montana (social service)
- Eastern Montana Community Mental Health Center
- Veterans Inc and VOA (homeless services)
- Montana Job Service
- Area Agencies on Aging
- Courts and law enforcement

Partnership rules that make the model work

- Define roles clearly: who assesses, who navigates, who treats, who follows up.
- Use a shared resource map and a current referral directory.
- Create predictable communication loops with partners.
- Treat local trust as an asset to be protected.

The navigator reduces friction for everyone.

How to measure whether the model is working

Reach
- # veterans/families served
- # outreach events
- # partner referrals received & made
- # of peer mentors & matches

Access
- VHA enrollment initiated/completed
- Appointments facilitated
- Telehealth sessions supported
- # connected to VBA
- # of facilitated BH TXs

Continuity
- Referrals completed
- Follow-up contacts
- Transportation rides coordinated
- Care coordination
- Case management

System value
- Satisfaction/feedback
- # active provider partners
- Cost savings / duplication reduced
  - Sustained housing
  - Maintained employment
  - Increased SMVF income
  - Reduced ED visits
  - Reduced recidivism

Start with simple counts.
Then move toward outcomes and system value as the program matures.

Miles City pilot and 18-month implementation roadmap

The scope identifies Miles City as the initial hub for southeastern Montana

Pilot conditions	Phase 1 Launch	Phase 2 Build network	Phase 3 Operate + refine	Phase 4 Evaluate + scale
• Initial annual budget estimate: $250,000 • Two navigators & a Program Support Specialist • Technology, travel, training, operations, vehicles, and equipment included	02/09/2025 Hire staff Equip tech Map resources	Community outreach ID Partners & Referral processes Peer mentor program setup	Telehealth support Benefits follow-up Transportation coordination Care coordination Case management	Quarterly reviews Annual impact Replication planning

The first pilot is intentionally narrow: prove the workflow, the partnerships, and the measurement approach before adding more rural sites.

Early lessons and scaling considerations

- Go where trust already exists, local events, partners, and community spaces matter.
  - Balance with data (SP, CRI, etc.)
- Train for boundaries and escalation pathways as carefully as for empathy.
- Treat telehealth and transportation as operational infrastructure, not optional extras.
- Keep the measurement set small and useful at the beginning.
- Build for replication: the model must work in frontier, tribal, and mixed-service environments.

Can the model preserve its core functions if the next community differs in geography, tribal context, partner density, or broadband access?

- Standardize the role and training.
- Localize the partner map and workflow.
- Keep the navigator accountable for follow-through.
- Utilize partners in other MT cities for office pace
- Use a fix of foundation, local, state, and federal funding
  - Evaluate locations for either VNN employees or contractor led operations

Closing message

The Rural Resource Navigator model puts a trusted, trained human bridge in the community—before, between, and after formal systems of care.

That is why the model is useful for suicide prevention: it converts access, trust, coordination, and follow-through into one accountable local function.

- **Use trained personnel to connect fragmented systems.**
- **Measure what improves access and continuity.**
- **Focus on outcomes, not just output**
- **Scale only after the workflow is proven locally.**

- Where do veterans in your region fall through the cracks?
- What measure would convince you the model is working?

Thank you!

Mike McManus
Program Manager, VNN
mike@veteransnavigation.org
(406) 435-9308

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