Published in final edited form as:

Home Health Care Serv Q. 2017 ; 36(2): 63–80. doi:10.1080/01621424.2017.1336960.

VA staff perceptions of the role of the extended care referral process in home and community-based services versus nursing home use posthospital discharge

Edward Alan Miller, PhD, MPA^{a,b}, Orna Intrator, PhD^{b,c,d}, Emily Gadbois, PhD^b, Stefanie Gidmark, MPH^e, and James L. Rudolph, MD, SM^{b,e,f}

^aDepartment of Gerontology and Gerontology Institute, John W. McCormack Graduate School of Policy and Global Studies, University of Massachusetts Boston, Boston, Massachusetts, USA

^bCenter for Gerontology and Healthcare Research, School of Public Health, Brown University, Providence, Rhode Island, USA

^cGeriatrics & Extended Care Data & Analysis Center, Canandaigua VA Medical Center, New York, USA

^dDepartment of Public Health Sciences, School of Medicine and Dentistry, University of Rochester, New York, USA

^eCenter of Innovation in Long-Term Services and Supports, Providence VA Medical Center, Rhode Island, USA

^fThe Warren Alpert Medical School, Brown University, Providence, Rhode Island, USA

Abstract

Little is known about how the extended care referral process—its structure and participants— influences Veterans' use of home and community-based services (HCBS) over nursing home care within the Veterans Health Administration (VHA). This study thus characterizes the extended care referral process within the VHA and its impact on HCBS versus nursing home use at hospital discharge. Data derive from 35 semistructured interviews at 12 Veterans Affairs Medical Centers (VAMCs). Findings indicate that the referral process is characterized by a commitment by care teams to consider HCBS if possible, varied practice depending on the clinician that most heavily influences care team recommendations, and care team emphasis on respecting Veteran/family preferences even when they are contrary to care team recommendations. Potential modifications include adopting systematic assessment practices; improving Veteran, family, and provider education; and promoting informed selection through shared decision making.

Keywords

Hospital discharge planning; noninstitutional care; qualitative; shared decision making; veterans

Introduction

Geriatrics and extended care service needs are strongly related to age; consequently, the number of impaired individuals needing long-term care and post-acute care will rise considerably over the next 40 years as the proportion of the population aged 65 years and over increases from 13% in 2010 to 20.2% in 2050 (Federal Interagency Forum on Aging-Related Statistics, 2012). Especially dramatic will be growth among the 85 years or older cohort—those most in need of postacute and long-term care—from 5.5 to 19 million during this time span. Veterans figure prominently in these numbers. Approximately 50% of the 65 years or older U.S. male population are Veterans; a proportion that rises to 68% among U.S. males 85 years or older (Federal Interagency Forum on Aging-Related Statistics, 2012).

The rise in frailty and disability associated with the aging Veterans population underlies growing demand for home and community-based services (HCBS; Kinoshian, Stallard, & Wieland, 2007; Westat, 2010). This demand is especially strong among Veterans eligible to receive care within the Veterans Health Administration (VHA) of the U.S. Department of Veterans Affairs (VA). In 2015, nearly half (47.3%) of the 8.5 million Veterans enrolled in the VHA were aged 65 years or older (Gasper, Liu, Kim, & May, 2015). The VHA's oldest enrollees used more extended care than other Veterans with 12.6% of enrollees aged 85 years or older reporting use of any nursing services at home compared to 1.3, 2.4, and 4.9% among enrollees under 65, 65–74, and 75–84 years, respectively (Gasper et al., 2015).

Concomitant with population aging, the Veterans Millennium Health Care and Benefits Act of 1999 (Public Law 106–117) sought to heighten the profile of noninstitutional care within the VHA (Ekastrand, 2006). Subsequently, the VHA has made a concerted effort to rebalance the provision of VA-paid extended care away from nursing homes (NHs) toward HCBS (Schoeps & O'Keefe, 2012; VHA, 2016). This priority is consistent with the views of Veterans and their families, who prefer to remain at home and in the community as long as possible (Guihan, Hedrick, Miller, & Reder, 2011; Sheets & Mahoney-Gleason, 2010).

Access to HCBS within the VHA rose considerably in the wake of the Millennium Act. The average daily census for HCBS tripled, from 11,706 to 52,242, between 2002 and 2011 (AMVETS, 2005, 2012); and expenditure on HCBS more than quadrupled, from \$240 million in 2001 to \$1.1 billion in 2011 (Schoeps & O'Keefe, 2012; U.S. General Accounting Office [GAO], 2002). Still, spending on NH care continues to predominate. In 2011, just 19.4% of the VA's \$5.9 billion extended care budget was devoted to HCBS (Schoeps & O'Keefe, 2012).

Discharge planning and case management outside the VHA are well described (Bennett, 2006; Bowers & Jacobson, 2002; Bowles, Foust, & Naylor, 2003; Chapin, Chandran, Sergeant, & Koenig, 2014; Coulton, Dunkle, Chow, Haug, & Vielhaber, 1988; Denson, Winefield, & Beilby, 2012; LeClerc, Wells, Craig, & Wilson, 2002; McAuley & Travis, 1997; Minichiello, Auerbach, & Wachter, 2001; Tennier, 1997; Watts, Pierson, & Gardner, 2006). Few studies, however, have examined extended care referral in the VA (Guihan et al., 2011; Office of the Inspector General [OIG], 2003; Reder, Hedrick, Guihan, & Miller, 2009). Consequently, little is known about how extended care referral at hospital discharge—its

structure and participants—influences Veterans' use of HCBS over NH care within the VHA, the largest integrated health care system within the United States. The purpose of this study is thus to characterize the extended referral process at VA Medical Centers (VAMCs) and its impact on HCBS versus NH use among Veterans posthospitalization.

Extended care referral within the VA

Rebalancing the provision of VA-paid extended care is official VA policy (Schoeps & O'Keefe, 2012; VHA, 2016). In the broader health sector, Medicaid is the primary payer of long-term services and supports and Medicare the primary payer of postacute and end-of-life care for older people and people with permanent disabilities. Noninstitutional services in the standard VA medical benefits package include HCBS covered by Medicaid—home maker/home health aide (H/HHA) care, adult day health care, and respite care; and Medicare—skilled home health care, hospice care, and palliative care (Department of VA, n/d; VHA, 2016). They also include home-based primary care, a unique service that provides long-term, comprehensive, in-home primary care using an interdisciplinary provider team (VHA, 2007). Services such as home-based primary care are provided by the VHA itself; other services such as H/HHA care and home respite are provided by community-based providers on contract with and paid by the VA; still others such as hospice/palliative care and adult day health care may be provided by both the VA and community providers. Community organizations must be state licensed or Medicare-Medicaid certified to receive VHA referrals.

To receive care paid for by the VA, Veterans must be enrolled within the VHA. The VA commitment to Veteran care depends on each Veteran's service-connected disability stemming from injuries or illnesses received while serving in the military (VHA, 2015). Service-connected status determines the level of financial contributions a Veteran needs to make toward their care. Home care programs are generally open to all Veterans, regardless of service-connected status. When resources are constrained, however, VAMCs may prioritize access, in part, to those with a service-connected disability of 50% or higher (VHA, 2006). Clinical eligibility requirements vary across programs. To receive skilled home care, for example, Veterans must display a need for skilled assessment, teaching, treatment, or monitoring, or intermittent, short-term, or transitional services (VHA, 2016). To receive H/HHA, adult day health, or respite care, a Veteran must be determined to need NH care in the absence of HCBS, have three or more activity of daily living (ADL) impairments, significant cognitive impairment, or impairment in two ADLs plus meet other criteria—e.g., 3+ instrumental ADLs (IADLs), age 75+, living alone. Veterans must be high utilizers and have diagnoses such as heart failure, diabetes, and cancer to receive home-based primary care. They must have a projected life expectancy of less than 6 months to receive hospice. VA staff generally have the discretion to provide services to Veterans who do not meet criteria should they determine that services are needed nevertheless.

Financially and clinically eligible Veterans may also receive VA-paid NH care. Unlike noninstitutional care, the VA establishes a hierarchy of priority status for NH care, with VAMCs covering the full costs for Veterans with a service-connected disability rating of 70% or greater, whose need for NH care stems from a service-related disability, or whose

service-connected disability rating is at least 60% and is determined unemployable or permanently and totally disabled (Wadsworth, 2017). VAMCs may provide NH care to other Veterans who may be subject to copays based on their level of service-connected disability and income and asset levels. VA NH care is provided by VA owned and operated community living centers (CLCs). It is also provided by community NHs on contract with the VA in addition to State Veterans Homes paid for and overseen, in part, by the VA but administered by the states. The VA pays for inpatient respite and hospice care in both CLCs and community NHs. Other potential placement options include medical foster homes and community residential care.

Noninstitutional extended care has become more prominent within the VHA's Geriatrics & Extended Care (GEC) portfolio. Between 2007 and 2015, the mix of Veterans using GEC services changed, with the proportion receiving institutional care declining from 31.4 to 25.0% and the proportion receiving noninstitutional care increasing from 79.1 to 85.5% (GEC Data Analysis Center, 2016). Particularly large increases in HCBS use were for H/HHA services (232%) and home-based primary care (129%). Use of contract community NHs (88.0%) and State Veterans Homes (21.8%) also increased, while use of CLCs decreased slightly (-6.4%). In all, 408,256 Veterans received any GEC services in 2015 with 99,899 (24.5%), 84,695 (20.7%), 15,605 (3.8%), and 10,134 (2.5%) using purchased H/HHA, skilled home care, home respite, and adult day services, respectively; and 53,385 (13.1%), 7,683 (1.9%), and 3,174 (0.8%) using VA-provided home-based primary care, hospice/palliative care, and adult day services (GEC Data Analysis Center, 2016).

VA policy requires that referrals to particular geriatrics and extended care programs and services be initiated by interdisciplinary care teams through which, at a minimum, physicians, nurses, and social workers are expected to work together to assess Veterans' dependencies, disabilities, and needs for services (IOG, 2003; VHA, 2016). Beginning in 2004, VA Central Office required care team members to make placement decisions, in part, using data obtained from the Geriatrics and Extended Care Form (VHA, 2004). The GEC Form collects information on Veterans' needs and circumstances, including ADLs, IADLs, cognitive status, living situation, unpaid caregivers, goals of care, and expected duration of care. Mandated use of the GEC Form was permitted to expire in 2009, however, because

many VAMCs did not fully integrate the GEC Referral tool into their processes, for a variety of reasons, including difficulties encountered in completing the form electronically and the belief that the time needed to complete the form outweighed any perceived benefits. (Schoenhard, 2009, p. 1)

VA Central Office expects Veterans and their caregivers to be well-informed of their options, and be active members of the care planning team (VHA, 2016). Consequently, shared decision making is emphasized, which the VA defines as "a collaborative, patient-directed decision making process that helps Veterans, together with their family caregivers and health care team, set goals and priorities, and make choices that meet patient needs while honoring patient values and preferences" (Department of VA, n/d, p.1). To promote patient and family participation in the extended care referral process the VA posted worksheets on the VA Central Office GEC website to help Veterans think about their extended care needs and preferences and to help caregivers assess their caregiving roles and responsibilities

(Department of VA, 2016). The VA also recognizes that surrogate decision making may be necessary when Veterans lack decision-making capacity (VHA, 2016).

Potential impediments to HCBS use that arise during the extended care referral process may preclude or slow progress toward achieving shared decision making. Two prior investigations examined extended care referral within the VHA. The VA OIG (2003) reported a lack of compliance with VHA policy that, at a minimum, a physician, nurse, and social worker complete an interdisciplinary assessment of patient needs for H/HHA services. In particular, OIG analysis of 142 medical records of H/HHA program participants found no evidence of interdisciplinary assessment in 42 (30%) of the records reviewed. It also found a lack of social worker, nurse, and physician participation, respectively, in 19 (19%), 29 (29%), and 36 (36%) of the 100 records where interdisciplinary assessment did take place. Physicians largely served as cosigners to referrals. Most in-depth documentation was undertaken by nurses or social workers. Guihan and colleagues drew on interviews with patients and informal caregivers and focus groups with VA staff to examine extended care referral at five Pacific Northwest VAMCs (Guihan et al., 2011; Reder et al., 2009). The interview findings revealed a reluctance to plan for long-term care despite a strong preference to stay at home, a lack of information and knowledge about HCBS options, funding, and eligibility, and the absence of someone who could aid in patient/caregiver decision making (Guihan et al., 2011). The interview and focus groups findings identified patient and caregiver reliance on physicians for information and guidance as a barrier to HCBS referral given physicians' lack of knowledge about HCBS and bias toward institutional placement (Reder et al., 2009). They also indicated a dearth of provider training on available service options to support patient and caregiver preferences for community placement.

The present study draws on semistructured interviews with VA staff at 12 VAMCs from around the country to understand the role that the extended care referral process plays in influencing the use of HCBS versus NH care among Veterans at hospital discharge. Thus, it contributes to the literature, in part, by specifically focusing on extended care referral within the inpatient setting, serving as only the second study to elucidate the views of health care personnel with the broadest experience in how decisions around extended care referral are made, and drawing more recent insight in this area through interviews with VA staff from a broader cross section of VAMCs nationally.

Methods

Twelve VAMCs were chosen for this study to ensure variation in geographic region (Northeast, South, Midwest, West), catchment area (rural, urban), and available NH options (VA, state, and community NHs). Data derived from semistructured interviews undertaken with subjects chosen through a combination of purposive and snowball sampling (Patton, 2002). This means that interview subjects were initially identified using our own knowledge about the VHA but subsequently on information provided by our interviewees regarding specific individuals who should be interviewed about extended care referral and contracting. Interviews were conducted until saturation, or the point at which no new information was

obtained and enough data had been collected to develop the categories required to describe the processes studied (Glaser & Strauss, 1967).

VAMC employees with different backgrounds and roles were recruited as interview subjects to ensure representation of different viewpoints about the extended care referral process and the process of arranging and monitoring contracts with non-VHA providers of services within the community (Glaser & Strauss, 1967). A diverse sample increases confidence in the accuracy of the processes being portrayed to the extent that the perceptions of those interviewed about that phenomenon converge (Jick, 1979). A diverse sample also increases the scope of the information analyzed while reducing the threat of single-source information bias (Pothas & De Wet, 2000).

In all, 35 in-depth interviews were conducted with 36 individuals between May 19, 2012 and December 6, 2012. One interview included two subjects. Those most knowledgeable about each VAMC's extended care referral and contracting processes were interviewed—including 20 social workers, 12 nurses, and four geriatric physician leaders. Approximately two-thirds of interviewees were supervisory and leadership personnel; the remaining one-third or so frontline staff. The VAMC setting meant that interviews primarily assumed an inpatient hospital rather than outpatient or community-based clinic perspective.

Two interviews took place in person, the rest over the telephone. Three interviews were conducted at all but one site, where two were conducted. Interviews lasted from about 60 to 90 minutes each. The first, third, and fourth authors—E. Miller, E. Gadbois, and S. Gidmark—conducted all interviews with at least two of the three present at each interview.

The interview protocol was drafted with input from both VHA practitioners and researchers and personnel from the VHA Office of Geriatrics and Extended Care. It was then fielded at one VAMC before being modified for use at other sites. Through the protocol, we sought to understand the basic structure of extended care referral within the VHA and its influence on HCBS and NH utilization. Interviewees were asked to identify and provide all pertinent documents to inform our understanding of extended care referral. These documents typically consisted of the GEC Form and the list of NHs on contract to provide care to Veterans in the community.

Conversations were recorded (with each interviewee's permission) and transcribed. The three interviewers coded the transcripts to identify recurring themes and patterns in responses (Miles & Huberman, 1994). An open-ended coding process was employed whereby the three coders independently generated potential coding categories through an initial review of 12 transcripts—one from each site (Glaser & Strauss, 1967). Once a full, final set of codes was agreed upon, all transcripts were coded/recoded by two authors (E. Gadbois, S. Gidmark) using the common set of codes developed. Codes were then used to identify, collect, and organize segments of text from across the transcripts into reports addressing specific topic areas. One investigator (E. Miller) reviewed the coded segments within each report, grouped them into themes/subthemes, and identified illustrative quotations (Table 1). Themes/subthemes were reviewed and finalized by the entire investigative team. Institutional Review Board approval was obtained.

Results

Growing use of HCBS prior to NH entry (theme 1)

Veterans often received and progressed through a complex array of HCBS prior to NH entry (1.A)—Increasing availability of HCBS options within the VA and elsewhere has led to growing numbers of Veterans entering NHs after receiving formal services within the community. Greater use of HCBS has helped keep Veterans at home longer, contributing to a higher acuity, more debilitated mix of residents in NHs paid for by the VA. Frequently, Veterans' hospitalizations were followed by some sequence of HCBS and, if they could afford it, assisted living services, before NH admission took place.

The divergence of institutional and noninstitutional care referrals in the VA (theme 2)

Care teams referred Veterans to institutional or noninstitutional services (2.A)—Interdisciplinary care teams typically decided whether to refer Veterans to HCBS or NH services; it was at this point in the extended care referral process that all care options were considered. Veterans deemed by the care team to be in need of NH care were referred to a NH consult, at which point NH program staff considered the appropriateness of the referral. Veterans deemed able to stay at home, say, with minimal to moderate supports, may have been referred to H/HHA services, skilled home care, or home-based primary care at which point staff from each program considered the appropriateness of the referral.

Further consideration of care options may have occurred after care team recommended a consult (2.b)—Formal divergence of NH and HCBS consults did not preclude further consideration of alternative placement options once additional screening had taken place. Thus, a few interviewees indicated that the CLC or contract NH program may refer Veterans to an HCBS consult after deciding that they might be better placed at home with services. Or, Veterans may be rejected by VA home care programs leading to NH placement, despite care team recommendations otherwise.

Key considerations in care team decision making (theme 3)

Care teams often sought placement in home and community-based settings contingent, in part, on clinicians' disciplinary perspectives (3.a)—The priority at many VAMCs was to place Veterans in home and community-based settings if possible rather than in a NH. Any member of a care team—physician, therapist, nurse, social worker—could initiate referral to a NH or HCBS program. Varying assessments about the need to place a Veteran in a NH versus HCBS setting sometimes occurred due to the unique perspectives of care team members. Social workers were more likely than doctors or nurses to engage in conversations with Veterans, their families, and other care team members around the receipt of services in home and community-based rather than NH settings.

Time pressures at hospital discharge reduced likelihood of community placement (3.b)—Centralization of the care team within the hospital made it easier to assess Veterans' care needs on an inpatient than outpatient basis, making intervening hospital stays likely before extended care referral occurred. However, clinicians faced pressure to discharge patients from the VA's inpatient hospital service. NH placement

sometimes proved a faster way of freeing up an inpatient hospital bed or providing a Veteran with the postacute or long-term care services they needed, because it would take care planners and families longer to organize the requisite services and supports in the community.

Care teams drew on several sources of information to determine clinical appropriateness (3.c)—Factors informing referral decisions included ADL and IADL deficits, cognitive impairment, therapy and treatment needs, prior hospitalizations, and medication management. Most interviewees did not report the use of systematic assessment tools to inform referral decisions. A few mentioned assessing Veterans' care needs using the GEC Referral Form. Whereas some found the form useful, others believed it took too long to complete and duplicated other work. More often Veterans' care needs were assessed using other information drawn from a variety of sources (e.g., the medical record) with resulting referral decisions based on professional judgment from the information gathered.

Primacy given to Veteran preferences even when choices contradicted care team recommendations (3.d)—Veteran preference and choice were stressed throughout the interviews. Indeed, interviewees reported that it was not unusual for Veterans to refuse NH placement even when the home environment was deemed insufficient. Under such circumstances, VA staff often felt that they had no option but to send Veterans home, given emphasis placed on Veteran self-determination and freedom of choice. VA staff would inform Veterans and their families about their options, advise them that they were going home contrary to medical advice, and then arrange appropriate consults for services that would be required for a successful discharge to home. When a Veteran was cognitively unable to make decisions the Veteran's family, if available, or VA staff could make the decision to enter a NH for the Veteran.

There were frequent rehospitalizations for Veterans who returned home despite care team recommendations (3.e)—Interviewees reported that Veterans discharged back to the community against staff recommendation often bounce back and forth between home and the hospital before ultimately being placed in a NH. Thus, it was not unusual for Veterans to end up in a NH after multiple hospitalizations had occurred.

Discussion

This study examined extended care referral within the VA. Findings indicate that VA staff sometimes eschews HCBS in favor of NH care for hospitalized Veterans in need of postacute, rehabilitative, or long-term care due to the need to free up scarce inpatient hospital beds. Prior research suggests that imperatives to discharge patients rapidly results in limited time with which to assess and weigh patients' discharge care needs and to educate, consider, arrange, and coordinate services within the community (Bennett, 2006; Bowles et al., 2003; Chapin et al., 2014; Michichiello et al., 2014; Payne, Kerr, Hawker, Hardy, & Powell, 2002). This lack of time is one reason why older hospital patients frequently have unmet needs for home care upon discharge (Bowles, Naylor, & Foust, 2002). It is also one reason why hospital discharges frequently end up in NHs, even though HCBS might have

been more preferred or appropriate (Hahn, Thomas, Hyer, Andel, & Meng, 2011; Mor et al., 2007).

The existing literature indicates that hospital staff awareness of available service options (Bowles et al., 2003; Chapin et al., 2014; OIG, 2003; Payne et al., 2002; Watts et al., 2006) and effective communication between hospital staff and community-service providers are necessary prerequisites for facilitating community placement (Bowers & Jacobson, 2002; Chapin et al., 2014; Payne et al., 2002; O’Conner, Long, Quach, Burgess, & Shea-Delaney, 2006). It also indicates that when care team members are not familiar or well-connected with available HCBS options, they rely disproportionately on NHs for clients in need of expeditious discharge from hospital to postacute or long-term care (Coulton et al., 1988; Jett, Coward, Schoenberg, Duncan, & Dwyer, 1996). Ideally, the discharge planning process should begin within 24 hours of hospital admission to maximize the amount of time for hospital staff to identify potential postdischarge options and to provide the education and guidance necessary for patients and their families to thoroughly consider and investigate the options available (Centers for Medicare and Medicaid Services, 2015; Nazir, Little, & Arling, 2014). Veteran, family member, and care team member access to needed services would be facilitated through establishment of one-stop sources of information and counseling on the full range of VHA provided and contracted services within each VAMC’s catchment area. These resources would be akin to the Aging and Disability Resource Centers that serve communities and states around the country (O’Shaughnessy, 2011), but with the added advantage of an integrated funding stream and Veteran-specific focus.

Interviewees highlighted the importance of Veterans’ preferences and choice. This finding is consistent with VA expectations that Veterans and family caregivers serve as active participants in the care planning process (Department of VA, n/d; VHA, 2016). Determining clients’ preferences is important given documented differences in values, priorities, and influence of elders, their family members, and health care professionals in the extended care placement decision (Denson et al., 2012; McAuley & Travis, 1997; McCullough, Wilson, Teasdale, Kolpakchi, & Skelly, 1993). It is also important given the need for hospital staff to balance concerns about patient safety with respect to client autonomy and self-determination (Chapin et al., 2014; Denson et al., 2012; Tennier, 1997). Patient and family consultation should result in increased use of preferred home and community-based supports even when, as documented in this study, the resources available at home may be insufficient and long-term success in the community unlikely.

Knowing how best to support patients requires that care team members devote the time necessary to develop intimate personalized knowledge of their needs and circumstances. Patient empowerment, person-centered assessment, shared decision making, and provider guidance/advocacy are among the mechanisms suggested to better account for patient and family preferences (Chapin et al., 2014; Dengenholtz, Kane, & Kivnick, 1997; Forbes & Hoffar, 1998; Jett et al., 1996; LeClerc et al., 2002; Tennier, 1997). Recently, the Centers for Medicare & Medicaid Services (2015) issued proposed rules under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (Public Law 113–185) revising Medicare and Medicaid discharge planning requirements to promote this objective. Provisions include requiring hospitals to begin discharge planning within 24 hours of

admission or registration and to develop discharge plans that give more weight to patient goals and preferences and prepare patients and caregivers to be active partners in postdischarge care.

The VHA already emphasizes client participation in the referral process, in part, by posting shared decision making and caregiver assessment worksheets that Veterans and their families can use to document their extended care needs, preferences, and roles (Department of VA, n/d). VistA, the VHA's electronic health record system, stores Veterans' health-related information in a single, common database accessible by all clinical and allied staff. Veterans and their family members should be encouraged to complete the shared decision making and caregiving assessment worksheets as soon as possible in the trajectory toward needing extended care services and supports. Making this information available electronically on VistA would, in turn, facilitate care team awareness of and ability to incorporate patient and family perspectives when planning and arranging services after hospital discharge.

Findings from this study suggest that VAMCs generally follow VA policy requiring referrals to particular programs and services to be initiated by Veterans' interdisciplinary care teams (VHA, 2006). It is likely that the collaboration and teamwork inherent in the use of interdisciplinary teams has important implications for achieving the VA's rebalancing goals. Prior research suggests that poor communication among hospital staff can impact the timely and accurate receipt of the information needed to facilitate home care referral (Chapin et al., 2014; Minichiello et al., 2001; Tennier, 1997; Watts et al., 2006). It also suggests, consistent with our own findings, preferred service modalities can vary across health professionals of varying types with, for example, physicians being less knowledgeable about HCBS and more likely to favor institutional care options than other health care providers—e.g., nurses, social workers (Reder et al. 2009). Together, the adverse implications of poor communication and provider bias for or against HCBS referral suggest that the interdisciplinary team approach used by the VA serves, in part, to facilitate Veteran use of HCBS (Bowles et al., 2003; Chapin et al., 2014; Minichiello et al., 2001; Tennier, 1997). Use of interdisciplinary care teams that possess the varying skills and perspectives required to meet clients' diverse needs is a hallmark of smaller scale initiatives such as the Program for All-Inclusive Care of the Elderly and the Wisconsin Partnership Program which, like the VHA, seek to coordinate acute and extended care services across settings of care (Miller & Weissert, 2003).

Previously, VA policy required program referral decisions to be informed, in part, by information documented in the GEC Referral Form (VHA, 2004). However, this mandate was permitted to expire due to intense objections in the field (Schoenhard, 2009). Thus, few interviewees mentioned the GEC Form or other systematic assessment of Veterans' care needs and circumstances. Rather, findings suggest that care recommendations were typically grounded in providers' general impressions based largely on information contained within the medical record. The lack of systematic assessment at VAMCs was consistent with practices in the broader health sector where discharge staff and other care planners often do not use consistent methods for collecting and synthesizing patient information (Bowles et al., 2003; Chapin et al., 2014; LeClerc et al., 2002; Watts et al., 2006).

A more deliberate, thoughtful, and holistic process is needed if the focus is to move beyond providers' general impressions to systematic assessment of patients' physical and medical needs and social, emotional, and other concerns—e.g., available caregiver, living arrangements, goals of care (Kane & Kane, 2000). Consequently, resources should be devoted to promoting and streamlining a modern assessment instrument that is informed by electronic health records and collects additional pertinent information that feeds into a continuously learning decision support system. By 2019, the Impact Act requires systematic collection of standardized patient assessment data across home health agencies, skilled nursing facilities, and other postacute care settings (American Health Care Association, n/d). Extension of these requirements to acute care hospitals would promote systematic patient assessment earlier on in the trajectory of care and facilitate care transitions through communication of standardized patient information between hospitals and other settings. Relative to prevailing fragmentation in the broader health care system, use of a single electronic health record accessible to all clinical and allied staff should give the VHA an advantage in developing, implementing, and promoting use of a systematic assessment instrument that both informs care referrals and facilitates transitions across settings.

Limitations

There are several limitations worth noting. First, we examined extended care referral at 12 VAMCs, a subset of the broader population of 148 VAMCs. On the one hand, we believe our findings are transferable given the range of VAMCs studied and the common policy environment within which they operate—i.e., Central Office regulations governing extended care benefits, planning, and referral. On the other hand, there is variability in local and regional market conditions and cultural norms across VAMCs that impacts the availability of programs, interpretation of policy, and application to practice, available disciplines, and reporting structure that may limit the generalization of the findings. Thus, although we attempted to reach out to a broad array of VAMCs, it is possible that other practices and perspectives exist which are important to understand and document. Second, potentially knowledgeable individuals may have been excluded in the absence of a known sampling frame. Consequently, our impressions may hinge, in part, on the specific persons interviewed, though we are confident that we spoke with most key personnel. We note that we primarily interviewed supervisory and leadership personnel, though front-line staff were represented and those in supervisory and leadership positions frequently reported working directly with patients and their families. We also note that this study was conducted from a hospital discharge planning perspective and not from the perspective of community-based clinics, which might have different methods and cultures of referrals. Relatedly, we were not able to capture information about the interactions of hospital personnel with Veterans' Patient Aligned Care Teams (PACTs) in the referral process. A PACT consists of "a team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s)) and manages and coordinates comprehensive health care services consistent with agreed upon goals of care" (VHA, 2017, p. 4). It is how the VA has implemented the primary care medical home model. Further research on the role of PACTs in referrals to extended care is warranted. Last, we focused exclusively on factors affecting extended care referral within the VA with unknown ramifications for the broader health sector.

Conclusion

This study examined the implications of extended care referral for Veterans' use of HCBS versus NH care at hospital discharge across 12 VAMCs. Findings confirm more general reports that growing numbers of Veterans access HCBS through the VHA (Schoeps & O'Keefe, 2012). They also confirm that Veterans and their family caregivers often have strong preferences for returning home with HCBS. Given the primacy assigned by VAMCs to Veteran choice, and limitations in the amount of VA HCBS, non-VA HCBS, and family resources available, Veterans often go back to the community with insufficient support to meet their needs. As a consequence, Veterans frequently undergo multiple transitions between hospital and home before NH admission occurs. Further consideration should therefore be devoted to identifying and addressing factors precluding successful community placement. Potential modifications include investing additional resources into HCBS so that more Veterans can be served and programs are available to meet more demanding needs. They also include modifying the extended care referral process, including developing strategies to spur widespread adoption of systematic assessment practices and to better educate Veterans, families, and providers about available options. Implementation of integrated referral practices should be considered as well, whereby staff from various programs come together to inform placement decisions rather than relying on individual practitioners to redirect referrals once specific service consults are made.

Acknowledgments

The authors would like to acknowledge insightful comments from Marianne Shaughnessy from the Office of Geriatrics & Extended Care on an earlier version of this manuscript. The authors would also like to acknowledge Kimberly Kelly, also from the Office of Geriatrics & Extended Care, who reviewed the manuscript. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

Funding

This study is based upon work supported in part by the Department of Veterans Affairs, including a Health Services Research & Development Grant IAD-07-106 to Dr. Intrator. Dr. Rudolph and Dr. Intrator are supported by the VA Health Services Research and Development Center of Innovation in Long-Term Services and Supports (CIN 13-419) and the VA QUERI-Geriatrics and Extended Care Partnered Evaluation Center for Community Nursing Homes (PEC 15-465).

References

- American Health Care Association. (n/d) Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. Washington, DC: Author Retrieved from https://www.ahcancal.org/advocacy/issue_briefs/Issue%20Briefs/IMPACT-IB.pdf
- AMVETS. (2005, 2012). *The Independent Budget: A comprehensive budget & policy document created by Veterans for Veterans, fiscal years 2006 and 2013*. Washington, DC: Author Retrieved from <http://www.independentbudget.org>
- Bennett PH (2006, 8). Clarification of roles and responsibilities of existing aging network providers participating in the nursing home transition process. Chicago, IL: University of Illinois at Chicago Retrieved from <http://www.illinois.gov/aging/communityservices/documents/responsibilities.pdf>
- Bowers BJ, & Jacobson N (2002). Best practice in long-term care case management: How excellent case managers do their jobs. *Journal of Social Work in Long-Term Care*, 1(3), 55–72. doi:10.1300/J181v01n03_08

- Bowles KH, Foust JB, & Naylor MD (2003). Hospital discharge referral decision making: A multidisciplinary perspective. *Applied Nursing Research*, 16(3), 134–143. doi:10.1016/S0897-1897(03)00048-X [PubMed: 12931327]
- Bowles KH, Naylor MD, & Foust JB (2002). Patient characteristics at hospital discharge and a comparison of home care referral decisions. *Journal of the American Geriatrics Society*, 50(2), 336–342. doi:10.1046/j.1532-5415.2002.50067.x [PubMed: 12028217]
- Centers for Medicare & Medicaid Services. (2015, 10 29). Discharge planning proposed rule focuses on patient preferences. Baltimore, MD: Author Retrieved from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-10-29.html>
- Chapin RK, Chandran D, Sergeant JF, & Koenig TL (2014). Hospital to community transition for adults: Discharge planners and community service providers' perspectives. *Social Work in Health Care*, 53(4), 311–329. doi:10.1080/00981389.2014.884037 [PubMed: 24717181]
- Coulton CJ, Dunkle RE, Chow J-C-C, Haug M, & Vielhaber DP (1988). Dimensions of post-hospital care decision making: A factor analytic study. *The Gerontologist*, 28(2), 218–223. doi:10.1093/geront/28.2.218 [PubMed: 2834271]
- Degenholtz HB, Kane RA, & Kivnick HQ (1997). Care-related preferences and values of elderly community-based LTC consumers: Can case managers learn what's important to clients? *The Gerontologist*, 37(6), 767–776. doi:10.1093/geront/37.6.767 [PubMed: 9432993]
- Denson LA, Winefield HR, & Beilby JJ (2012). Discharge-planning for long-term care needs: The values and priorities of older people, their younger relatives and health professionals. *Scandinavian Journal of Caring Sciences*, 27(1), 3–12. doi:10.1111/j.1471-6712.2012.00987.x [PubMed: 22497666]
- Department of Veterans Affairs (VA). (n/d) Guide to long term services and supports. Washington, DC: Author Retrieved from <http://www.va.gov/GERIATRICS/Guide/LongTermCare/>
- Ekastrand LE (2006, 1 9). VA long-term care: Trends and planning challenges in providing nursing home care to Veterans: Testimony before the Committee on Veterans' Affairs, U.S. Senate. Washington, DC: U.S. Government Accountability Office Retrieved from <http://www.gao.gov/assets/120/112701.pdf>
- Federal Interagency Forum on Aging-Related Statistics. (2012, 6). Older Americans 2012: Key indicators of well being. Washington, DC: U.S. Government Printing Office.
- Forbes S, & Hoffer N (1998). Elders' decision making regarding the use of long-term care services: A precarious balance. *Qualitative Health Research*, 8(6), 736–750. doi: 10.1177/104973239800800602 [PubMed: 10558344]
- Gasper J, Liu H, Kim S, & May L (2015, 12 11). 2015 survey of Veteran enrollees' health and reliance upon VA. Rockville, MD: Weststat Retrieved from http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf
- Geriatric and Extended Care Data Analysis Center. (2016). [Institutional and non-institutional services use]. Unpublished data.
- Glaser BG, & Strauss AL (1967). *The discovery of grounded theory*. New York, NY: Aldine De Gruyter.
- Guihan M, Hedrick S, Miller S, & Reder S (2011). Improving the long-term care referral process: Insights from patients and caregivers. *Gerontology & Geriatrics Education*, 32(2), 135–151. doi: 10.1080/02701960.2011.572041 [PubMed: 21598147]
- Hahn EA, Thomas KS, Hyer K, Andel R, & Meng H (2011). Predictors of low-care prevalence in florida nursing homes: The role of medicaid waiver programs. *The Gerontologist*, 51(4), 495–503. doi:10.1093/geront/gnr020 [PubMed: 21642238]
- Jett KMF, Coward RT, Schoenberg NE, Duncan RP, & Dwyer JW (1996). The influence of community context on the decision to enter a nursing home. *Journal of Aging Studies*, 10(3), 237–254. doi: 10.1016/S0890-4065(96)90023-7
- Jick TD (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Sciences Quarterly*, 24(4), 602–611. doi:10.2307/2392366
- Kane RL, & Kane RA (2000). Assessment in long-term care. *Annual Review of Public Health*, 3, 659–686. doi:10.1146/annurev.publhealth.21.1.659

- Kinosian B, Stallard E, & Wieland D (2007). Projected use of long-term-care services by enrolled Veterans. *The Gerontologist*, 47(3), 356–364. doi:10.1093/geront/47.3.356 [PubMed: 17565100]
- LeClerc CM, Wells DL, Craig D, & Wilson JL (2002). Falling short of the mark. *Clinical Nursing Research*, 11(3), 242–263. doi:10.1177/10573802011003002 [PubMed: 12180639]
- McAuley WJ, & Travis SS (1997). Positions of influence in the nursing home admission decision. *Research on Aging*, 19(1), 26–45. doi:10.1177/0164027597191002
- McCullough LB, Wilson NL, Teasdale TA, Kolpakchi AL, & Skelly JR (1993). Mapping personal, familial, and professional values in long-term care decisions. *The Gerontologist*, 33(3), 324–332. doi:10.1093/geront/33.3.324 [PubMed: 8325519]
- Miles MB, & Huberman AB (1994). *Qualitative data analysis: An extended sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Miller EA, & Weissert WG (2003). Strategies for integrating Medicare and Medicaid: Design features and incentives. *Medical Care Research & Review*, 60(2), 123–157. doi: 10.1177/1077558703060002001 [PubMed: 12800681]
- Minichiello TM, Auerbach AD, & Wachter RM (2001). Caregiver perceptions of the reasons for delayed hospital discharge. *Effective Clinical Practice*, 4(6), 250–255. [PubMed: 11769297]
- Mor V, Zinn J, Gozlo P, Feng Z, Intrator O, & Grabowski DC (2007). Prospects for transferring nursing home residents to the community. *Health Affairs*, 26(6), 1762–1771. doi:10.1377/hlthaff.26.6.1762 [PubMed: 17978396]
- Nazir A, Little MO, & Arling GW (2014). More than just location: Helping patients and families select an appropriate skilled nursing facility. *Annals of Long-Term Care*, 22(11), 30–34.
- O’Conner D, Long L, Quach E, & Burgess L, & Shea-Delaney E (2006, 2 15). Diversion and transition services in the U.S.: Promising practices and options for the future. Boston: University of Massachusetts Medical School, Center for Health Policy and Research Retrieved from http://www.nasuaad.org/sites/nasuaad/files/hcbs/files/84/4184/DiversionInventory_NationalReport.pdf
- Office of the Inspector General (OIG). (2003, 12 18). Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program (Report No. 02–00124–(48). Washington, DC: Department of Veterans Affairs, Office of Inspector General Retrieved from <http://www.va.gov/oig/54/reports/VAOIG-02-00124-48.pdf>
- O’Shaughnessy CV (2011). Aging and disability resource centers can help consumers navigate the maze of long-term services and supports. *Generations*, 35(1), 64–68.
- Patton MQ (2002). *Qualitative research & evaluation methods*. Thousand Oaks, CA: Sage.
- Payne S, Kerr C, Hawker S, Hardey M, & Powell J (2002). The communication of information about older people between health and social care practitioners. *Age and Ageing*, 31(2), 107–117. doi: 10.1093/ageing/31.2.107 [PubMed: 12033184]
- Pothas A-M, & De Wet AG (2000). Two imperatives for qualitative research. *Systematic Practice and Action Research*, 13(2), 139–164. doi:10.1023/A:1009590503606
- Reder S, Hedrick S, Guihan M, & Miller S (2009). Barriers to home and community-based service referrals: The physician’s role. *Gerontology & Geriatrics Education*, 30(1), 21–33. doi: 10.1080/02701960802690241 [PubMed: 19214844]
- Schoenhard W (2009, 12 31). Memorandum of understanding [regarding VHA Directive 2004–059: Geriatrics and Extended Care (GEC) referral] Washington, DC: Department of Veterans Affairs, Veterans Health Administration.
- Schoeps DJ, & O’Keefe P (2012, 3 6). VA long-term care services. Washington, DC: Department of Veterans Affairs Retrieved from <http://docplayer.net/18981573-Va-longterm-care-services-6-march-2012.html>
- Sheets CJ, & Mahoney-Gleason H (2010). Caregiver support in the Veterans Health Administration: Caring for those who care. *Generations*, 34(2), 92–98.
- Tennier LD (1997). Discharge planning: An examination of perceptions and recommendations for improved discharge planning. *Social Work in Health Care*, 26(1), 41–60. doi:10.1300/J010v26n01_03 [PubMed: 9406338]
- U.S. General Accounting Office (GAO). (2002, 3 29). VA long-term care: Implementation of certain Millennium Act provisions is incomplete, and availability of noninstitutional services is uneven

(GAO-02-510R). Washington, DC: Author Retrieved from <http://www.gao.gov/assets/100/91181.pdf>

Veterans Health Administration (VHA). (2004, 10 21). VHA directive 2004-059: Geriatrics and Extended Care (GEC) referral. Washington, DC: Author.

Veterans Health Administration (VHA). (2006, 7 21). VHA handbook 1140.6: Purchased home health care services. Washington, DC: Author Retrieved from https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1457

Veterans Health Administration. (2007, 1 31). VHA Handbook 1141.01: Home-Based Primary Care Program. Washington, D.C.: Author Retrieved from https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1534

Veterans Health Administration. (2015, 9 24). VHA HANDBOOK 1601A.03: Enrollment Determinations. Washington, D.C.: Author Retrieved from https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3144

Veterans Health Administration. (2017, 5 27). 1101.10(1). Patient Aligned Care Team (PACT) Handbook. Washington, D.C.: Author Retrieved from https://www.va.gov/VHAPUBLICATIONS/ViewPublication.asp?pub_ID=2977

Veterans Health Administration. (2016, 10 11). VHA Handbook 1140.11: Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics. Washington, D.C.: Author Retrieved from https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3267

Wadsworth M (2017). Veterans eligibility for VA nursing home care. Berkeley, CA: NoLo Retrieved from <http://www.nolo.com/legal-encyclopedia/veterans-eligibility-va-nursinghome-care.html>

Watts R, Pierson J, & Gardner H (2006). Critical care nurses' beliefs about the discharge planning process. *International Journal of Nursing Studies*, 43(3), 269-279. doi:10.1016/j.ijnurstu.2005.04.005 [PubMed: 15979076]

Westat (2010, 10 18). National survey of Veterans, active duty service members, demobilized National Guard and Reserve members, family members, and surviving spouses: Final report. Rockville, MD: Author Retrieved from <https://www.va.gov/SURVIVORS/docs/NVSSurveyFinalWeightedReport.pdf>

Table 1.**Major Themes Arising From Key Informant Interviews With Illustrative Quotes.**

Theme 1: Growing use of home and community-based services (HCBS) prior to nursing home (NH) entry

1.a. Veterans often received HCBS before being admitted to an NH

“Frequently ... patients that we do have going to that higher level of care have already exhausted either home-based primary care or skilled nursing, other options that they’ve had in the community.... We have probably less and less patients that are going from a community setting with no service directly into an NH.” (nurse manager, largely rural, Midwest)

“Generally we go from [the VAMC] to sending a visiting nurse, the visiting nurse pulls out because the patient doesn’t meet the criteria anymore ... so ... we might try and get in home-based primary care.... There is only two ways that our patients get discharged from home-based primary care, either they die or in fact they come back into the hospital and are discharged to a NH.” (nurse manager, urban, East)

Theme 2: The divergence of institutional and noninstitutional care referrals in the VA

2.a. Care teams referred Veterans to institutional or noninstitutional services

“The first or second day after admission ... the team will start with recommendations as far as where do you think this Veteran is going to be able to go? Do we think he’s going to be able to go back to his home? Do we think we’re going to have an NH placement here?” (nurse manager, urban, East)

“A lot of times we’ve already ruled [HCBS] out based on our conversation with the patient and the family and the treatment team.” (social work manager, urban, South)

“If they were going to be in long-term institutional care, they went that route, otherwise if they were being referred to any of the community programs they referred individually to noninstitutional care programs.” (nurse manager, urban, South)

2.b. Further consideration of care options may have occurred after care team recommends a consult

“We may come back with some questions to make sure that they’ve ruled out some of those other lower level of care settings.... Sometimes they miss something or we come up with ... a different creative plan or something that may result in them not being placed in an NH facility.” (nurse manager, urban, West)

“If we have a Veteran that’s difficult to manage in the community and there’s a referral to home-based primary care and they decline the Veteran for one reason or another, we can be pretty much sure that Veteran is going to end up in an NH at some point in time.” (social work manager, urban, West)

Theme 3: Key considerations in care team decision making

3.a. Care teams often sought placement in home and community-based settings contingent, in part, on clinicians’ disciplinary perspectives

“The treatment team [seeks the] least restrictive level of care that the Veteran’s needs can be met. Is that going to be met in the home with home care coming in? Is that going to be in the home and then they go to adult day care while the wife who’s still working works? How can we make that work?” (social worker, largely rural, West)

“Well, we also look at some of the other areas along the spectrum before you go right to NH. [Are there] noninstitutionalized care programs that [can] fill the gaps in the spectrum between noninstitutionalized care and NH care?” (social work manager, rural, West)

“We prefer if [it was the] doctor or physical therapist [who made the referral], but nurses are able to ... almost everyone is able to.” (social worker, urban, West)

“There’s many different disciplines. Not everybody[’s] perspective ... is the same. I engage in many a conversation of least restrictive levels of care when, say, for example, a nurse or the doctor ... feel [that someone] need[s] to go to an NH.” (social worker, urban, Midwest)

3.b. Time pressures at hospital discharge reduced the likelihood of community placement posthospital discharge

“Patients are referred to [hospital] from [an outpatient clinic] ... so that we ... can kind of process them through.... They have a social worker working with them and their psychiatrist and medical doctors ... for however long it takes to place [them].” (nurse, urban, South)

“[The HCBS programs are] definitely fabulous when the Veteran is outpatient. When they’re inpatient, it’s kind of hard to get all those programs started and then make sure it’s a safe discharge [in the limited time available].” (social work manager, urban, South)

3.c. Care teams drew on several sources of information to determine clinical appropriateness

“We have ... a [Geriatric and Extended Care (GEC)] form ... to determine ADLs and IADLs.... We use it ... for our home and community NH programs.... It’s a good guide to measure somebody’s functional ability and cognitive abilities.” (social worker, largely rural, Midwest)

“[The GEC form includes] seven pages of questions. Not all of which are important.... That ... gets in the way of exchange of information and maybe lengthens the amount of time it takes to get the process done. And it certainly adds a layer of duplication of work.” (social worker, urban, Midwest)

“We haven’t actually done a form which checks off that the person is missing so many ADLs or IADLs. It’s a professional judgment.” (physician manager, urban, East)

3.d. Primacy given to Veteran preferences even when choices contradicted team recommendations

“This is based on patients’ rights and ... choice.... If you say to us ‘I am not going [to an NH], I am going home.’ That’s their right.” (nurse manager, urban, East)

“If they’re able to make decisions then if they say ‘I’m not going to an NH,’ then we say ‘ok then we’ll send you home’ and we try to beef up as much home support as we can even if we think it’s not [safe].... They have a right to make choices even if you disagree.” (social worker, largely rural, West)

“If we think their decision making is impaired and they’re not cooperating ... then ... we get psychology or psychiatry service involved.” (social worker, largely rural, West)

3.e. There Were Frequent Rehospitalizations for Veterans Who Returned Home Despite Care Team Recommendations

“What happens is people come in [and] we’ll recommend ‘you really can’t take care of yourself, what about going into an NH’ ... and they say ‘no, no, no.’ We probably see them 3–4 hospitalization[s] before.... they decide that in fact ‘okay this is what I have to do.’” (nurse manager, urban, East)

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript