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VA Staff Perceptions of Barriers and Facilitators to Home-and Community-Based Placement Post-Hospital Discharge

Edward Alan Miller^{a,b}, Orna Intrator^{b,c,d}, Emily Gadbois^b, Stefanie Gidmark^e, James L. Rudolph^{e,f}

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

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

^cCanandaigua VA Medical Center, Canandaigua, New York, USA;

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

^eProvidence VA Medical Center, Providence, Rhode Island, USA;

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

Abstract

This study identifies factors U.S. Department of Veterans Affairs (VA) staff perceived to promote or impede home- and community-based services (HCBS) placement post-hospital discharge among Veterans cared for within the VA. Data derive from 35 semi-structured interviews with staff from 12 VA medical centers from around the country. VA staff reported that Veteran's care needs and social and financial resources influence HCBS placement. They also reported prerequisites for successful placement, including housing, unpaid informal care, and non-VA services funded privately and by public programs such as Medicaid and the Older Americans Act. Lack of staffing and failure to offer the specific types of services needed limit referral to and use of HCBS. Budgetary imperatives influence the relative availability of HCBS across VA medical centers. Findings highlight patient-, provider-, and system-level constraints that impede successful placement at home and in the community of Veterans in need of long-term services and supports after hospitalization.

Keywords

Veterans Affairs; home- and community-based services; nursing homes; long-term care; qualitative interviews; hospital discharge planning

Introduction

As the population ages, the concomitant rise in frailty and disability will increase the demand for long-term care (LTC). In no health system is this more prevalent than in the Veterans Health Administration (VHA) of the U.S. Department of Veterans Affairs (VA). Currently, 47.3% of 8.5 million Veterans enrolled in the VHA are aged 65 years or older, a number that is expected to rise in the coming decades (Gasper, Liu, Kim, & May, 2015). The aging of the Veteran population spurred top officials within the VA to develop a “more coherent and comprehensive approach to LTC for Veterans,” including increased investment in home- and community-based services (HCBS) (Rutherford, 2004). The aim is to “facilitate Veteran’s independence in the least restrictive home-like environment, delay or prevent institutionalizations ... and provide intensive caregiver support and respite” (VHA, 2016).

In 1998, the Federal Advisory Committee on the Future of VA Long-Term Care recommended increasing the proportion of extended care services provided in noninstitutional settings (Shay, Hyduke & Burris, 2013). Subsequently, the Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106–117) sought to change the nature of LTC provision within the VHA by requiring the VHA to provide access to both institutional and noninstitutional LTC and to make specific personal care services—adult day health and respite care—available to all eligible Veterans (U.S. General Accounting Office, 2002). Thus, around this time adult day health, respite, and other noninstitutional services—homemaker/home health aide, skilled nursing, and home-based primary care—were added to the VA benefits package. While encouraging a shift toward use of HCBS, the Millennium Act also required the VHA to maintain institutional care capacity at 1998 levels and created a mandatory nursing home (NH) benefit for certain Veterans.

This emphasis on expanding access to HCBS has been firmly integrated into VA policy. This is reflected in the mission statement of VHA’s Office of Geriatrics and Extended Care Services (n.d.), which seeks, in part, to “honor Veterans’ preferences by increasing the delivery of long term services and supports (LTSS) in home- and community-based settings.” It is also reflected in initiatives undertaken pursuant to Geriatrics and Extended Care’s strategic planning processes (Shay & Burris, 2008; Shay, Hyduke & Burris, 2013). These include efforts to drive HCBS growth, in part, through annual, rising region-specific performance targets for the noninstitutional care daily census. They also include pilot programs with which to test innovative noninstitutional care models deemed successful in other settings but not yet widely unavailable within the VA. Notable examples are participant-directed services (known as Veteran-directed [VD]-HCBS; Garrido et al., 2017), medical foster home services (Levy et al., 2016), Program of All-Inclusive Care for the Elderly (Administration on Community Living, 2014), and rural adaptations of established programs (e.g., home-based primary care; Kramer, Cote, Lee, Creekmur, & Saliba, 2017). Beginning with its FY 2015 budget submission, the VHA sought to promote HCBS further by shifting 2% of funds initially designated for NH care to HCBS, a shift that has continued in each subsequent year.

Driven by gains in utilization, VA HCBS expenditures have grown dramatically since 2000, increasing by five times in 10 years, from \$240 million (fiscal year [FY] 2001) to \$1.0 billion (FY 2011) and then doubling to \$2.1 billion (FY 2015) in the subsequent 5 years (Colello & Panangala, 2017; U.S. General Accounting Office, 2002). Only modest progress has been made rebalancing VA LTC spending away from institutional to noninstitutional supports, however. Between 1995 and 2010 the proportion of VA LTC spending devoted to HCBS increased less than 1% annually, or from about 5% to 18.6% (Colello & Panangala, 2017; Schoeps & O’Keefe, 2012). The annual rate of growth has since risen to 2%, with the proportion of VA LTC devoted to HCBS increasing to 28.6% in FY 2015 (Colello & Panangala, 2017). By contrast, Medicaid HCBS for older adults and people with physical disabilities increased from 16.7% to 43.9% of total LTSS spending from 1995 to 2015 (Eiken, Sredl, Burwell, & Woodward, 2017). Drawing from the experience of VA staff, this study identifies perceived barriers and facilitators to HCBS use post-hospital discharge.

A primer on VA LTC

The VHA’s Office of Geriatrics and Extended Care establishes system-wide policies regarding the provision of geriatric medical care and extended care services within the VHA. Administration is decentralized to 18 Veterans Integrated Service Networks (VISNs) and their constituent VA medical centers (VAMCs). All clinically eligible VHA enrollees are eligible for noninstitutional VA benefits if they are available (Department of VA, n.d.a; Veterans Health Administration, 2016). Noninstitutional LTC in the VA medical benefits package includes home-based primary care, homemaker/home health aide care, adult day health care, respite care, skilled home health care, hospice care, and palliative care (Table 1). Home telehealth care is not a required benefit but may be used to supplement required services. VD-HCBS in which Veterans exert greater choice and control by purchasing home care and other services using flexible budgets may be used as the mechanism through which care is provided, although it is not a required benefit either. Some HCBS are provided entirely within the VA (home-based primary care), other HCBS by community-based providers paid for by the VA (homemaker/home health aide care, skilled home care), and still others by both VA and community providers (adult day care, respite, hospice). Residential care options may be available, too, with room and board typically paid for by Veterans and quality/safety oversight and wraparound services, if any, provided by the VA if the Veteran has certified needs and is enrolled in the VHA. These programs include community residential care, medical foster home care, adult family homes, and assisted living facilities. Eligible Veterans may also receive VA-paid NH care in VHA-owned and -operated community living centers, community NHs on contract with the VA, and State Veterans Homes, which are run by states but underwritten, paid for, and overseen, in part, by the VA.

There were 140 VAMCs in 2016. Each VAMC provided home-based primary care and hospice/palliative care in that year; 56 provided adult day health services (Figure 1). All VAMCs contracted for homemaker/home health aide and skilled home care, and nearly all contracted for outpatient hospice/palliative care ($n = 139$), home respite care ($n = 138$), and adult day health services ($n = 135$). A little more than one-third of VAMCs ($n = 54$) offered VD-HCBS.

Between 2007 and 2016, the number of Veterans using VA-paid noninstitutional care programs increased dramatically (Table 2). Particularly large increases in HCBS use were evident in VA-provided hospice/palliative care (664.0%), purchased home respite care (369.7%), homemaker/home health aide services (249.6%), skilled home care (132.3%), and home-based primary care (125.6%). In all, 409,042 Veterans received any geriatrics and extended care services in 2016, with 105,329 (25.8%), 82,268 (20.1%), 15,250 (3.7%), and 10,171 (2.5%) using purchased homemaker/home health aide services, skilled home care, home respite, and adult day services, respectively, and 52,632 (12.9%), 33,075 (8.1%), and 3,395 (0.8%) using VA-provided home-based primary care, hospice/palliative care, and adult day services, respectively. Only 1,395 Veterans used VD-HCBS.

Veterans must exhibit a need for skilled assessment, teaching, treatment, or monitoring or intermittent, short-term, or transitional services to qualify for skilled home care (Veterans Health Administration, 2016). To qualify for homemaker/home health aide and adult day health care, a Veteran must be determined to need NH care in the absence of HCBS. Target populations include those with three or more activity of daily living (ADL) impairments, significant cognitive impairment, or impairment in two ADLs plus two or more of the following: three or more instrumental ADL impairments, recent or planned discharge from an NH, age 75 or older, high use of medical services, depression, and/or living alone. Respite care employs similar criteria but requires caregivers to need temporary or intermittent relief. There are no specific diagnostic requirements for home-based primary care. The primary focus is on providing longitudinal care to Veterans with complex, chronic, disabling conditions for whom routine clinic-based care is not effective. Hospice is open to Veterans with projected life expectancies of less than 6 months. VA staff typically have discretion to provide services to Veterans who do not meet criteria should they judge that services are nonetheless required.

The VA's obligation to provide VHA coverage to honorably discharged Veterans depends on each Veteran's priority status, which is determined by the percentage of service-connected disability resulting from injuries or illnesses received while serving in the military, as determined by rating specialists, as well as income and assets (VHA, 2015). Priority status determines the financial contributions a Veteran needs to make. Home care programs are generally open to all Veterans; Veterans need not be service-connected to access them. Should local resources prove insufficient to meet demand, VAMCs may set limits on service use and scope; the VA requires VAMCs to establish and monitor electronic waitlists under such circumstances (Veterans Health Administration, 2016). When resources are constrained, the VA gives priority to eligible Veterans in need of home health care who are currently receiving or in need of NH care for a service-connected disability or who have a service-connected disability of 50% or higher (VHA, 2006).

Eligibility for VA-paid NH care is based on the same priority hierarchy as HCBS. However, the Millennium Act requires VAMCs to cover the full costs of NH care provided to "mandatory," or P1A, Veterans, defined as those with a service-connected disability rating of 70% or greater or whose need for NH care derives from a service-related disability (VHA, 2004). Other Veterans may be provided NH care at each VAMC's discretion, subject to copayments depending on their priority status. Thus, whereas VAMCs must provide NH care

to the highest-priority Veterans with other, lower priority Veterans limited by available resources, the provision of HCBS to all Veterans is contingent on available resources, regardless of priority status.

Study aim

Few studies have examined extended care referral within the VHA (Guihan, Hedrick, Miller, & Reder, 2011; Reder, Hedrick, Guihan, & Miller, 2009). Consequently, little is known about what facilitates or hinders use of VA HCBS when referrals are made. This study helps to fill this gap by identifying factors VA staff perceive to promote or impede HCBS placement post-hospital discharge. Data include 35 in-depth interviews with VA staff from 12 VAMCs from around the country.

Methods

Data for this study derived from semi-structured interviews. Participants were selected through a combination of purposive and snowball sampling, with selection first based on our own knowledge about the VHA but later on information provided by interviewees regarding specific actors who should be interviewed about the VHA's extended care referral and contracting processes (Patton, 2002). Twelve VAMCs were selected for this study to ensure variation in geographic region—Northeast ($n = 2$ sites), South ($n = 2$), Midwest ($n = 4$), and West ($n = 4$)—and catchment area—rural ($n = 4$) or urban ($n = 8$). Sites were also chosen to ensure variability in available NH options—community living centers (0 to 2), contract community NHs (5 to 48), and State Veterans Homes (0 to 5) (Department of VA, 2009). We selected most sites beforehand to ensure variation on these characteristics. However, we selected some sites based on information provided by our interviewees. 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).

Thirty-five interviews were conducted with 36 individuals between May 18, 2012, and December 6, 2012. One interview included two participants. Two interviews took place in person, the remainder over the telephone. Interviews lasted from 60 to 90 minutes each. Interviewees were selected based on which VA staff were most knowledgeable about each VAMC's extended care referral and contracting processes, including 20 social workers, 12 nurses, and 4 geriatrics physician leaders. The VAMC setting meant that interviews primarily assumed an inpatient hospital rather than outpatient or community-based clinic perspective.

The interview protocol was drafted with input from VHA practitioners and researchers and Office of Geriatrics and Extended Care Services personnel. The protocol was fielded at one VAMC before being refined for use in the study. Minimal changes were made to the protocol after the pilot; consequently, data from this site were included in the analyses. Through the protocol, we sought to understand extended care referral within the VHA, including the choice between HCBS or NH placement and factors promoting or impeding HCBS and NH placement at the point of hospital discharge. We also sought to identify and explain similarities and differences across VAMCs. The role that national regulations and regional

and local rules, practices, resources, and capacities play in extended care referral was examined as well.

Conversations were recorded (with each interviewee's permission) and transcribed. Each transcript was coded by the authors to identify recurring themes and patterns in responses (Miles & Huberman, 1994). An open-ended coding process was employed whereby coders independently generated potential coding categories through an initial review of the transcripts (Glaser & Strauss, 1967). Once a full, final set of codes was agreed upon, all transcripts were coded using the common set of codes. The coded text was then reviewed and grouped into themes and subthemes with illustrative quotes (Table 3). Institutional review board approval for this research was obtained.

Results

Main themes relate to health, social, and financial factors restricting the use of HCBS (theme 1), HCBS supply limitations (theme 2), and resource allocation decisions across VAMCs (theme 3). Subthemes elaborating on theme 2 largely pertain to factors affecting HCBS use across VA and non-VA settings, whereas subthemes elaborating upon theme 3 largely pertain to VA-specific factors. This is in contrast to subthemes elaborating on theme 1, which include factors pertinent to both cross-system and VA-specific factors. Results for theme 1 are thus reported in order of increasing relevance to the VA.

Theme 1: Factors limiting the use of HCBS options

Care needs too great to manage at home—Typically, VA staff reject home-based care for Veterans whose level of care needs exceeds what could be provided at home; for example, someone's need for around-the-clock oversight and assistance surpasses the resources that can be allocated from the homemaker/home health aide program. LTC, intravenous antibiotics, medication management, wound care, and rehabilitation were identified by various interviewees as care needs that can be difficult to meet in some Veterans' homes due to the amount of supports that can be made available.

Unpaid, informal care is critical for HCBS to work—The presence of unpaid, informal care from a spouse, child, or other friend or family member is especially important if Veterans in need of LTC are to remain at home and in the community even with the provision of formal HCBS. A number of Veterans live alone. Consequently, home-based care-givers are sometimes not available to provide the supplemental care and support required to keep frail and disabled Veterans at home.

Caregiver burden can compromise informal care provision—Often Veterans have had a home-based caregiver, but that individual is no longer willing or able to provide the level of care required to keep them home. Caregiver burden and stress is a major issue in this regard. Dementia, transferring, ambulation, and bowel and urinary incontinence can preclude continued caregiving. Skilled nursing needs, medication management, and tube feeding pose problems for informal caregivers as well.

Homelessness can complicate/preclude HCBS placement—The process involved in providing HCBS to homeless Veterans can be quite challenging. The result for many homeless Veterans is to go without needed care or to be admitted into an NH even though they might not otherwise qualify. Although homelessness serves as an impediment to service use generally, it is particularly salient to the VA given the historically high rate of homelessness among the Veteran population (U.S. Government Accountability Office, 2016).

Linking Veterans to supplemental services and supports—VA staff report trying to connect Veterans to additional services and supports. Often, discharge planners would try to coordinate with non-VA services to supplement care paid for by the VA. Indeed, the ability to link up with Medicaid, Older Americans Act services, and other programs can prove critical in keeping a Veteran at home. At a minimum, it was reported that discharge planners would let families know about other community resources. VA staff connecting with supplemental services and supports is particularly relevant for the VHA, since most Veterans are not enrolled in the VHA while a large proportion who are enrolled are dually or triply eligible for VA, Medicare, and/or Medicaid benefits (Gasper et al., 2015; Weststat 2010).

Challenges linking Veterans to supplemental services and supports—Interviewees highlighted potential challenges linking Veterans to supplemental care in the community. Lack of eligibility for Medicaid and other programs is one impediment. Another impediment is Veteran or family reluctance to pay for or apply for non-VA support. Two main reasons underlie such hesitance: expense in the case of private services and stigma and asset depletion in the case of public programs. Still another impediment to accessing supplemental services is supply, resulting from limitations in Medicaid- and non-Medicaid-funded HCBS, both generally and during adverse state budgetary circumstances. Overcoming challenges connecting with supplemental services and supports is particularly relevant to the VA, which has increasingly sought to meet Veteran's care needs, in part, by partnering with other agencies/providers within the community (Department of Veterans Affairs, 2017a; Kramer et al., 2017; U.S. Government Accountability Office, 2017).

Theme 2: Limitations in the supply of VA HCBS options

Insufficient availability of VA providers poses a barrier to HCBS placement—The VA provides home-based primary care directly while contracting with local agencies to provide homemaker/home health aide services. A few respondents reported adequate supply of VA HCBS options at their VAMCs. More often interviewees reported that the supply of options available was insufficient to meet demand.

Level and type of staffing pose barriers to HCBS placement—Provider availability is a necessary but not sufficient condition for keeping Veterans at home. Sometimes VA-paid providers do not offer the types of services required to meet Veteran's care needs (e.g., physical therapy, speech therapy). Other times VA-paid providers offer the types of services required but lack the requisite staffing capacity, thereby contributing to delays in care receipt among Veterans recommended for services.

Challenges providing HCBS in rural and urban areas—Staff unwillingness to enter certain neighborhoods due to crime and safety concerns can prove problematic when trying to serve Veterans in densely populated areas. On the other hand, the need for staff to travel great distances can prove problematic when trying to serve Veterans in sparsely populated areas. So too can staff availability; there are often not enough well-staffed agencies to meet the demand for care in rural communities.

Theme 3: Allocating resources to HCBS programs across VAMCs

Budgetary pressures impact HCBS availability—VAMCs allocate resources to the HCBS programs within their jurisdictions based, in part, on budgetary considerations. Strategies adopted in light of prevailing budgetary limitations include establishing electronic waitlists, restricting geographic service areas, and limiting the number of hours of services provided and/or number of Veterans served.

Highly service-connected Veterans sometimes receive priority for HCBS—A number of interviewees indicated that highly service-connected Veterans were given priority for VA-paid HCBS. These include “mandatory” (P1A) Veterans otherwise eligible for full coverage of VA-paid NH care.

Establishing electronic waitlists for HCBS—Electronic waitlists were commonly used for both home-based primary care and homemaker/home health aide services, although waitlist length could vary across programs. Thus, for example, one respondent reported an extensive waitlist for homemaker/home health aide services, a modest waitlist for home-based primary care and contract adult day health care, and no waitlist for purchased skilled home care. VA staff reported that in certain cases Veterans would receive priority for admission despite the presence of a waitlist, for example, if they had frequent hospitalizations or were in need of hospice care. Only a few interviewees reported that no waitlists were maintained for any of their HCBS programs.

Variation in decisions affecting the number of service hours and Veterans served—VAMCs make different decisions about how to allocate service hours in light of prevailing budget limitations. The varying approaches taken stem, in part, from different philosophies about how those resources should be used. Some sites, for example, serve fewer Veterans but provide them with relatively high numbers of homemaker/home health aide hours in an effort to prevent NH entry. Most VAMCs, however, seek to spread the wealth, providing homemaker/home health aide services to as many Veterans as possible. Here, there may be few people on the waitlist but the hours provided may be insufficient to maintain their care in the community; supplemental supports are needed to fill in the gaps. Exceptions to the typical limits placed on homemaker/home health aide hours are sometimes made, for example, in the case of spinal cord injury or caregiver illness.

Providing HCBS within a portion of the catchment area—Some VAMCs managed their budgets by offering HCBS programs within certain service areas. Most interviewees reported the presence of home-based primary care programs affiliated with their VAMC. These programs, however, provide care within established radiuses surrounding the VAMC

or a community-based outpatient clinic. Those living outside the home-based primary care catchment area lack access to these services, making it more difficult to keep them at home. The primary factor limiting the geographic reach and scope of home-based primary care is recruiting sufficient staff to cover the service area.

Discussion

VA staff from 12 VAMCs from around the country were interviewed to identify factors that hinder or promote HCBS placement within the VHA post-hospital discharge. Issues identified by interviewees included factors common to HCBS use in VA and non-VA settings. Findings thus support prior investigations in the VA and other settings suggesting that limited availability of VA HCBS options derives, in part, from inadequate supply of home care agencies, paraprofessional workers (e.g., home health aides, personal care aides), and professional workers (e.g., registered nurses, physicians, therapists; Bardo, Applebaum, Kunkel, & Carpo, 2014; Costa & Hirdes, 2010; Miller, 2014; Office of the Inspector General (OIG), 2006; U.S. General Accounting Office, 2003; Stewart, Felix, Dockter, Perry, & Morgan, 2006). They are also consistent with prior research in highlighting the importance of accounting for care needs and unpaid, informal care and caregiver burden when seeking to maintain care of frail and disabled Veterans in the community (Costa & Hirdes, 2010; LeClerc, Wells, Craig, & Wilson, 2002; Robison, Shugrue, Porter, Fortinsky, & Curry, 2012).

Highlighting benefits associated with becoming a VA contractor could serve as part of the strategy VAMCs use to bolster their formal service supply. When recruiting providers, for example, VAMCs could emphasize the prospect of higher, timelier, and more stable reimbursement compared to Medicaid (Miller, Gadbois, Gidmark, & Intrator, 2015). They could also emphasize the prospect of having a regular referral source that offers enhanced care transitions and coordination relative to other referring entities. Perceived value in serving Veterans, a highly vulnerable and respected population, may be used to leverage contracts with available HCBS agencies/providers as well.

Emphasizing the potential benefits of VA contracting, however, can only go so far. Burdens posed by federal contracting requirements would continue to inhibit expansion of HCBS supply, particularly when there are too few referrals to make it worthwhile for providers to become contractors (Miller et al., 2015). This suggests that the VA should explore alternative practices for forming relationships with providers to enable Veterans to choose from a larger array of VA-paid options, thereby increasing the likelihood that they might find needed community services.

The Veterans Choice Program established under the authority of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113–146) aims to improve Veteran's access to care in response to reports that large numbers of Veterans never received requested doctor appointments or had to undergo unreasonably long waits before doing so (U.S. Government Accountability Office, 2017). Although recently extended by six months, the Veterans Choice Program is a three-year initiative that draws on a special fund to provide Veterans access to non-VA services in the community. The Veterans Choice Program seeks to

facilitate provider recruitment through use of provider agreements that eliminate regulations and requirements otherwise associated with VA contracts. So far, the target of the Veterans Choice Program has been primary and specialty care, in part, because of the Veterans Access, Choice, and Accountability Act's limited applicability to geriatrics and extended care services (Coleman, 2017). The VA's 2018 revised appropriations request, however, sought to fund about one-quarter of its proposed \$2.7 billion noninstitutional LTSS budget through the Veterans Choice Program (Department of VA, 2017b). The Senate Committee on Appropriations (2017) instructed the VA to continue to fulfill its obligations to noninstitutional care entirely outside of the Veterans Choice Program in the likelihood that additional funding for the program would not be forthcoming.

In 2013, the VA proposed a rule that would have permitted VAMCs to use Medicare or state procedures to enter into provider agreements to acquire extended care services (McFetridge, 2013). A major aim of the proposed change was to promote the VA's rebalancing efforts by increasing VAMCs' ability to recruit HCBS providers who otherwise had no desire to become federal contractors (Schoeps, 2012). Potential benefits for providers included use of a simpler, less burdensome process with which they were already familiar and exemption from data reporting and wage payment requirements under general federal contract law. They also included use of the same terms and rates as providers' separate agreements with Medicare or Medicaid. Providers with agreements with both programs would have been subject to the terms and rates of the agreement with the highest rates. The rule would have applied to geriatric evaluation, NH care, domiciliary services, adult day health care, noninstitutional palliative and hospice care, home health care when used as alternatives to NH care, and respite care. The rule was rescinded, however, after the VA concluded that Congress would need to pass specific legislation authorizing it (Coleman, 2017). Congress could help further LTSS rebalancing within the VA by passing legislation permitting the use of provider agreements for geriatrics and extended care services and reauthorizing the Veterans Choice Program for a longer period of time at higher funding levels while broadening its applicability to the full scope of noninstitutional HCBS.

The VA recognizes the importance of unpaid, informal care for successful community placement. The VA's national office expects both Veterans and their caregivers to be well informed of their options and to be active members of the care planning team (Veterans Health Administration, 2016). Moreover, to promote patient and family participation in the referral process, the VA posted a shared decision-making worksheet to help Veterans think about their extended care needs and preferences and a caregiver self-assessment worksheet to help caregivers assess their caregiving roles and responsibilities (Department of VA, n.d.b). The VA should consider strengthening its discharge planning requirements to begin discharge planning within 24 hours of admission or registration to better arrange needed HCBS following hospitalization and to better prepare patients and caregivers to be active partners in postdischarge care. It should also consider strengthening its discharge planning requirements by requiring VA staff to explicitly account for factors such as caregiver support, non-health care services, and community-based care when evaluating discharge needs.

Expansion of VD-HCBS could serve to ameliorate caregiver burden and stress as well. VD-HCBS focuses on Veterans at risk for NH placement whose needs exceed the hours typically available for the homemaker/home health program or who have difficulties with traditional agency-based services. VD-HCBS helps to alleviate caregiver burden and stress, in part, by permitting Veterans or their designees (typically family) to use the budgets allocated to hire family members to provide caregiving assistance at hourly, geographically adjusted rates determined by the VHA. Even when family members are not paid, however, VD-HCBS helps to reduce the physical, emotional, and financial strain of caregiving to the extent that greater choice and control enable Veterans and their families to better tailor the goods and services purchased to their unique needs and circumstances (Milliken, Mahoney & Mohoney, 2016).

Similar to prior investigations, findings indicate that limited use of VA HCBS options derives, in part, from service caps, eligibility restrictions, and other limitations placed on accessing and using those services (Bardo et al., 2014; LeClerc et al., 2002; O'Connor, Long, Quach, Burgess, & Shea-Delaney, 2006; OIG, 2006, 2013, 2015; Stewart et al., 2006; U.S. General Accounting Office, 2003). However, the confluence of mechanisms through which these service limitations play out are unique to the VA context, involving the interaction of electronic waitlists, priority-status-based eligibility restrictions, number of service hours allocated, and size of the catchment area served. The VA's national office requires that VAMCs maintain electronic waitlists when local resources/funding are insufficient to meet the demand for services (Veterans Health Administration, 2016). Caps on how many Veterans could receive services at any one time are common, resulting in a non-negligible number of otherwise eligible Veterans being placed on waitlists until openings or resources become available (OIG, 2015). The presence of waitlists, however, does not necessarily mean that they are complete. Estimates suggest that in FY 2012 there were at least 49,000 Veterans nationally who had needs for homemaker/home health aide, respite, and skilled care (i.e., purchased home care services) who were not on program waitlists (OIG, 2013). Keeping, monitoring, reporting, and acting on electronic waitlist information is important for matching local and system service capacity to demand. Incomplete waitlists are problematic to the extent that Veterans do not receive priority for needed services should openings occur or additional resources become available. They also compromise the ability of VAMCs to account for unmet needs when assessing capacity and allocating resources relative to other priorities. Nationally, complete and accurate waitlists are important to the extent that they enable the Office of Geriatrics and Extended Care Services to track the need for HCBS system-wide, to adjust its budget and allocate resources in light of that need, and to assess progress toward the VA's goal of increasing the delivery of extended care services in home- and community-based settings.

Results reinforce earlier reports finding that VAMCs apply more stringent eligibility criteria than required, in particular, limiting access to HCBS to Veterans with certain service-connected disability levels (e.g., 70% or higher), including those otherwise eligible for NH services (OIG, 2006, 2013; U.S. General Accounting Office, 2003). Federal law requires that NH care be a benefit that VAMCs provide to certain Veterans (e.g., P1A Veterans); other Veterans may be served at each VAMC's discretion. Federal law also requires that adult day health and respite care be made available to eligible Veterans, but this mandate has not been

followed and, as such, eligibility for these services like other HCBS is not guaranteed to any Veteran. VA policy thus suggests that (1) high-priority (P1A) Veterans would be more likely to choose NH than HCBS care, all else being equal, because the VA is required to pay the full costs of the former but not the latter, but that (2) P1A Veterans would not necessarily receive HCBS before other equally deserving Veterans because their priority status does not extend to noninstitutional supports. Despite this logic, a number of respondents indicated that P1A Veterans were nevertheless given priority for VA-paid HCBS. This finding may stem from NH eligibility standards having spillover effects for Veteran access to HCBS, perhaps, in part, because VAMCs view the purpose of noninstitutional care programs as NH diversion and it is less expensive to care for Veterans who qualify for mandatory VA-paid NH care at home and in the community. However, it may also stem from the VA's national office permitting individual VAMCs to give priority for home health care to Veterans who have service-connected disabilities of 50% or higher or who are otherwise receiving or in need of care in an NH, when funding is limited (Veterans Health Administration, 2006).

Because access to HCBS is not guaranteed to any group of Veterans, the type and scope of services available and to whom they are provided are largely at each VAMC's discretion. VAMCs thus have more freedom managing their HCBS than NH programs (where access is mandatory for certain groups). Results indicate that VAMCs choose to allocate resources differently in light of prevailing resource constraints. Although most seek to spread the hours available to as many Veterans as possible, some serve comparatively few Veterans but with relatively high numbers of hours. Either way, the resulting imposition of eligibility restrictions, service limitations, and waitlists contributes to the institutionalization of Veterans who might otherwise have been cared for within the community. It also suggests that progress toward the VA's LTC rebalancing goals will be incomplete as long as access to HCBS remains entirely at each VAMC's discretion. Clearly, the VA's national office has an important role in ensuring the application of standardized eligibility criteria throughout the system and in monitoring local funding allocations in light of prevailing need (IOG, 2013). Consideration, however, should also be given to bringing HCBS eligibility standards into alignment with eligibility standards for VA-paid NH care by requiring VAMCs to cover the full costs of HCBS provided to Veterans with service-connected disability ratings of 70% or greater or whose need for care derives from a service-related disability.

Findings indicate that further restrictions on HCBS use and expansion within the VA include limiting the geographic area within which services are provided due to distances staff must travel to Veterans' homes. This practice is consistent with the VA policy that permits each VAMC to designate the geographic area within which home-based primary care is offered (VHA, 2017). Low population density, long travel distances, poor cell phone and Internet service, and limited availability of potential contractors and clinicians can make it challenging to provide HCBS to ruraldwelling Veterans (Kramer et al., 2017; OIG, 2006, 2013; Veterans Health Administration, 2016). Recently, the VA has prioritized the extension of home-based primary care into underserved communities. This is reflected in VA national office regulations that "emphasize VA's responsibility to expand the program services to all areas of each VA's catchment area" (Veterans Health Administration, 2017, p. C-3). Specific provisions aimed at spurring expansion include encouraging VAMCs to establish satellite extensions of existing home-based primary care programs or independent satellite sites in

areas with sufficient demand. They also include strategies suggested for addressing challenges posed by considerable rural driving distance such as hiring staff locally, keeping vehicles near staff, employing laptops and mobile documentation software, reducing provider and interdisciplinary team member caseloads, and using telehealth and other technology-assisted programs to facilitate access and monitoring and to incorporate off-site disciplines.

In addition, the VA has sought to improve rural access to home-based primary care through collaborations with local providers such as programs established to serve American Indian reservations and their neighboring rural communities under a memorandum of understanding between the VA and Indian Health Service. Lessons from this latter initiative include the need to conduct population-based needs assessments to estimate the number of potential users and to prioritize relationship building with community partners to build buy-in and to facilitate promotion (Kramer et al., 2017). They also include the need to develop strategies for overcoming challenges to identifying, hiring, and retaining locally based providers, to develop local referral mechanisms, and to reduce caseloads to manage drive times. Seed funding is key to spurring the development of new programs; addressing stakeholder concerns about future financial sustainability, for example, through a commitment to annual funding appropriations, should be considered as well.

Issues identified by interviewees that were particularly unique to the VA context include the role of the VA budgeting process in HCBS utilization, the importance of linking Veterans to supplemental services and supports in the community, and the impact of homelessness on arranging receipt of HCBS for Veterans. VA's national office funds the VHA's 18 regional networks (VISNs) using a risk-adjusted per-person allocation formula, adjusted for labor/contracting costs and other factors (U.S. Government Accountability Office, 2011). VISNs, in turn, distribute funds to the VAMCs within their jurisdictions. There are several ways in which this process might adversely influence HCBS. One possibility is that the resource allocation methodology does not adequately account for case-mix differences giving rise to HCBS use. Another possibility is that the methodology does not adequately consider the costs of serving lower-priority groups. Still another possibility is that discretion VISNs and VAMCs have in distributing the funds allocated to particular programs and services influences the resources available for HCBS relative to other needs.

The last explanation is reflected in prior reports that highlight the discretion VISNs and VAMCs have in allocating financial resources to their noninstitutional care budgets and, in fact, to allocating resources to the full extent of their services (OIG, 2006, 2013; U.S. Government Accountability Office, 2011). This flexibility leads VA officials to put into place restrictions in HCBS utilization and spending in light of competing priorities. In FY 2012, for example, the VHA spent \$175 million less than the \$676 million Congress approved for noninstitutional purchased home care services (OIG, 2013). The VA OIG (2013) concluded that the VHA did not distribute \$76 million of Congress' original allocation because restrictions placed on HCBS by the VAMCs meant that they were not expected to meet the service targets on which the full allocation was based. Furthermore, the OIG concluded that VAMCs spent \$99 million less than the \$599 million that was ultimately allocated for noninstitutional purchased home care services. This funding, according to the

OIG, “was redirected by senior officials at the VA medical facilities ... to address other unidentified VA medical facility needs” (p. 2).

Because the HCBS VAMCs can provide are limited, VA staff report trying to meet Veterans’ care needs, in part, by linking them with supplemental community resources, including services paid for privately or by Medicaid, the Older Americans Act, and other programs. These linkages are particularly important if Veterans otherwise in need of NH care are to remain successfully within the community. State and local policies play a key role in influencing the supplemental resources available, so these options vary considerably across states and communities (Ng et al., 2015). Consequently, the supplemental options with which VA staff can potentially connect to Veterans depend on location. Moreover, findings suggest that concerns about asset depletion play a prominent role in influencing whether Veterans take advantage of the options available. Federal law requires states to cover aged and disabled individuals who meet the income and asset requirements of the Supplemental Security Income (SSI) program (Colello, 2017). However, states may elect to adopt more stringent financial eligibility requirements than the SSI program or elect to extend Medicaid coverage to optional eligibility groups, including individuals with three times the income required to receive the basic SSI benefit or who do not qualify for SSI but incur medical expenses that surpass specified income and asset levels. States may also exceed federal minimum estate recovery requirements when collecting from deceased Medicaid recipients’ estates as repayment for benefits provided. It is likely that VAMCs in states with more generous Medicaid eligibility criteria and weaker estate recovery provisions find it easier to employ non-VA resources when seeking to meet the care needs of Veterans within the community.

Limited knowledge and awareness about available community resources can serve as a potent barrier to identifying and accessing supplemental supports (Chapin, Chandran, Sergeant, & Koenig, 2014; Bardo et al., 2014; Guihan et al., 2011; Kane, 2011; Miller, 2014; Reder et al., 2009; Stewart et al., 2006); so too can poor communication between VA staff and community service providers and programs (Chapin et al., 2014; Kane, 2011). Care fragmentation can make successful home- and community-based placement challenging, particularly for those otherwise in need of NH care (Bardo et al., 2014; Costa & Hirdes, 2010; LeClerc et al., 2002; Miller, 2014; O’Conner et al., 2006; Stewart et al., 2006). Developing knowledge and relationships and communicating and coordinating with Medicaid, Medicare, Older Americans Act, and other non-VA-funded programs are thus critical for linking Veterans with necessary services. In this respect, the VA has built up experience promoting integration between VA and non-VA hospice services through Hospice-Veteran Partnerships. Participants vary across the 104 sites currently in operation but include VAMCs, community hospices, state hospice organizations, Veterans Service Organizations, and military hospitals, among other organizations (We Honor Veterans, 2017). The aim is to increase access to and improve end-of-life care and palliative care for Veterans across all sites and levels of care by strengthening relationships among hospices, VA programs, and community organizations. Specific activities thus seek to raise awareness of Veterans’ special needs; educate state, county, and local hospice providers about VHA services and benefits; and inform VA staff about public and private hospice and palliative care resources within the community (Veterans Health Administration, 2016).

Experience with Hospice-Veteran Partnerships led the VA to launch Veteran Community Partnerships (VCPs) in 2010 to facilitate access to and transitions across the full continuum of noninstitutional services within the VA and community. Specific goals include improving communication, collaboration, and coordination of care and benefits across VA and community organizations and agencies while increasing Veteran and caregiver awareness and choice among the options available. The program has grown from three pilot sites in 2011 to 48 sites in 23 states in FY 2016, involving a wide range of community partners, including Area Agencies on Aging, state and local governments, senior organizations, and providers/provider associations of varying types. Knowing each other's benefits and eligibility requirements should help both VA and non-VA programs identify the full range of service options available to Veterans and their families. These options can, in turn, supplement one another if Veterans are eligible for both VA and other programs, thereby better enabling Veterans to remain at home and in the community, or serve as substitutes when eligibility and service restrictions (e.g., resulting from prevailing resource constraints) preclude access to one or the other program's benefits. Several challenges inhibit VCP expansion and effectiveness despite the potential benefits for Veterans, VAMCs, and community partners. These include the limited time local VA staff can dedicate to coordinating VCPs in light of other assigned duties, a lack of enthusiasm and engagement among other VA staff, and the absence of funding for program expenses (Department of VA, 2017a). Requiring stronger integration of VCPs with other forms of community engagement already being undertaken locally would help expand the reach of the program nationally. So too would providing the financial support required to staff and resource local VCP development.

Another approach to bolstering the VA's capacity to meet Veterans' community care needs would be to establish formal relationships with other government agencies to expand the array of service options available. VD-HCBS could serve as a model for interagency partnerships in this regard. VD-HCBS were launched in 2008 as a joint initiative between the VHA and the Administration for Community Living to adapt participant direction to the unique needs of the Veteran population. Under the program, interested VAMCs partner with Aging and Disability Network Agencies (ADNAs) to provide services and manage benefits. These agencies—Aging and Disability Resource Centers, Area Agencies on Aging, Centers for Independent Living, and State Units on Aging—must undergo readiness reviews to confirm their ability to perform the tasks required, after which they enter into provider agreements with the sponsoring VAMC specifying the terms and conditions of the partnership, including payment. Program coordinators at the VAMCs are responsible for referring and/or approving Veteran participation and for overseeing program operations and performance. Options counselors at the participating ADNAs are responsible for advising participants, helping them to identify and plan for their needs, manage their budgets, and obtain other goods and services, including hiring workers. They are also responsible for arranging financial management services to pay bills and manage payroll. Nationally, budgetary and personnel constraints have limited VD-HCBS growth, pending findings from a large randomized evaluation currently in progress (Garrido et al., 2017). Locally, factors facilitating program success include frequent and ongoing communication between the VAMC and ADNA, ADNA training in VAMC policies and billing practices, and VA

personnel who have the time and commitment necessary to champion the program and serve as a reliable point of contact for the ADNA (Thomas & Allen, 2016). Joint VAMC-ADNA participation in all phases of program development may be particularly helpful for clarifying roles and responsibilities and bridging organizational cultures, both prerequisites for a smoothly operating program.

Since 2009, the VA in partnership with the U.S. Department of Housing and Urban Development and other federal agencies has made a concerted effort to reduce homelessness among Veterans. The VA, both on its own and in collaboration with federal and community partners, provides homeless Veterans with housing, employment, health care, prisoner reentry, and other programs (Department of VA, n.d.b). Housing programs include the Domiciliary Care for Homeless Veterans Program, which provides time-limited residential care for Veterans with medical, psychiatric, substance abuse, and vocational needs, and the Grant and Per Diem Program through which the VA pays state, local, and community partners to provide up to 24 months of transitional housing and/or services to homeless Veterans. Health care programs include Health Care for Homeless Veterans—which provides outreach, case management, and residential treatment services with the aim of transitioning homeless Veterans from the street or institutions to stable housing—and the Homeless Patient Aligned Care Team program, which provides homeless Veterans with comprehensive, individualized medical care, mental health and substance abuse treatment, and case management services, among other services and supports. Together efforts such as these have contributed to a nearly 50% decline in homeless Veterans, from 74,087 in 2010 to 39,471 in 2016 (U.S. Government Accountability Office, 2016).

Findings, however, indicate that homelessness can complicate or prevent HCBS placement post-hospital discharge and that, as a consequence, homeless Veterans may be admitted to an NH or go without needed care in the community. Multiple chronic health conditions combined with comparatively high rates of mental illness and substance abuse disorders, poverty, and a lack of stable housing and social attachments make homeless Veterans especially challenging to serve. Further investment should thus be devoted to overcoming the fragmented, under-resourced infrastructure available for meeting homeless Veteran's post-hospital discharge needs within the community. Especially important is stronger integration and collaboration, both among VA homeless and HCBS programs and between the VA and community service providers (Hale, LaCoursiere-Zuccherro, Cragin, Briggs, & Kalp, 2016). Specific strategies to better care for chronically ill homeless Veterans after hospitalization include the provision of transitional housing at respite care centers capable of meeting Veteran's immediate postdischarge needs, followed by subsequent placement in longer-term supportive housing environments that offer the services necessary to keep them off the streets and out of hospitals and NHs (Kertesz et al., 2009; Sadowski, Kee, VanderWeele, & Buchanan, 2009). They also include provision of the case management services required to identify and place homeless Veterans in appropriate housing and to coordinate necessary medical, psychiatric, and social supports tailored to Veteran's particular needs and circumstances (Lamanna et al., 2018; Sadowski et al., 2009).

Limitations

There are several potential study limitations. First, we examined perceived barriers and facilitators to HCBS placement at 12 VAMCs, a subset of the 140 VAMCs within the VHA system in 2016. On the one hand, we believe our findings are transferable due to the diverse array of VAMCs studied and the common policy environment within which they operate (i.e., national office regulations and guidance governing extended care benefits, planning, and referral). On the other hand, there is local VAMC variability in the availability of programs, interpretation of policy, types of personnel, and reporting structure that may limit the generalizability of our conclusions. Second, bias may have been inherent in the combined purposive/snowball sampling approach used. Because there was no known sampling frame, potentially knowledgeable individuals may have been omitted. Consequently, our impressions may depend, in part, on the particular persons interviewed, although we are confident that we identified most key personnel. Third, this study took a hospital discharge planning perspective; as such, findings do not reflect community-based clinics, which may have different practices and norms around use of HCBS. Fourth, we did not interview Veterans, family members, or community service providers about their perceptions of barriers and facilitators to HCBS use, which may complement, reinforce or contradict the impressions of VA staff. Fifth, we focused exclusively on factors affecting extended care placement within the VHA; as such, caution should be taken when drawing lessons from our findings for the broader health sector.

Sixth, the VHA has undergone changes since we conducted our interviews, which may lessen the applicability of study findings to the current environment. Notably, the VD-HCBS program has grown in visibility as an innovative alternative to traditional agency-directed services, and the Veterans Choice Program has increased opportunities for Veterans to receive non-VA services within the community. The VD-HCBS, however, continues to enroll comparatively few Veterans annually and has yet to be implemented nationally, while the focus of the Veterans Choice Program has been on primary and specialty care and not extended care services. Together the limited size and geographic reach of VD-HCBS and exclusion of extended care from the Veterans Choice Program suggests that the basic array of agency-directed services available in 2012 continues to be the dominant mode of noninstitutional service delivery today. Moreover, it is likely that perceived challenges to HCBS placement identified by interviewees persist as no major alterations have taken place to VA rules around the hospital discharge process during the intervening time period.

Conclusion

This study examined barriers and facilitators to using HCBS within the VA across 12 VAMCs. Data derive from staff most familiar with each site's geriatrics and extended care referral process. As such, it documents challenges to HCBS placement from the vantage point of those working on the front lines to rebalance LTSS away from institutional to noninstitutional settings. Findings highlight the impact of patient-, provider-, and system-level constraints impeding successful community placement. Patient-level constraints arise from Veteran's care needs and resources, particularly with respect to housing and informal caregivers. Provider-level constraints stem from limitations in supply, especially with respect

to potential contracting agencies and staff. System-level constraints derive both internally, from prevailing budgetary imperatives, and externally, from the availability of supplemental community programs. Notably, these constraints vary across VAMCs and over time, thereby suggesting the need to develop strategies to promote rebalancing that account for each VAMC's unique circumstances. Consequently, further effort should be devoted both to developing and disseminating policies that enhance the likelihood of successful community placement and to determining how those policies might be modified and leveraged to achieve the most optimal outcomes possible in different contexts.

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Figure 1.

Number of VA Medical Centers with Veterans Receiving Care Through Geriatrics/Extended Care Programs, 2016 (N = 140).

VA = U.S. Department of Veterans Affairs.

Source: Geriatric and Extended Care Data Analysis Center.

Table 1.**Noninstitutional and Residential Care Options in the Veterans Health Administration.**

Adult Day Health Care: Therapeutically oriented ambulatory day programs through which an interdisciplinary team of providers offers health maintenance, rehabilitation, and supervision to patients in need of personal assistance, usually during daytime hours, Monday to Friday.

Home-Based Primary Care: Provides long-term, comprehensive, in-home primary care using an interdisciplinary provider team, focusing on Veterans otherwise at risk for nursing home placement, hospitalization, emergency room visits, or outpatient clinic utilization.

Homemaker and Home Health Aide Care: Personal care and related support services that enable frail or disabled Veterans to live at home. Home health aides assist with basic activities of daily living (i.e., bathing, dressing, eating, transferring, toileting). Homemakers assist with instrumental activities of daily living (e.g., light housekeeping, laundering, meal preparation, and grocery shopping).

Hospice and Palliative Care: Offer a continuum of comfort-oriented and supported services to Veterans with advanced life-limiting disease to achieve the best quality of life possible through comprehensive management of physical, psychological, emotional, social, and spiritual needs.

Respite Care: Seeks to enhance Veteran and caregiver quality of life by providing temporary relief to unpaid caregivers of chronically ill Veterans from routine caregiving tasks ranging from supervision to the maintenance of Veterans' personal and skilled care needs.

Skilled Home Care: In-home services that promote, preserve, or restore health through skilled nursing, physical therapy, occupational therapy, speech therapy, social work services, clinical assessment/reassessment, and/or education, monitoring, planning, treatment, referral, and follow-up.

Telehealth: Employs telehealth technologies, health informatics, and disease management to support noninstitutional care by providing ongoing monitoring, assessment, and coordination by VA staff, thereby helping to maintain Veterans at-home care and avoiding institutional placement.

Veteran-Directed Care: Offers a consumer-driven approach whereby Veterans and caregivers are given a flexible budget through which they assume greater choice and control over hiring their own personal care aides and deciding on and purchasing needed items and services.

Community Residential Care: A supportive housing program where Veterans reside and receive supervision in VA-approved group homes and VA staff provide case management and monitor care.

Medical Foster Homes/Adult Family Homes: Private homes in which trained caregivers provide care to Veterans with the medical foster homes also receiving services from a home-based primary care or other care team and adult family homes supplemented by VA care, if necessary.

Assisted Living Facilities: Provide care to Veterans in a group environment. The VA may pay for additional needed services.

Note. Adapted from Veterans Health Administration, 2006, 2015 and Department of VA, n.d.a.

VA = U.S. Department of Veterans Affairs.

Table 2.

Patients Receiving Services Through the VA's Geriatrics and Extended Care (GEC) Program, 2007, 2012, and 2016.

				% Change	% GEC
	2007	2012	2016	2007–2016	Users in 2016
Any GEC service	267,223	356,000	409,042	53.1%	—
Noninstitutional care					
Homemaker/home health (contract) ¹	30,130	65,929	105,329	249.6%	25.8%
Adult day health (VA)	2,253	2,471	3,395	50.7%	0.8%
Adult day health (contract)	4,896	8,833	10,171	107.7%	2.5%
Home respite (contract)	3,247	10,330	15,250	369.7%	3.7%
Home-based primary care (VA)	23,326	47,724	52,632	125.6%	12.9%
Purchased skilled home care (contract)	35,415	65,099	82,268	132.3%	20.1%
Hospice/palliative (VA)	4,329	24,560	33,075	664.0%	8.1%
Hospice/palliative (contract)	4,637	7,329	7,556	63.0%	1.8%
Veteran-directed care ²	—	—	1,395	—	0.3%
Institutional care					
Community living centers (VA)	45,050	44,057	42,552	−5.5%	10.4%
Hospice (VA)	8,609	13,417	15,335	78.1%	3.7%
Respite (VA)	4,446	3,882	3,559	−20.0%	0.9%
Community nursing homes (contract)	14,357	21,215	28,613	99.3%	7.0%
Hospice (contract)	688	2,097	3,425	397.8%	0.8%
Respite (contract)	610	1,524	2,853	367.7%	0.7%
State Veterans home (VA, state)	26,207	29,326	31,903	21.7%	7.8%
Residential care					
Community residential care (contract)	2,794	5,440	9,399	236.4%	2.3%
Medical foster homes (contract) ³	73	2,591	4,184	5631.5%	1.0%

¹ Includes Veteran-directed care and Program of All-Inclusive Care for the Elderly (PACE) through January 2015.

² Starting tracking separately in February 2015.

³ 2007 column reports 2008 data; use was 0 in 2007.

VA = U.S. Department of Veterans Affairs.

Source: Geriatric and Extended Care Data Analysis Center.

Table 3.**Major Themes Arising From Key Informant Interviews With Illustrative Quotes.**

Theme 1: Factors limiting the use of home- and community-based services (HCBS) options	
1.a. Care needs too great to manage at home	<p>“One of the reasons would be that the program won’t be enough to maintain the Veteran [at] home. That we feel the program will fail. That our providing x-number of hours of home health aide a day aren’t going to keep a Veteran who’s in bed 24 hours a day at home.” (Urban, Midwest)</p> <p>“The level of care, the number of hours of care or supervision that the patient’s going to require exceeds what could be done in the home. For example ... this gentleman needs more around-the-clock oversight, assistance with medications, [intravenous] therapy, things like that.” (Urban, East)</p>
1.b. Unpaid, informal care is critical for HCBS to work	<p>“We do have some patients ... who probably wouldn’t be able to stay in home if they didn’t have that caregiver there and twenty-four[-hour] monitoring and care.” (Highly rural, Midwest)</p> <p>“If [the VA] can only bring in 21 hours a week of home care, and the person doesn’t have the finances or any other resources or family to fill the gap, then it kind of starts ruling out that as an option.” (Rural, West)</p> <p>“Certainly a single Veteran, with no social support system that needs 24/7 care or monitoring of care ... is ruled out pretty quickly.” (Urban, South)</p>
1.c. Caregiver burden can compromise informal care provision	<p>“There are many times the caregiver has burned out, they’re up all times of night ... and their resources [are] maxed out.” (Highly rural, Midwest)</p> <p>“It might be unsafe behaviors related to dementia ... but generally it gets down to the urinary and bowel incontinence and the [ability to manage the] ambulation difficulties and transferring difficulties.” (Largely rural, Midwest)</p> <p>“If someone has skilled nursing needs that are beyond the capability of the family, then even though the family wants to provide the care ... then that’s just not feasible.” (Largely rural, Midwest)</p>
1.d. Homelessness can complicate/preclude HCBS placement	<p>“[Sometimes the reason home care is ruled out] is that they didn’t have a home to go to.” (Urban, South)</p> <p>“The difficult guys are the ones who don’t have a home. And caring for them in a homeless setting is very difficult, because they want those guys out of the beds in the daytime.” (Largely rural, West)</p>
1.e. Linking Veterans to non-VA services and supports	<p>“Are there any other support services? Are there any other family members? Does the Veteran have any private funds that can supplement what the VA is paying? Any state programs the Veteran might qualify [for] that in conjunction with VA service can maintain him at home?” (Urban, Midwest)</p> <p>“We will do home therapy referrals. People’s Medicare benefits, and then of course we do work in conjunction with the Department on Aging agencies, but, that’s Medicare/Medicaid, subsidized.” (Urban, Midwest)</p> <p>“Typically in terms of [HCBS] through Medicaid we give the information. I don’t know how often they follow up on it.” (Urban, West)</p>
1.f. Challenges linking Veterans to non-VA services and supports	<p>“We do try to link them up with non-VA resources that will provide quite a few more hours of in-home services but, you know, you have to meet the criteria for income, etc. And some of our vets don’t meet that.” (Urban, South)</p> <p>“We have a hard time getting people to apply for [Medicaid]. You have a population that doesn’t want handouts.” (Largely rural, Midwest)</p> <p>“The biggest barrier at times to people staying at home is people are hesitant to purchase services privately or they do not want to apply for the medical assistance programs because of concerns of depleting their assets.” (Largely rural, Midwest)</p> <p>“[Medicaid HCBS] were always looked at but in [this state] quite honestly Medicaid funding is extremely limited and there’s long waiting lists for Medicaid diversion programs.” (Urban, South)</p> <p>“The budgetary disaster that [our state] is experiencing ... has limited the area Agency on Aging services. ... We definitely can see a decrease in the state supports for keeping people at home[, which] is impacting some ... eventual outcomes for Veterans. No question about that.” (Urban, Midwest)</p>
Theme 2: Limitations in the supply of VA HCBS options	
2.a. Insufficient availability of VA providers poses a barrier to HCBS placement	<p>“I don’t think there’s enough. We would do better with having more home-based primary care in our [VA system].” (Urban, East)</p> <p>“We’ve had some areas ... that have more limited services ... I believe that’s probably been the case ... where ... they haven’t had the community resources in their areas that would keep them in home longer.” (Highly rural, Midwest)</p>

Theme 1: Factors limiting the use of home- and community-based services (HCBS) options

2.b. Level and type of staffing pose barriers to HCBS placement

“We may have a [home health] agency but they don’t have ... a speech therapist, and that’s what the Veteran needs. ... Or they have a physical therapist but that can only provide services twice a week and the Veteran needs five.” (Largely rural, West)

“Hours pretty much depend on what the home health agency can staff.” (Highly rural, Midwest)

2.c. Challenges providing HCBS in rural and urban areas

“Well, some Veterans pose too high [a] risk for nurses. We live in a metropolitan area and some of the areas are not good.” (Urban, Midwest)

“They’d have to drive hours to get to a place to then do the service. ... At one time that they [didn’t] get money for their drive. ... That really would deter an agency to accept a contract ... for a Veteran who lives out in the woods.” (Rural, West)

“Especially in a rural area our options are so limited. ... We have a whole section ... which we cannot get any home health or hospice to at all. So it’s not ever an option. ... It’s isolated and so no agency really services them.” (Largely rural, West)

Theme 3: Allocating resources to VA HCBS programs across VA medical centers
3.a. Budgetary pressures impact HCBS availability

“I ... could provide care to the 200 people on the waitlist ... but I just don’t have the money in the budget to do that.” (Urban, South)

“Nationwide there has been a push to cut back on the hours provided ... because there’s a finite pot of money.” (Urban, South)

3.b. Highly service-connected Veterans sometimes receive priority for HCBS

“If they’re priority 1 and [the discharge planners] say ‘Hey, it’s either this or the guy goes in a nursing home,’ then there’s not a waitlist. We’ll get them on the program.” (Urban, South)

“Some of the higher service-connected percentage Veteran[s] might get to the top of the waitlist for homemaker/home health aide services quicker whereas a non-service-connected Veteran’s going to take a year or more.” (Urban, South)

3.c. Establishing electronic waitlists for HCBS

“The short of it is we’re operating with limited resources. ... more people on the waitlist for [our homemaker/home health aide program] than we actually have people that are enrolled in it.” (Rural, West)

“There’s a waitlist for home-based primary care services but for home health care referrals ... there’s not a wait.” (Urban, West)

“[Home-based primary care] is a very popular program [with] a 3–5-month waitlist. If someone has had frequent hospitalizations or is more hospice-appropriate, then they can sometimes prioritize patients and admit them sooner.” (Urban, West)

“We haven’t found a need for a waitlist with any of them. ... We’ve pretty much always been able to arrange something, as long as there’s an agency within that catchment area that can pick them up.” (Highly rural, West)

3.d. Variation in decisions affecting the number of service hours and Veterans served

“In our network, the most people get for homemaker home health aide is 6 hours of care a week and we have Veterans in [another network who] could be getting 20 hours a week.” (Largely rural, West)

“You can either have 20 people getting 24/7 care or 200 people getting a couple hours a week so ... [we] lean ... towards the latter where we’d provide a couple of hours a day, three days a week, that way we can serve more Veterans.” (Urban, South)

“It depends on the condition. ... So if you’re a spinal cord injury or [multiple sclerosis] then you’re ... typically ... approved for more.” (Largely rural, Midwest)

3.e. Providing HCBS within a portion of the catchment area

“Well, anybody that lives within 30 miles of the medical center’s eligible for home-based primary care. But if they live 31 miles away, or 51 for a spinal cord injury, then that service is not available to them.” (Highly rural, Midwest)

“Our catchment area is large. If we have Veterans ... in [a distant town] there’s no way we could send a provider out there to spend an hour with a patient and drive 12 hours there and back. So that’s a significant barrier for home-based primary care.” (Largely rural, West)

“The big challenge is that the initial investment in terms of staffing and space and equipment is substantial. ... To actually expand out there we’d have to recruit and hire staff and get space and all that.” (Largely rural, West)

VA = U.S. Department of Veterans Affairs.