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Launching Medical Foster Home Programs: Key Components to Growing This Alternative to Nursing Home Placement

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Abstract

Objective: The objective of this research was to examine and explain elements that enhanced or thwarted program growth of the United States Veterans Health Administration Medical Foster Home program.

Methods: This qualitative study was conducted nationally through individual interviews over the phone and in-person ($n = 22$) with coordinators ($n = 15$ at slow-growth programs; $n = 6$ at fast-growth programs), program support assistants (PSAs) ($n = 1$ at slow-growth program), and home-based primary care team members ($n = 3$), as well as three in-person focus groups ($n = 28$ total participants) with home-based primary care team members. All participants ($N = 53$) were involved with programs in existence for at least two years.

Results: Facilitators and barriers that enhanced or thwarted program growth emerged around four themes: *A full-time coordinator; Unmitigated home-based primary care team engagement; Pursuit and receipt of appropriate referrals; and Match between caregiver, home, and Veteran.*

Conclusions: To facilitate program growth, program leaders should consider themes identified and how to foster situations and shape policies that put themes into practice.

Keywords

Veterans; aging; veterans health administration; nursing homes; adult foster care; qualitative methods

Introduction

There are approximately 9 million veterans in the United States over the age of 65 (U.S. Census Bureau, 2012) and a concomitant demand that the U.S. Veterans Health Administration (VHA) must provide for many of these aging veterans (Horgan, Taylor, & Wilensky, 1983; Kinosian, Stallard, & Wieland, 2007; Laberge, Weech-Maldonado,

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Johnson, Jia, & Dewald, 2008). Based on projections of veterans' increasing needs for long-term care (Geiling, Rosen, & Edwards, 2012; Kramer, Creekmur, Cote, & Saliba, 2015) for the VHA, expansion of home- and community-based long-term care services has been recommended (Kinosian et al., 2007). One such program is the VHA Medical Foster Home (MFH) program. VHA MFHs are for medically complex and disabled veterans who are unable to live alone and prefer to reside in a private home of a VHA-screened and approved 24-hour caregiver, rather than in a traditional nursing home setting (Edes, 2010; Levy et al., 2016; Levy, Jones, Haverhals, & Nowels, 2014; Manheim, Haverhals, Jones, & Levy, 2016). One goal of the MFH program is for veterans to remain in MFHs until end of life.

The MFH program has rapidly expanded from three programs in 2008 to 117 programs nationally by 2015 (U.S. Department of Veterans Affairs, Medical Foster Home Program, 2015). While the VHA's goal is to open programs at all main VHA facilities, program growth has varied considerably, with strong growth at some programs and slow growth at others. An evaluation of one MFH program (Levy et al., 2014) laid the groundwork for conducting a national, mixed-methods study of VHA MFHs, which included a specific focus on identifying factors contributing to variation in program growth.

Programs are led by coordinators at each VHA site who recruit both potential caregivers and veterans, and create a placement by matching veterans with caregivers in the right home. Coordinators collaborate with members of interdisciplinary VHA home-based primary care (HBPC) teams to enroll veterans in MFHs and place them with a caregiver in a caregiver's home in 95% of programs—the other 5% utilize Mental Health Intensive Care Management or Spinal Cord Injury programs—but for purposes of this article, HBPC collaboration is referenced. The coordinator and HBPC team screen caregivers and inspect caregivers' homes to verify appropriateness for veteran residence. The HBPC team provides medical care to veterans in MFHs and educates caregivers. The coordinator provides oversight and conducts at least one unannounced visit to every MFH monthly to monitor care in the home (VHA Handbook 1141.02, 2009). Caregivers generally have previous caregiving experience, as illustrated by a case study of experiences of families, caregivers, and HBPC providers in one MFH program (Manheim et al., 2016), and to date nearly 700 caregivers have been recruited to care for veterans in MFHs (U.S. Department of Veterans Affairs, Medical Foster Home Program, 2015).

Veterans pay privately to live in MFHs and costs vary depending on care requirements. Payment for MFHs is negotiated between the caregiver, the veteran, or the veteran's financial decision maker to determine the monthly cost the veteran will pay the caregiver. Based on their dates of military service and medical needs, veterans may apply for supplemental VHA funding to help cover costs of care in MFHs.

As veterans desire more home- and community-based care (Harris & Cooper, 2006; Shay & Schectman, 2010; Van Houtven, Oddone, & Weinberger, 2010), personalized care provided by HBPC teams has led to better health outcomes for veterans compared to traditional, institutionalized long-term care (Beales & Edes, 2009; Edes et al., 2014; Edwards, Prentice, Simon, & Pizer, 2014) and has been shown to reduce costs and rehospitalizations (Burke &

Coleman, 2013; Edes et al., 2014; Eric De Jonge et al., 2014; Kripalani, Theobald, Anctil, & Vasilevskis, 2014; Mor & Besdine, 2011; Naylor et al., 1999).

While MFHs are unique to the VHA, researchers have examined factors associated with program growth sustainability in alternative long-term care options outside the VHA that have similar aims of creating home-like environments. These include the Green House models of care, which began in 2003 and house 10 to 12 elderly residents in small homes with staff who coordinate care (Rabig, Thomas, Kane, Cutler, & McAlilly, 2006; Zimmerman et al., 2016). Recent mixed-methods studies have evaluated the Green House model (Miller, Mor, & Burgess, 2016), and while some outcomes such as hospital readmissions were lower (Zimmerman et al., 2016), researchers found that variation in implementation was substantial (Cohen et al., 2016) and expansion of the model was dependent on the degree to which staff were collaborative and skilled (Bowers, Nolet, & Jacobson, 2016). Additionally, researchers studying the Welcome Home model (Pomeroy et al., 2011) have found person-environment fit (P-E fit) to be an important consideration as residents are matched to a long-term care environment. In addition, the social ecological model (SEM) (Kumar et al., 2011; Quinn, Thompson, & Ott, 2005; Stokols, 1996) provided a theoretical foundation to describe the complex interplay between environment and other factors influencing “fit” within long-term care settings.

Theoretical framework

The social ecological model was also used by Levy et al. (2014) in the original pilot study and was similarly used to guide this study. The SEM suggests choices and outcomes may be affected by a wide range of environmental influences including interpersonal/mesosystem, intrapersonal/microsystem, community/exosystem, and organizational factors/macrosystem (Levy et al., 2014). Using the SEM as a guide, this study aimed to describe and explain the interplay of such factors within and between these environmental layers, and how they influence MFH program growth. Figure 1 illustrates a conceptual model of MFH environmental factors based on the SEM.

Study aims and research question

The aims of the present study were to examine and explain what factors enhance or thwart MFH program growth, particularly from the perspective of MFH coordinators and HBPC team members contrasting slow- and fast-growth programs. As the need for more long-term care options for veterans generally (Kinosian et al., 2007) and the desire for more personalized care specifically (Edes et al., 2014; Kramer et al., 2015) increase, it was deemed important to pinpoint factors affecting expansion of national MFH programs to better position veterans to access the resources they need, deserve, and desire for those delivering their care. Thus, understanding variation in growth was crucial in order to gather data with hopes to facilitate MFH program development and inform VHA MFH and long-term care policies. This study is one of the only research efforts to study in-depth opinions of those providing personalized care in MFH programs nationally.

The research in this study is one part of a national, mixed-methods study designed to answer the question: *Is MFH a safe, cost-effective substitute to nursing home care for eligible*

veterans? Aims of the larger study assessed adverse events, costs, and physical health of veterans in nursing homes compared to MFHs through propensity matching as well as collection of Minimum Data Set (MDS) data from MFH veterans. Additionally, the larger study aimed to identify barriers and facilitators to program growth through in-depth interviews and focus groups with HBPC staff, MFH coordinators, veterans, family members, and MFH caregivers.

Method

A sequential, exploratory design was used to identify a sample based on maximum variation (Polkinghorne, 2005). The study consisted of three phases: (1) telephone interviews with coordinators at slow-growth programs; (2) in-person key stake-holder interviews and focus group interviews with HBPC teams at slow-growth programs; and (3) telephone interviews with coordinators at fast-growth programs. This design allowed emergent analytic themes from interviews with slow-growth coordinators to influence and direct purposeful selection of site visits of context-rich variation (Fortune, Reid, & Miller, 2013; Hesse-Biber & Leavy, 2010). The research team drew on perspectives of those providing MFH services at the individual and group level, and later identified the need to obtain a clearer sense of programs with faster growth (see Figure 2).

Sample

Maximum variation sampling (Miles & Huberman, 1994; Polkinghorne, 2005) was used to identify programs that were slow- and fast-growth. Slow-growth programs had been in existence for at least two years and had fewer than 10 veterans enrolled during that time. There were 100 programs at the beginning of the study period, with 52 existing for over two years. Twenty-two programs had fewer than 10 veterans, with five closing and one used for a pilot interview, leaving 16 eligible for inclusion. The two national MFH coordinators e-mailed invitations to coordinators from the 16 eligible programs. Fifteen coordinators (all social workers) and one program support assistant agreed to be interviewed by phone from 14 programs. The remaining two coordinators did not respond to invitations.

Fast-growth programs had 18 or more veterans enrolled after two years of starting. There were seven coordinators identified and invited to participate in a telephone interview. Of those (all social workers), six agreed to be interviewed. All interviews were conducted by telephone.

Programs were purposively selected for site visits by the research team considered the following factors: current viability of the program; diversity in location and perceived rurality; and specific cultural diversity identified by coordinators. The research team contacted programs to determine willingness to participate in site visits. From the three site visits, 28 HBPC team members participated in three focus groups ($n = 9$; $n = 10$; $n = 9$), and three HBPC team members were interviewed, two in-person and one on the phone, as they could not attend focus groups.

In total, 53 participants contributed to the data analyzed. All participants agreed to participate in the study voluntarily, and there were no incentives provided to participants.

Both phone interviews and in-person focus groups were necessary to capture a more complete picture of factors influencing growth of MFH programs. Focus groups with HBPC team members were ideal because they work as an interdisciplinary unit and for practicality reasons. Site visits were also conducted at three larger MFH programs, and data from those visits will be presented in future manuscripts. The study was approved by the national VHA Central Institutional Review Board (CIRB #12–31). All research team members are VHA-credentialed and approved to conduct research both on site and over the phone. All participants were assured of confidentiality and precautions were taken to assure confidentiality in the manuscript.

Qualitative data collection

Site visits were conducted by four members of the VHA research team: a physician with board certification in geriatrics and palliative care; a doctoral-prepared senior qualitative nurse researcher; a social worker; and a master's-level communication and health research specialist. The combination of varied disciplinary perspectives was a significant strength that added depth to in-field qualitative data collection and analysis. Rapport with the local coordinators and meticulous site-visit planning ensured ability to access appropriate key stakeholders during one-to-two day site visits. Ninety-minute focus group interviews were conducted with HBPC teams who provided written consent to be recorded; written consent for study participation was not required by the VHA Central Institutional Review Board. Focus group interviews were guided by a semi-structured interview script. All interview data were digitally recorded.

Semi-structured individual interviews with coordinators at slow-growth programs were conducted by telephone by two members of the research team and overseen by two members of the team with extensive experience in qualitative interviewing. This strategy ensured that questions were prepared in advance regarding anticipated themes and captured unique characteristics of individuals' experiences. Interviews ranged from 22 to 76 minutes (mean duration = 45 minutes). Participants agreed to verbally consent by phone; a waiver for written documentation of consent had been previously approved by the VHA Central Institutional Review Board. Interview guides were refined iteratively by the research team through consensus as is common with qualitative methods (Creswell, 2014; Hesse-Biber & Leavy, 2010).

Following interviews with coordinators at slow-growth programs and site visits, the research team perceived a gap in knowledge from perspectives of coordinators at faster-growth programs in their first two years of existence. The study protocol was amended to include these participants, and semi-structured individual interviews with coordinators at fast-growth programs were conducted by telephone by two members of the research team using the same semi-structured interview guide as slow-growth programs. Table 1 and Table 2 illustrate comparisons between slow- and fast-growth programs.

Qualitative data analysis

A team-based, general inductive approach to theme analysis was used that employed a dynamic and iterative interplay of inductive and deductive analytic strategies (Jones,

Nowels, Sudore, Ahluwalia, & Bekelman, 2015; Morgan, 2010; Patton, 2014). A priori codes based on interview guides and an earlier MFH study were created (Levy et al., 2014) and as interviews were analyzed line-by-line, additional in vivo codes emerged. Team members also used memos to note their observations while coding the data. Through this process themes materialized and were identified by the team using inductive and deductive reasoning. This approach commenced at the first interview and was ongoing throughout all phases of data collection. A series of team meetings and discussions resulted in the formulation of a team coding schema comprised of both types of codes. Application of vertical (in-depth within individual interviews) and horizontal (across slow- versus fast-growth programs) theme analysis was conducted. Interviews were transcribed verbatim by a professional transcription service and analyzed separately by three members of the research team using Archive for Technology, Lifeworld and Everyday Language, text interpretation V7.5.2 data management software (Atlas.ti Version 7.5.2, 2014).

Results

This study resulted in approximately 650 pages of text data (transcripts and field notes) from across the three phases of the study. Four themes were identified that enhanced or, if absent, thwarted program growth: (a) a full-time MFH coordinator; (b) unmitigated HBPC team engagement; (c) pursuit and receipt of appropriate referrals; and (d) match between caregiver, home, and veteran. Together these themes relate in order to describe contextual factors that influenced the pace and magnitude of program growth.

Full-time MFH coordinator

Participants stated their ultimate goal was successful placement of an appropriate veteran with a compassionate and capable caregiver. In order to accomplish this goal, coordinators stated they had to complete many tasks: recruiting and screening potential caregivers; facilitating a multidisciplinary team to inspect and approve caregivers' homes; educating VHA providers, social workers, veterans, and families about MFHs as an option for long-term care; and engaging medical center leadership to support the program. They pursued referrals of veterans into the program, worked closely with the HBPC team to encourage program adoption, addressed issues of medical monitoring in MFHs, and interpreted VHA benefits to help secure payment. Coordinators also addressed issues once veterans were placed in MFHs, all while working within local VHA policy, state licensure requirements, and national VHA regulations. To balance these duties, the national MFH handbook states: "An experienced senior level social worker is recommended due to the complex nature of this position" (VHA Handbook 1141.02, 2009, p. 7). Therefore, the coordinator managed demands of families and veterans navigating the MFH placement, HBPC team members delivering and coordinating veteran care, VHA leadership expecting to see program success, and caregivers needing support and feedback. Further, coordinators managed the supply of qualified and available caregivers with appropriate and accessible MFHs.

Based on the complexity of serving as a coordinator, full-time positions proved crucial to pace of growth in the programs studied. Coordinators described a willingness to devote themselves to their roles and to growing programs; however, at slow-growth programs,

uncertainty regarding funding proved problematic. The national VHA incents local VHA facilities to initiate programs by providing the salary for the coordinator for a two-year start-up period with the expectation that the program will become financially self-sustaining after that time. Some coordinators at slow-growth programs described concern among local leadership that the program would not become self-sustaining, and as a result after the first year coordinators were saddled with additional responsibilities or their jobs were reduced to part-time and combined with additional, unrelated positions. One coordinator who had three full-time positions without a program support assistant said, “Lack of growth, in this program, is a result of me also being a coordinator for these other two programs” (slow-growth coordinator). Participants at several slow-growth programs reported MFH coordinator vacancies for over a year. For example, at some slow-growth programs, an MFH coordinator may have started the program but then left the position, and during the time the position remained vacant, the program dissolved. By the time a new coordinator was hired, little to none of the program structure remained, and the new coordinator was essentially rebuilding the MFH program from scratch. One noted, “It ended up being about a year and a half to two years that it was vacant” (slow-growth coordinator). In such cases, local leadership needed to agree to re-fund the position. Together, these restrictions and/or limited availability of resources thwarted program growth given the pivotal role of the coordinator despite identical resource allocation in start-up funds from VHA Central Office.

In contrast, fast-growth coordinators who were interviewed devoted 90% to 100% of their time to building and maintaining programs, and most had worked in the VHA system for shorter periods of time (0 to 3 years) compared to slow-growth coordinators. Because of their shorter tenure at the VHA, fast-growth coordinators seemed less likely to be saddled with collateral duties compared to slow-growth coordinators who may have transferred from another VHA position. Also, participants at fast-growth programs felt leadership support was strong compared to that of slow-growth programs. The combination of a full-time coordinator and leadership support led to coordinators at fast-growth programs being highly motivated, while those at slow-growth programs reported frustration in the absence of these factors. Fast-growth coordinators were also able to dedicate increased time to fostering interpersonal relationships between veterans, families, caregivers, and HBPC team members, which led to increased program growth.

Unmitigated HBPC team engagement

Those interviewed stated that support from HBPC teams was essential for program growth. HBPC teams provide medical care to veterans in MFHs, and caregivers can call HBPC teams with questions and concerns. This led to perceptions of stronger personalized care coordination and cohesive case management amongst HBPC team members who often facilitated MFH referrals:

I thought it [Medical Foster Home program] was great, a huge focus of home-based [care] is to keep people out of the nursing [home], out of the hospital, in the home environment.

(HBPC nurse practitioner)

Open communication between caregivers and HBPC was reported as a strength, which coordinators felt helped prevent hospitalizations. In turn, HBPC team members interviewed thought veterans received higher quality care with the addition of a dedicated caregiver, which led them to lend more support for program growth:

I found the [MFH] caregiver is always there for the visit as opposed to some of my other patients, family members. And actually taking notes, she checks, she makes sure he does the blood pressure and all of this, she keeps a log.

(HBPC registered nurse)

Another participant attributed program success to rolling out HBPC and MFH programs concurrently, with an increased focus on joint patient management:

I think because we're really working with the home-based primary care team, the medical director, and the clinic coordinator for home-based primary care that we kind of all shared the common goal of wanting the program to be successful.

(fast-growth coordinator)

However, a challenge that arose regularly was the HBPC team's caseload. One coordinator explained it this way: "The HBPC has to have an opening; if they don't have an opening that veteran cannot be admitted into the Medical Foster Home Program" (slow-growth coordinator). Therefore, some coordinators shared that combining MFH programs with existing HBPC programs created problems, as HBPC teams felt their loads were already too big, causing issues or delays during start-up phases. One participant made the following suggestion:

I hope this program could develop and have its own medical home-based team. Coordinating with HBPC is not easy. It takes so much of a toll on coordinators ... So if we had our medical team for Medical Foster Home it would be great.

(fast-growth coordinator)

Another noted:

In the places where HBPC and the Medical Foster Home are aligned together, I think those people [fast-growth] have a better time [growing the program] than mine where ... I'm under social work and HBPC is under primary care.

(slow-growth coordinator)

Pursuit and receipt of appropriate veteran referrals

HBPC support positively correlated with increased MFH growth, facilitating appropriate veteran referrals to MFHs. However, participants from all programs interviewed shared that obtaining appropriate veteran referrals still proved challenging even with HBPC support, and agreed that increasing awareness of MFH programs was difficult. While coordinators worked diligently to spread the word to providers in and outside of the VHA about MFHs, coordinators reported that in the majority of cases providers often still did not have the program on their radar. When referrals did reach coordinators, many did not result in a successful veteran placement in an MFH: "The concept of medical foster homes for some is a bit over their head, that's one. And then two ... getting the veteran to part their ways with

their income to pay for care is another challenge” (slow-growth coordinator). Participants also reported the MFH concept was difficult for veterans and families to comprehend, as it is a nontraditional form of long-term care or veterans never considered leaving their homes. To curb misunderstandings and facilitate growth, efforts by coordinators to educate veterans, providers, and families about appropriate referrals to the program were critical. One coordinator described:

You need to have a coordinator who really wants to get out and really market and that is, some of that you can't really learn ... in some ways that's sort of a gift or talent that you can't really just snap your fingers, and some already have [that talent].

(slow-growth coordinator)

This need for marketing and outreach skills was echoed in all interviews with fast-growth coordinators. One noted, despite having a background in marketing and public relations, challenges were still experienced:

Most of my challenges were in the VA ... I have encountered many of these experiences [coordinating marketing and public relations efforts] so I was pretty confident about many things. Unfortunately, in the VA people weren't used to seeing someone being so enthusiastic about making something happen.

(fast-growth coordinator)

Marketing efforts mentioned by coordinators included mailings to churches and community groups and newspaper, radio, and television advertisements. These efforts added to the complexity of their jobs and forced them to be creative. One coordinator shared, “I will ask the local newspapers or TV stations to do an article or some sort of a report on where we are at with the medical foster homes, and that definitely is helpful” (slow-growth coordinator). Another who lived in a community where most homes were multistory walked around neighborhoods with one-story homes and placed flyers in mailboxes. Coordinators also worked with local VHA public relations departments, but stated challenges:

There is so much more I could be doing and I, even in our own VA facility, I can't even put flyers up without, we have six elevators and they put one flyer in one of the elevators. I want them in all six. Just to have that freedom of marketing, how and where I'd like to market [would be helpful].

(slow-growth coordinator)

Providers also often made assumptions that veterans could not afford the program as they knew veterans paid out of pocket, and so the providers did not make referrals at all. One said, “When you know that [potential veteran] doesn't have the money ... you're not going to make that referral” (HBPC nurse practitioner). Coordinators described this reasoning as inappropriate because they had the means to assist veterans in applying for benefits to subsidize the costs of MFHs.

Participants reported that sometimes families and veterans are reluctant to choose an MFH because it may influence their finances, particularly in cases where the veteran's income may be subsidizing the veteran's family's income. One coordinator shared, “[The family]

still won't want their veteran to go into a medical foster home because of the money situation. So now they have a barrier ... because the family is getting their money so they can't lose that income" (fast-growth coordinator). This was reiterated by another coordinator regarding veterans' reluctance to pay for MFHs:

Our veterans believe that the VA should pay for almost everything they receive. It kind of puts us in a different position so we have a very limited number of patients who would actually qualify as well as who can afford to pay for the service.

(slow-growth coordinator)

Another factor that thwarted appropriate Veteran referrals at slow-growth programs was inability to be nimble at the time of hospital discharge. When veterans are eligible for a rehabilitation stay under the Medicare Skilled Nursing Facility benefit (U.S. Department of Health and Human Services, 2015), it is a more rapid path to discharge than to place in an MFH; MFH placement requires a more detailed enrollment process to match veterans with caregivers, resulting in a missed opportunity during this critical care transition window. Despite this fact, most participants noted when providers were familiar with the program, they mentioned MFHs as an option. Thus, while some veterans transitioned first to a nursing home, the MFH search process also began. One coordinator at a fast-growth program said, "Most of my veterans actually came from inpatient and from family members who have heard of the program" (fast-growth coordinator).

Fostering alignment: Right caregiver, right home, right veteran

Participants shared that when referral challenges mentioned above were cleared (i.e., providers referred veterans to MFHs with HBPC support), program growth increased, regardless of slow- or fast-growth status. Participants mentioned HBPC team members often had cared for veterans for many years and built strong relationships with veterans and families. One participant had cared for a veteran in HBPC for 10 years and then referred him to an MFH: "He really did not want to try it [MFH] but he did go and he loved it. The lady [caregiver] treated him like part of the family" (HBPC nurse practitioner). Participants noted that once veterans were placed into MFHs, it could make a tremendous difference in their and their caregivers' lives, and coordinators used success stories to promote growth. For example:

You know, rarely in our job in home-based primary care do we see an improvement, we have the sickest people ... it was a good day to see that [he was placed in an MFH] and [it was] a good life for him, much better. He has somebody who cares about him ... he was a real loner so now he has this relationship.

(HBPC physician assistant)

Thus, alignment between caregiver, home, and veteran led to successful placement of veterans in MFHs and ultimately to program growth. This fit was a key to program growth:

I think I like most seeing when we find a really good fit.... I really enjoy seeing the end result of all of the hard work leading up to the placement.

(slow-growth coordinator)

Right caregiver

While slow-growth coordinators were optimistic when a match was reached, achieving alignment was still a challenge. Recruiting and screening caregivers were often cited as the most important coordinator roles. Coordinators reported receiving many initial calls from potential caregivers, but often once caregivers learned the level of care veterans required, the majority declined to pursue the job. Coordinators repeatedly mentioned the importance of determining potential caregivers' motivations: "I want to hear that I [potential MFH caregiver] love taking care of people and I actually hear those words from the caregivers" (slow-growth coordinator). Participants said the right caregivers are comfortable opening their homes and caring for veterans who often require intense nursing home-level care: "It's just finding the right caregiver with the right homes, in the right area" (slow-growth coordinator).

Right home

Thus potential caregivers must also have the right home to accommodate veterans. HBPC teams visit MFHs immediately after a veteran moves in to review medications and observe how veteran and caregiver adapt. Minor modifications may be made to MFHs, such as grab bars in bathrooms or railings on stairs. Homes must have wired smoke detectors and security systems in place, which caregivers install and maintain at their own expense. One HBPC team member shared that a safety benefit of having a security system in place was that "all the homes have [a security system] so they [veterans] can't just walk out and just disappear. And every time the door opens it will let you know that somebody is coming in or coming out" (HBPC physical therapist). Participants believed homes with such accommodations made veterans and families feel safer when considering MFHs, and fast-growth coordinators stressed in-person visits by veterans and/or families were key to successful placements.

Multistory homes were more common in some parts of the country, and locating wheelchair-accessible homes for veterans was the major focus of MFH recruitment efforts. Thus review and consideration of appropriate homes was reported as a time-intensive and detailed process for coordinators and varied geographically. For example, one slow-growth coordinator said some caregivers viewed stairs as an opportunity for enhancing and maintaining veterans' mobility rather than acting as a hindrance.

Right veteran

Screening veterans must also fall into place to complete the right caregiver, home, and veteran triad. Participants used varied approaches to screening veterans, and HBPC's level of participation also varied at slow- and fast-growth programs, but coordinators were always the initial screener. One shared this challenge with screening veterans:

It's very confusing when you're told that the [HBPC] nurse practitioners cannot screen individuals who are in existing nursing homes or assisted living facilities or in hospitals. So how are we gonna get this person in the program? Where are they supposed to stay at in the meantime?

(slow-growth coordinator)

Further, many coordinators at slow- and fast-growth programs believed HBPC veteran admission criteria were restrictive:

I think my biggest resistance was HBPC because they were used to taking a certain type of patient and the threshold for medical foster home is very different. HBPC had to review their own regulations together with medical foster home regulations to make sure that they weren't disqualifying patients when they actually were a fit for HBPC ... There is just a whole education process, a lot of friction and finally some consensus.

(fast-growth coordinator)

Once the caregiver, home, and veteran were matched, coordinators spoke of how caregivers saw veterans as members of their family, and vice versa. This sometimes led to caregivers housing the maximum of three veterans and once a veteran died, the caregivers often placed a new veteran in their home. While not all placements lasted, the majority of participants spoke of the positive relationship between caregivers and veterans. One noted about a veteran, "He has a place where he fits in ... when your heart is happy, everything else falls into place" (HBPC registered nurse).

Discussion

This qualitative study is the first to describe factors influencing pace of growth of VHA MFH programs from the perspectives of MFH coordinators and HBPC team members caring for veterans in MFHs. Findings from this study showed four themes that influence fast or slow growth. These include the following, which, if present, enhanced program enrollment and, if absent, stalled growth: (1) a full-time MFH coordinator; (2) unmitigated HBPC team engagement; (3) pursuit and receipt of appropriate referrals; and (4) fostering alignment: right caregiver, right home, right veteran.

Challenges to delivering high-quality, long-term care options for the elderly have been identified in previous literature by Huskamp, Kaufmann, and Stevenson (2012), who conducted a literature review of 69 articles covering two decades (1980–2010) on end-of-life and long-term care in the United States. Their findings identified several delivery-system barriers to receipt of adequate long-term care, including lack of staff training, communication gaps, issues with joint patient management, challenges in transitions across care settings, and drawbacks in physical environments (i.e., crowded, nonprivate nursing home settings). Findings from the current study, guided by the social ecological model, highlight unique environmental factors of the newer, personalized MFH model of care and add to the literature with its focus on noninstitutionalized settings for long-term care. Describing these factors influencing MFH growth using the social ecological model as a guide shows promise to overcome long-term care delivery challenges.

Findings from this study suggested that coordinators in particular play an integral role in successful growth of MFH programs. Coordinators, who are all trained social workers, are key to implementation and maintenance of programs through creating solid interpersonal relationships, (the mesosystem level in the SEM) with all parties involved in MFH placement and care coordination processes; they must facilitate communication between

HBPC team members, caregivers, and family members. Despite this fact, many coordinators at slow-growth programs had to take on multiple collateral duties which did not allow them to fully dedicate time to expand programs, focus adequate attention on retention of current exceptional caregivers and ensure ongoing training for them, or encourage appropriate referrals of veterans from VHA providers and community referral sources. In reference to the SEM, these factors caused growth to be thwarted on both an exosystem/community level and a macrosystem/organizational level. Further, this study found coordinators' appointments are only funded for a limited start-up period, after which programs are expected to self-sustain. This left smaller programs vulnerable to continued slow growth and potential loss of coordinators with adequate social work experience, weakening the macrosystem/organizational level of these MFH programs.

Leadership from coordinators was imperative as recruitment and vetting of potential caregivers are fundamental roles served by coordinators and essential factors in maintaining program integrity. Despite the fact that it takes concerted effort to recruit and retain quality caregivers, coordinators shared that recruiting and working with the right caregivers were among the most rewarding parts of the program and process. Coordinators took great pride in executing the match between caregiver, veteran, and home, particularly because the home-like environments of MFHs are so desirable to veterans and their families. However, coordinators who had multiple collateral duties did not have time to hone their skills to screen care-givers, potentially causing turnover and hindering growth. In turn, inability to fully recruit the highest caliber caregivers hindered the ability of coordinators to find the correct match between caregiver, home, and veteran, despite the fact that such personalized care has been shown to improve health status (Edes et al., 2014) and be desirable to aging veterans (Harris & Cooper, 2006; Shay & Schectman, 2010; Van Houtven et al., 2010).

As supported by prior research conducted in the VHA (Donahue Baldwin, 1994), this research showed the importance of appropriate referrals from providers and HBPC in order for MFH programs to grow. At fast-growth programs, MFH programs were often embedded within the HBPC programs, allowing for increased ease of joint patient management and communication flow between coordinators and HBPC team members, which extended to positive experiences for caregivers in MFHs and thus improved care coordination. Additionally, while coordinators are knowledgeable about VHA eligibility criteria necessary to receive additional benefits that could be used to pay for care in MFHs, if providers do not make initial referrals, funds cannot be procured. However, at fast-growth programs where interpersonal relationships were stronger between HBPC, coordinators, and caregivers, program growth was facilitated through smoother transitions to MFHs where veterans were often happier due to the home-like environment and personalized care. Further, to obtain buy-in of veterans and families and to instill a sense of place for the veteran, visiting caregivers in MFHs was crucial for deciding to live there, particularly if the veteran liked the physical feel of the MFH and if the MFH was in relatively close proximity to the veteran's family. Thus, such cohesive factors at fast-growth programs led to stronger microsystem/intrapersonal experiences for the veterans as well as solid mesosystem/interpersonal relationships. Finally, along with their many other duties, coordinators must conduct ongoing outreach and education efforts to raise awareness about MFHs, which proved time-intensive and challenging. Again, however, if the interpersonal (relationships with all major

players) and intrapersonal (veteran felt a strong sense of place) environmental factors were solid, this positively influenced organizational factors, thus increasing MFH growth rates.

Most HBPC team members interviewed strongly supported expansion of MFH programs, but also noted that newly enrolled veterans contributed, in some cases, to an already strenuous workload. This tempered their enthusiasm for the program and potentially led to strained relationships between HBPC and coordinators. To realize program growth, MFHs cannot simply be added to HBPC. Integration of programs is essential with forethought to adjusting caseloads, approaches to screening for new referrals, and thoughtful interdisciplinary team management. A continued focus on joint team management can potentially strengthen organizational factors contributing to increased growth and improved care coordination between HBPC team members and MFH caregivers.

Strengths and limitations of the study

This study represents an attempt to explain factors that enhanced or thwarted growth of the VHA MFH program nationally from perspectives of individuals coordinating and providing care in slow-and fast-growth MFHs. Findings presented can help inform implementation strategies for other MFH coordinators, providers, VHA leadership, and policy makers in developing adult foster care programs. Further, successful MFH programs with strong care coordination with HBPC can serve as examples to other types of long-term care services outside of the VHA in terms of appropriate delivery of long-term care. While the study presented here is not comprehensive of all experiences with VHA MFHs, other manuscripts are in progress focusing more specifically on the match between the veteran and caregiver from the perspective of veterans, caregivers, and families from three large MFH programs who took part in the larger MFH study. Finally, future research that focuses on interviewing providers who are referral sources of veterans to MFHs, particularly when veterans may be transitioning from one care setting to another, as well as local facility leadership may provide additional perspectives on other factors influencing MFH program growth.

While the results of this study are not intended to be generalizable, the study design included interviews with a diverse geographic range of coordinators and HBPC teams at 14 slow-growth and six fast-growth programs to provide a more thorough summary of the nature of program growth nationally. However, using a descriptive design, it is noted that the participants studied here represent a snapshot of the landscape of MFH programs nationally, and analyses are kept within these boundaries. In turn, having multiple research team members independently conduct and review the analysis increases trustworthiness of the findings. Also, while all participants who agreed to be interviewed were eager to share their experiences, particularly about struggles with program growth, it is possible they may have withheld some criticisms, which is a limitation of this study. Considering this is the first in-depth research of its kind of elements influencing MFH growth, it offers important insight into factors to consider in fostering MFH programs in the VHA.

Conclusions

The VHA MFH program provides an alternative for eligible veterans to live in a private home receiving 24-hour individualized care in lieu of traditional, institutionalized nursing

home care. MFH program growth is enhanced if interpersonal relationships between MFH coordinators and the other stakeholders—HBPC providers, VHA leadership, caregivers, veterans, and families—are strong. MFH coordinators must manage demands of these parties with the supply of high-quality caregivers and appropriate MFHs. Strong interpersonal relationships mediated by the MFH coordinators lead to improved and stronger organizational factors, which lead to positive MFH program growth, and most importantly, alignment of the right caregiver and right veteran in the right home.

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Figure 1.
Conceptual Model of Medical Foster Home Environmental Factors.

Figure 2.
Sequence of data collection for medical foster home (MFH) study.

Table 1.

Slow-growth medical foster home (MFH) participants interviewed.

MFH Slow-Growth Site ID	Percentage of Coordinators' Time Allotted to MFH Program	Coordinators' Number of Years With VA	Original or Replacement Coordinator & Length of Time Between Coordinators	Percentage of Program Support Assistant's (PSA) Dedicated Time	Active Homes 2 Years From Program Start ^a	Cumulative Veterans Enrolled in the MFH Program at 2-Year Mark ^a
1Sa	100%	3–6 years	Original	30%	3–4	4–6
1Sb	100%	> 10 years	Replacement: During first 6 months as MFH coordinator had to also cover former VA position	30%	3–4	4–6
2S	33%	3–6 years	Replacement: Original was 100%. When original left, the replacement had 2 other permanent VA positions (3 jobs)	No PSA	1–2	4–6
3S	<i>n/a</i>	> 10 years	Interim: Replacement to be hired at 100%; interim coordinator in place for 9 months at time of interview	100%	3–4	7–9
4S	100%	6–10 years	Original: Note that for 6 months prior to becoming full-time coordinator was 50% while covering another program	10%	1–2	1–3
5S	10%	> 10 years	Original: Had been 100% for 2 years, then became HBPC program director and became 10% MFH	25%	3–4	1–3
6S	100%	6–10 years	Replacement: Position was open for over 2 years between coordinators	50%	1–2	1–3
7S	90%	> 10 years	Replacement: Position was unfilled for over 6 months	50%	1–2	7–9
8S	50%	6–10 years	Replacement	50%	0	0
9S	85%	6–10 years	Original	100%	5–6	1–3
10S	15%	3–6 years	Replacement: Took over from a coordinator that was 100%	50%	1–2	1–3
11S	33%	6–10 years	Original: Always 33% time	No PSA	1–2	1–3
12S	100%	3–6 years	Original: First 3 years of the program 50%; became 100% 2 months before interview	No PSA	3–4	7–9
13S	50%	0–3 years	Original	50%	3–4	1–3
14S	50%	3–6 years	Original	50%	1–2	1–3

Note.

^aRanges used to preserve anonymity.

Table 2.

Fast-growth medical foster home (MFH) participants interviewed.

MFH Fast-Growth Site ID	Percentage of Coordinators' Time Allotted to MFH Program	Coordinators' Years With VA	Original or Replacement Coordinator & Length of Time Between Coordinators	Percentage of Program Support Assistant's (PSA) Dedicated Time	Active Homes 2 Years From Program Start ^a	Cumulative Veterans Enrolled in the MFH Program at 2-Year Mark ^a
1F	90%	0–3 years	Replacement: No gap between coordinators	50%	7–8	19–21
2F	100%	0–3 years	Original	100%	9–10	25–27
3F	100%	0–3 years	Original	No PSA	9–10	25–27
4F ^b	100%	0–3 years	Original	25%	13–14	71–75
5F	100%	0–3 years	Original	No PSA	9–10	19–21
6F	100%	0–3 years	Original	No PSA	5–6	25–27

Note.

^a Ranges used to preserve anonymity.^b This program was developed by incorporating a large neighboring program, which is why numbers are considerably higher than the other five sites.