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Fostering Excellence: An Examination of High-Enrollment VHA Medical Foster Home Programs

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Abstract

This qualitative study aimed to assist the US Veterans Health Administration (VHA) to efficiently target recruitment into VHA Medical Foster Homes (MFHs) by understanding how high-enrollment MFH (HE-MFH) program attributes optimized MFH enrollment. We used an emergent exploratory design to study 3 HE-MFH programs across the United States. Data were collected from August 2013 through June 2014 through individual in-person and phone interviews and in-person focus group discussions with 39 MFH care providers. Three main themes emerged as essential for optimizing HE-MFH program enrollment: (1) alignment of right caregiver, right home, and right Veteran; (2) care practices that support caregiver, Veteran, and home-based primary care (HBPC); and (3) workplace practices and processes that demonstrate support of the MFH coordinator role by facility leadership and the HBPC team.

Keywords

caregivers; long-term care; Veterans; program development; aging; adult foster care; community dwelling

Introduction and Background

The US Veterans Health Administration (VHA) has seen significant growth, and anticipates continued growth, for older Veterans who require supportive long-term care services.¹ New models for long-term care in the community have emerged in recent years as policy is framed by a desire for aging in place and more individualized care.^{2–4} In particular, most of the projected increase in long-term care will be provided by home and community-based services.⁵

The VHA Medical Foster Home (MFH) program launched nationally in 2008⁶ and serves as an alternative to nursing home care for Veterans who meet requirements for nursing home–

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level care. Veterans reside in private homes of 24-hour caregivers, who are recruited and screened by VHA MFH program coordinators. While MFH caregivers are not VHA employees, all personal care for Veterans is provided by the MFH caregivers, who contract with the Veterans and/or Veterans' families for monthly payment. Occasionally, caregivers are supported by privately employed aides, including certified nursing assistants.^{2-4,7} Each MFH accommodates a maximum of 3 care recipients. The program was successfully piloted in 2001 in Little Rock, Arkansas, and expanded to the "Support at Home- Where Heroes Meet Angels" initiative in 2008. As per correspondence with the National Program Director of the Medical Foster Home Program of the Department of Veterans Affairs, D. Goedken, LICSW (e-mail communication, May 2017), there are over 123 MFH programs in 45 states, which have served over 4,000 Veterans.

In MFHs, in-home medical care is primarily provided to MFH Veterans by the VHA's interdisciplinary home-based primary care (HBPC) teams. Each team consists of physicians, registered nurse (RN) case managers, nurse practitioners, social workers, psychologists, dietitians, rehabilitation therapists, and pharmacists.⁸ Research has shown VHA HBPC is an effective model providing long-term care services to homebound Veterans who have serious chronic diseases and disabling conditions, improving health care access and outcomes,⁹ and achieving high patient satisfaction while reducing medical exacerbations, emergency visits, hospitalizations, and total costs.¹⁰ Furthermore, recent data from a large, matched case-control study suggest that, compared with VHA nursing homes, noninstitutional care by nonfamilial caregivers in MFHs does not increase hospitalization rates for common medical conditions, and lowers hospitalization rates for anxiety disorders, mood disorders, skin infections, pressure ulcers, and bacterial infections.^{11,12}

MFH coordinators, often senior-level social workers, work alongside HBPC teams to determine eligibility of Veterans to enroll into MFHs as well as recruit, screen, and provide ongoing education and support for MFH caregivers.¹³ MFH caregivers work directly with Veterans to provide 24-hour supervision and negotiate room and board costs with Veterans or their families, while tailoring care to Veteran's preferences.

The objective of this qualitative study is to assist VHA in describing characteristics of high-enrollment MFH (MFH) programs from the perspectives of MFH coordinators and HBPC providers. The Holistic Approach to Transformational Change (HATCh) model¹⁴ guided this study. It aims to restore control, choice, and normalcy to individuals in long-term care settings, thereby fostering person-centered care environments where meaningful relationships can develop. It is theorized that improving person-centered care practices improves resident outcomes in nursing homes.¹⁵ The way in which MFH programs operationalize Veteran-centered care reflects the HATCh model in a smaller care setting.

Methods

We used an emergent exploratory design to interpret optimal Veteran-centric care across MFH programs. We conducted in-person focus groups and semistructured interviews with HBPC providers and MFH coordinators and included field notes from 3 in-person site visits

in data collection. We conducted telephone interviews when participants were unable to meet in-person.

Setting

We defined high-enrollment MFH sites as having the top 10% annual admission of all VHA MFH programs in August 2011. We then determined site selection based on the 3 highest enrollment locations. Enrollment implies Veterans who remained in the program past the initial 90-day assessment period. Characteristics of the 3 HE-MFHs studied are displayed in Table 1.

Participants

Eligible participants included MFH coordinators, MFH program support assistants (PSAs), and HBPC providers who cared for MFH Veterans at the 3 high-enrollment MFH sites. We purposively sampled from these groups to identify potential participants. Participants volunteered their time and did not receive remuneration.

Data Collection

Data collection occurred between August 2013 and June 2014. We developed semistructured interview guides and further refined them after the first site visit. Furthermore, the research team debriefed after all interviews and focus groups. Researchers' audio recorded interviews and focus groups after obtaining written consent from participants. A VHA-approved transcription company transcribed interviews and focus groups verbatim. VHA's Central Institutional Review Board (CIRB #12-31) approved the study. Across the 3 MFH sites, our study sample included N = 39 participants: HBPC providers (n = 31, who participated in 4 focus groups); MFH coordinators (n = 6); and MFH PSAs (n = 2). Demographics and profession of VHA staff participants are displayed in Table 2.

Data Analysis

We used an inductive and deductive analytic toolkit to qualitative theme analysis, as framed by Thomas,¹⁶ which included reflexive team procedures (e.g., debriefing, refining interview guides). We analyzed interviews and focus groups line-by-line and coded using both a priori and in vivo codes. We also reviewed field notes and team reflections for analysis. We used the software Archive for Technology, Lifeworld and Everyday Language, text interpretation V7.5.2 data management for organization of data.¹⁷

Results

Three themes emerged from our reflexive team approach and include optimization of enrollment in MFH programs through (1) finding the "right match" between the MFH caregiver and the Veteran; (2) care practices that supported caregiver, Veteran, and HBPC; and (3) workplace practices and processes that demonstrated the MFH coordinator as a relationship leader. Themes are described with illustrative participant text in narrative form below. Table 3 highlights each theme in detail by MFH site using participant quotes.

Theme 1: The "Right Match" between MFH Caregiver and Veteran

You really have to know them [MFH caregivers] and their skill sets and their experience and match, because that's when they're going to be happy. When they're doing what they love, working with female World War II patients or young TBI [traumatic brain injury] poly-trauma patients, God bless anyone that can do that level of care and supervision ... when you feed them what they love then they can do amazing things.

(MFH coordinator)

A key component to finding the right match proved to be having enough caregivers within each MFH program to be selective in matching individual Veterans and their needs while simultaneously identifying caregivers with the right motivation, skill set, and home. Before placement in MFHs, participants shared how Veterans are assessed for medical, social, cultural, and personal needs. These included understanding the era of war/conflict the Veteran experienced, complex health needs, and social considerations such as the potential for conflict with other Veterans in the home. At sites visited, identifying potential MFH caregivers did not appear to be challenging. In fact, at one site, a participant noted they had a waiting list of individuals interested in becoming caregivers. As the overall size of MFH programs is limited by how many MFHs a coordinator can manage (maximum caseload is 30–35 Veterans), these sites reported that having caregivers waiting to serve the program allowed for increased opportunities to make “right match.” One PSA for the MFH program noted, “We have all different types of caregivers. They speak multiple languages. They have multiple family make-ups. ... I think we have great caregivers. They're all different.”

Some HBPC providers interviewed noted they perceived Veterans in MFH settings as at least as medically or psychologically complex as Veterans in nursing homes. One HBPC occupational therapist noted, “I don't think some people realize we have quadriplegics that are full care in a [MFH] home.” Despite the physical burden this type of caregiving entails, and MFH coordinators sharing that caregivers often perceived their remuneration to be low for the extent of their duties, MFH coordinators retained caregivers through building strong relationships with them and sustaining them over time through monthly visits to the MFH, telephone contact, and semiannual caregiver trainings.

Those interviewed noted that the presence of a dedicated and solution-focused MFH coordinator proved essential in maintaining the right match between Veteran and MFH caregiver, as the MFH coordinator monitored the Veteran/caregiver relationship on an ongoing basis from the time of screening into the program throughout the provision of care. One HBPC social worker said,

I think the coordinators do an excellent job. I do. They are making that initial adjustment with them [MFH Caregiver], they are working with them, they are holding their hand initially and getting everything going well. It's really a warm handoff of that patient. With follow-up with follow-through and they're monitoring this patient going forth and I think that sets up the success.

MFH coordinators met with and advocated for Veterans and their families (if involved) by phone and through announced and unannounced visits to the MFH. MFH coordinators are also charged with providing support to the MFH caregiver by maximizing the caregiver's

home environment to support Veteran independence and safety over time, and HBPC providers also reported efforts to assist with home renovations. One respiratory therapist said,

CPAP [continuous positive airway pressure] medical equipment is very difficult for them [Veterans] to manage if they're home alone. I think one of the reasons sometimes that they are in the Medical Foster Home is to try to keep them obviously safe and the [caregiver's] ability to use the equipment. I've seen it as a very positive option.

Theme 2. Care practices that support caregiver, Veteran, and HBPC

I think what works really great is the home-based primary care goes into the home ... We have the APN (advanced practice nurse) that goes in one day and you've got a social worker going in maybe two, three days later and a dietician going in and a chaplain for some ... and a psychologist. So, you've got all those eyes going in that home and ensuring that the best care that Veteran can get is right there.

(MFH coordinator)

Within the MFH program, participants described sophisticated care practices developing alongside changing complexity of Veterans. As the overarching goal of the program is to keep the Veteran in their MFH until the end of life, participants described how MFH caregivers communicate with the HBPC team about care coordination on an almost weekly basis. One HBPC pharmacist explained it this way:

I think that the caregivers are a lot better at reporting when something starts to go wrong. Like, they're gonna check a [Veteran's] temp or some of them [caregivers] may take blood pressure or their blood sugars are going crazy. They're [caregivers] gonna call whereas the patient wouldn't have even have thought to call in.

HBPC meetings incorporated this involvement of caregivers regarding decision-making related to the day-to-day care (including but not limited to medication management) of Veterans and their changing health status and allowed HBPC teams to be responsive to both Veterans and MFH caregivers.

Participants also highlighted when they visited MFHs and interacted with both caregivers and Veterans, they assessed signs of caregiver burnout, need for respite, and need for caregiver support. One MFH coordinator made this a high priority, indicating, "Anything we can do to help these caregivers ... not only manage better, keep them from burning out [we do]." The same coordinator also pointed to challenges in providing respite, however, remarking that,

Even when you put 'em [Veterans] in respite, there's problems there. They come back sometimes, there's maybe bed sores or they're agitated and depressed and they [the MFH caregivers] have more work for three weeks after they come back then when they went.

Furthermore, an HBPC nurse noted that because of the fear of their MFH Veterans health deteriorating while in respite, some coordinators hesitated to use it. "And they [Caregivers] may not be willing to ask for it too because they [think] 'This is my job. This is what I

signed up to do.’ I can think of one that gets sick when she isn’t there because she worries about what’s going on when she’s not there.”

Despite respite concerns, the interprofessional care provision by the MFH caregiver, MFH coordinator, and the HBPC team offered what was described by participants as a highly Veteran-centered model of care by recognizing each Veteran’s unique needs. While typically participants shared that this coordinated oversight led to increased enrollment in MFH programs, participants said the composition of the HBPC team influenced the degree to which care needs are considered acceptable at the time of Veteran referral and following enrollment in the program. For example, an HBPC dietitian said regarding HBPC, and therefore their MFH program, “We [HBPC] don’t accept patients undergoing dialysis, any type of oncology treatment, you know, active treatment, ... ventilators.”

Theme 3. Workplace practices and processes that demonstrate the MFH coordinator as a relationship leader.

I’ve had the opportunity to mentor a few [MFH] sites ... I guess if there’s one thing I could always, I try to instill with them, is that this is a process and maybe it’s an overarching philosophy than it is point a, b and c, and it’s a process and it’s hard work and it’s about persistence and having faith and just knowing that in the end if you help one person, it’s worth it.

(MFH coordinator)

Participants identified that the right scope of practice, skills, and vision for a MFH coordinator proved fundamental to a MFH program expanding at an optimal rate. HBPC providers shared that MFH coordinators enabled the program to meet the dynamic needs of the Veteran population rather than trying to force the Veteran into a rigid care model, which assisted in expanding their MFH programs. MFH coordinators who had more flexibility in marketing, promotion, and community engagement particularly thrived. Participants argued that the “can do” or “workaround” tenacity of the MFH coordinator to facilitate Veteran-centric care through the MFH program built confidence in the program’s success and sustainability for the MFH program.

Promotion and marketing of relationships with a variety of MFH referral sources (including internal resources such as HBPC and VHA leadership) on an ongoing basis proved necessary to optimize appropriate Veteran referrals to the MFH program. In addition, the MFH coordinator lead the building of strong relationships between themselves and the HBPC team as they interacted within the Veteran’s MFH home while serving as a bridge to the larger VHA health care system. Participants suggested that the standardized manual of procedures for MFH coordinators and the ability to network with other MFH coordinator mentors both regionally and nationally were foundational to developing innovation in “what could work” for the Veteran in the MFH program, thus optimizing the MFH program as a whole.

Discussion

Our analysis of qualitative data, through use of the HATCh model,¹⁴ illustrated how each MFH program optimized and sustained enrollment through the environment, care practices, workplace practices, and fostering of meaningful relationships. High-enrollment MFH programs operationalized 3 key facets of established safe, quality long-term care practices. The first facet encompassed consistent assignment with a 24-hour a day, 7 days a week presence of a paid caregiver.² Well-supported screening practices by the MFH coordinator ensured that the MFH caregiver chose to participate in the MFH program due to an intrinsic love and dedication of older people in need,¹⁸ and MFH coordinators, HBPC providers, and MFH caregivers facilitated solid matches by working to better understand the importance of the “effects of service vary by era”¹² on Veterans. Medication management and health condition surveillance through the HBPC team and the MFH caregiver¹¹ emerged as a second facet and included a home-like environment that supported mental health care needs.¹⁹ Participants identified one benefit of the MFH program as the MFH coordinator and HBPC team actively supported MFH caregiver needs by identifying resources on an ongoing basis.²⁰ The strength of quality relationships between the Veteran(s) and the MFH caregivers emerged as a third facet, a relationship often described as familial, which has been echoed in previous work.^{21,22} This facilitated connectedness with the community, including other Veterans, which has shown potential to prevent loneliness in older adults.²³

Care practices supported all parties—Veteran, caregiver, HBPC, and MFH coordinator—involved in growing these MFH programs. Past research has also shown that “HBPC in the patient’s home has demonstrated higher satisfaction and lower costs, thus, it may be reasonable to assume that HBPC in combination with MFH may produce similar outcomes.”¹⁰ Our study provides empirical evidence that HBPC providers and MFH coordinators felt that MFH caregivers played a significant surveillance role, promoting early identification of changes in Veterans’ overall condition, early intervention in medication management, and timely and effective communication with the HBPC team. In comparison, in one online survey of over 1,200 traditional familial caregivers, half reported serving as caregivers through obligation, feeling no sense of choice in taking on their caregiver role, and thus experienced increased stress, which has been shown to lead to possible underreporting of red flag changes early enough in their loved one’s condition.²⁴ In turn, it is important to note the literature also shows studies which reported perceived benefits/rewards for familial caregivers.^{25,26}

HBPC providers included the MFH caregiver as a valued and intrinsic part of the health care team which served the goal of improving the “work life” of the MFH caregiver, minimizing burnout, stress, or attrition from the program while promoting continuity of care and improved safety for Veterans aging in place. The MFH setting restructured the meaning of home, in the context of long-term care provision by paid caregivers, “through the material and social practices of care recipients and caregivers.”²⁷ Within the MFH program, home reflected both a public and private space and a workplace for the MFH caregivers. Veteran-centric care therefore involved attention to the caregivers and the conditions in which they work including remuneration.^{20,27}

The HBPC team proved fundamental in monitoring MFH caregivers' health in relation to Veteran safety rather than solely constructing safety as part of the Veteran's health maintenance. MFH caregivers sometimes hesitated to use respite services for fear of poor outcomes or Veteran decline outside of their watchful eye, similar to other research completed among paid, unpaid, or familial caregivers who experience having to relinquish their control over care.^{28–30} This is an important finding for all MFH programs to be aware as reluctance to accept respite opportunities could be ameliorated by empowering caregivers to utilize it through such recommendations as a “model of care that engages and promotes user control and fosters genuine participatory relations between informal and professional carers.”²⁸ Such an approach can build trust that quality respite can attend to the social and emotional as well as the physiological needs of care recipients.³⁰

The link between the MFH long-term care model and Veteran or caregiver outcomes also hinges on how health professionals structure their working practices.³¹ Our study has illustrated that enrollment in a Veteran-centric care model within high-enrollment MFH programs is a product of a triadic environment-caregiver-Veteran setting and MFH coordinator and HBPC interprofessional team practice and processes.¹¹

Limitations

These findings may not transfer to other community-based long-term care settings without the presence of an in-home interprofessional team such as the HBPC team. Furthermore, the VHA system of service delivery may produce unique contexts for how care is provided that differ from other health care systems. The Veteran culture in US communities and among the general population is a product of its unique history which may vary by location or military experience. Despite these limitations, many opportunities exist to learn how to provide person-centered care within a framework of aging in place in the community when a home belongs to a paid caregiver.

Conclusion

In summary, when a climate of supportive workplace practices and processes existed, including leadership, team support, and mentoring, HBPC providers felt MFH coordinators developed flexible and visionary roles to sustain the MFH model, which optimized program growth and retention of MFH caregivers. Such high-enrollment programs can serve as a model for both smaller and new MFH programs which are developing. Application of this person-centered program for noninstitutional long-term care outside of the VHA system is also needed, especially as the US aging population continues to grow.

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Table 1.

Characteristics of Medical Foster Home (MFH) Programs Studied.

Site	Year MFH program started	Number of MFH Veterans served as of April 2014	Number of MFH Veterans served as of December 2015
A	2009	52	67
B	2004	289	352
C	2000	310	323

Table 2.

Demographics of Medical Foster Home (MFH) Veterans Health Administration Staff Study Participants (N = 40).

Profession	Female	Male	Total
Acting director of home-based primary care	1	—	1
Advanced practice nurse	2	—	2
Licensed practical nurse	1	—	1
Medical director	—	1	1
MFH coordinators	5	2	7
MFH program support assistant	2	—	2
Nurse practitioner	2	—	2
Occupational/physical therapist	1	—	1
Pharmacist	2	1	3
Psychiatrist	1	—	1
Psychologist	2	1	3
Recreation therapist	1	—	1
Registered dietitian	4	—	4
Registered nurse	1	1	2
Respiratory therapist	1	—	1
Social worker	6	1	7
Skilled care orient	1	—	1
	33	7	40

Table 3.

Provider Perspectives of Veteran-Centric Care in US Medical Foster Home Programs.

Themes	Selected quotes
Theme 1. The “Right Match” (caregiver, Veteran, home environment)	<p>“We had to find the right MFH for him [Veteran]. That was the key finding the right match caregiver-wise and he’s done so well. He’s just fit into that family just beautifully. You know, the caregiver loves him, her family loves him, the other Veterans love him, I mean, it’s just been a nice fit.”—<i>HBPC Psychiatrist</i></p> <p>“I have a Veteran that was a homeless Veteran. And now he’s in part of a family. And he’s in his 80’s. So this is, you know, a wonderful way for him to live now.”—<i>HBPC Advanced Practice Nurse</i></p> <p>“I don’t feel like they [MFH Caregiver and Veteran] need me as much honestly, because they get along so well. If I am needed for any sort of support or mediation, I haven’t had to do it between a caregiver and a Veteran yet ... And I check with both of them on all my visits, do you need anything from me or the team and they usually tell me no I’m fine, but I am checking just to be sure.”—<i>MFH Coordinator</i></p> <p>“You realize it really is they just need three meals a day, they’re gaining weight and thriving again and the other problems just disappear then. Their mental faculties could improve with regular nutrition and hydration, and they’re not alone, eating alone. There in a social environment and treated like one of the family members and you know. You’re more like to eat. Eating is a social event.”—<i>HBPC Dietitian</i></p> <p>“I term her the ghost walking the hallway, because at the nursing home she would walk with her rollator a bit, her hair was disheveled, it was this graying red and her fingernails were broke, her clothes just hung on her. Her clothes didn’t fit. She was just lost. She was this soul that didn’t matter in the world and now, I mean within a week she looks, and it’s not uncommon within a week you go back and see that veteran and they already look 100 times different. They’re clean, they’re shaven. They’re getting great food that’s home cooked. (Veteran) decreased her mental health medication. She decreased her pain medication, increased her flexibility and strength. She took her first trip in like 15 years out West to see her family with the help of our caregivers which was a huge learning experience too.”—<i>MFH Coordinator</i></p> <p>“I’ve seen people [MFH Veterans] whose diabetes stabilizes. That’s certainly good. Hemoglobin A1C is dropping. Wound care improving. You know that we’ve had Veterans in our program that you just know if like we hadn’t gotten them out of the nursing home or if they end up in the nursing home they would have been dead. You just see that functional status like closer exercise, better nutrition, consistency.”—<i>MFH Coordinator</i></p> <p>“They (caregivers) get, become very attached. I mean, when you go into these homes they feel like it’s part of their family so the loss can be really hard on them. And I think also recognizing that they may not be so ready to take another patient on right away, and like kind of giving that space or time to grieve before we just are okay we have a free bed, give this person that’s been waiting a long time, let’s get them in there you know. I think we’re all pretty sensitive to that.”—<i>HBPC Respiratory Therapist</i></p> <p>“We have one that can’t eat anything by mouth and so hearing it from a caregiver is really hard and they get more of the brunt of it but hearing it from us is more like, okay, this is the recommendation from the medical center, so it just kind of takes that burden off the caregiver a little bit.”—<i>HBPC Dietitian</i></p> <p>“I think like any care giving relationship there are conflicts that come up from time to time between the veteran and the caregiver and that’s probably where the HBPC team is really helpful in kind of negotiating that and talking that through.”—<i>HBPC Social Workers</i></p> <p>“I always tell them [potential MFH Veterans] to spend time with the caregiver, get to know and listen to your gut instinct ... I’ve even offered, this isn’t something that’s in the handbook but just and I’ve put out there, if they were really unsure ... I would say why don’t we work out an unofficial adult daycare [in the MFH], so how about you work out with a caregiver that they stay there three days out of the week or five days, get to know the family member, eat the food see if you like it and if you do then one day you just stay overnight, if you don’t leave then its worked.”—<i>MFH Coordinator</i></p> <p>“Forge a strong relationship with your home based team or wherever your main referral source is going to be. Keep those lines of communication open.”—<i>MFH Coordinator</i></p> <p>“What I really tried pulling out and extrapolating was people that would be leaders and try and understand program development of the Storming Norman and Foreman concepts and pulling out right personalities that would be that example, that would be yes people, that would be energy people, that encourage others or kind of say, oh sure they have some mental health, but it’s fine let’s do it.”—<i>MFH Coordinator</i></p> <p>“Let other people know that the program exists in other parts of your VA because you know, the initial thought as I said before, is nursing home, nursing home, nursing home, it doesn’t have to be that way. Work on finding quality caregivers. I know when you’re a new program you may feel desperate to get anyone into the program, but trust your instincts, trust your gut.”—<i>MFH Coordinator</i></p>
Theme 2. Optimizes enrollment through care practices that support caregiver, Veteran, and HBPC	
Theme 3. Workplace practices and processes that demonstrate the MFH coordinator as a relationship leader	

Themes	Selected quotes
	"We (MFH Coordinators) market very well here in the VA because we go to different meetings, like the nurses will have their monthly meetings and they'll ask one of us or myself to come and talk to them about our program and social work is a program that will invite us at least once a year to come and talk to them."— <i>MFH Coordinator</i>
	"Finding someone [for the MFH Coordinator position] who has that passion because you know we're five years in and I can tell you a lot of days I still feel like I'm climbing the Matterhorn."— <i>MFH Coordinator</i>

Note. MFH = medical foster home; HBPC = home-based primary care.