VETERAN-DIRECTED HOME AND COMMUNITY-BASED SERVICES:
A PROGRAM EVALUATION

Author(s): Ellen Mahoney, Ph.D., Dianne Kayala, M.S.

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Veteran-Directed Home and Community-Based Services: A Program Evaluation

The National Resource Center for Participant-Directed Services (NRCPDS) & Financial Management Services (FMS) Membership

At the National Resource Center for Participant-Directed Services (NRCPDS), housed at Boston College, our mission is to infuse participant-directed options in all home and community-based services. We have more than 2 decades of experience making participant direction a reality, and we provide national leadership, technical assistance, training, education, and research that improves the lives of people of all ages with disabilities.
Executive Summary:

I. Introduction
The Veteran-Directed Home and Community-Based Program (VD-HCBS) began enrolling Veterans in February 2009 in Battle Creek, Michigan. Developed through a partnership between the Department of Veterans Affairs and the Administration on Aging (now Administration on Community Living – ACL), this program is a purchased service where local Veterans Affairs Medical Centers (VAMCs) enter into provider arrangements with Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), or State Agencies on Aging (SAA) to provide the Veteran-Directed program. Veterans manage their own budget to hire and direct workers and purchase other goods and services that will best meet their needs. In many cases Veterans designate a family member or other close person to be a representative to handle the management functions of the program. The ADRC or AAA conducts a comprehensive assessment, and provides supports for spending and service plan development and implementation, monitoring of the Veterans well-being, and financial management services (FMS) either directly or through a subcontract.

VDHCBS Program Coordinators (n=27) from Medical Centers with active VDHCBs programs in February, 2012 were surveyed about their experiences and perceptions of the VDHCBs program, the Veterans enrolled and services they receive, and outcomes attributable to the program. In addition, Coordinators were asked to submit assessment scores and current services or spending authorizations for the ten most recent VD-HCBS and Homemaker/Home Health Agency (H/HHA) program participants as well as service plan and invoices for the VD-HCBS Veterans. The major purpose of the study was to answer the question: “Should VD-HCBS be sustained?” A second purpose was to identify whether the program spending plans support the flexible Veteran-centered program philosophy. The third purpose was to compare Veterans in VD-HCBS with those in the traditional H/HHA programs in terms of case-mix assessments (acuity) and level of service to discern if service level authorizations are commensurate with individual need. Specific elements evaluated included: A) Program effectiveness; B) VD-HCBS program characteristics linked to outcomes; C) Enrollees and services; and D) VA Medical Center implications

We are grateful to the VD-HCBS Program Coordinators who thoughtfully shared their experiences, insights and recommendations to develop the survey and to inform program sustainability and continuous quality improvement in community-based services for Veterans. Throughout this process, and in the results reported here, the commitment to Veterans and to VD-HCBS as an accessible, high quality Veteran-centered care option was highly evident.

II. Key findings and recommendations:
Results of the survey demonstrated that VD-HCBS is filling a very special niche in home and community-based services for Veterans whose level of need for care and services places them at risk for nursing home placement, but who choose to remain in their own home and maintain choice and control with their plan of care. Based on the combined results of the Coordinator Survey and quantitative data, the following key findings and recommendations emerge:

1. The VD-HCBS Veterans had significantly higher acuity than Veterans utilizing traditional agency-based homemaker/home health services. The VA Central Office (VACO) had recommended that the highest need Veterans be referred for the Veteran-Directed program and this was found to be the case. Coordinators added important dimensions to understanding “high need” as the interaction of person and environment and noted that the program has created alternatives for the Veteran with higher needs.

2. The VD-HCBS costs were consistent with acuity-based reimbursement (as measured by case mix rates). However, in comparison, current H/HHA authorization levels were significantly lower than case mix levels. It is unknown exactly what impact this low H/HHA per Veteran service level has, although higher caregiver burden and more institutionalization stays can be hypothesized (Gaughler, Kane, Kane & Newcomer, 2005; Miller, Rosenheck & Schneider, 2012). At the medical center level, an implication of the imbalanced funding is that costs for VD-HCBS were perceived by some Coordinators as higher when compared to the underfunded H/HHA program. Contrary to
this perception, several Coordinators noted cost savings from VD-HCBS as a benefit to the medical center.

3 VD-HCBS was perceived as effective in meeting Veterans’ needs (92.3%), helping Veterans remain at home (96.2%), improving satisfaction (96.2%) and improving access (96.2%). Average ratings of very-to highly effective are supported and explained by qualitative data revealing a broad spectrum of functional, health, psychosocial, emotional, safety and quality of life outcomes. Caregiver outcomes included decreased burden and stress and improved satisfaction.

4. VD-HCBS elements linked to effectiveness include flexibility, choice, person-centeredness, autonomy/empowerment, and support. Services were matched to individual needs across spectrum of acuity.

5. Flexibility of VD-HCBS is highly valued. It has been applied primarily in the realm of services, and to a lesser extent for goods. The VD-HCBS budgets were allocated to self-directed workers (71%), administrative and support service costs (19%), other goods and services (6%) and homemaker/home health agency services (4%). The few examples of creative application suggest an untapped potential to meet special needs of Veterans. Coordinators requested policies for allowable expenses and this need for more guidelines is reinforced by apparent differences across sites in interpreting existing policies. In addition, flexible and creative use of funds to impact health, well-being and remaining in the community may be an area where specialized expertise within the VA, or from Independent Living Centers, could supplement expertise within the aging network.

6. Veterans with a broad range of physical, mental health and psychosocial needs have been served through VD-HCBS. There is some disagreement among Coordinators about the characteristics of Veterans who are most likely to choose or benefit (or be excluded) from this program. While there is agreement about the importance of a match between program philosophy and Veterans’ preferences and needs, it is not always clear who decides and on what range of criteria. Among Veterans who were identified as most likely to choose or benefit from VD-HCBS, the range of Veterans’ physical, behavioral health and substance use issues supports current Program referral criteria based on Veteran choice with availability of a representative as desired. Suggestions emerge about developing a plan of supports with the aging network for Veterans with interest in the Program but a limited support network and about how the role of the representative might be refined for Veterans with behavioral or mental health issues. Referral to VD-HCBS of interested Veterans will be facilitated by expanded funding so that those who are eligible and interested can be served with this program.

7. Collaboration between VA Medical Centers and the aging network has been enhanced with mutual benefit in a number of sites, although there have also been a few who named these collaborations as sometimes complicated and difficult. Exemplar cases could provide a model for achieving this goal at all sites. Role clarification may be helpful to maximize the complementarity of roles of VA and Aging Network Coordinators in education and outreach, assessment, matching Veteran needs with program options and preferences, development of the budget and plan of care and responsibilities for monitoring and follow-up.

8 Improvements in Program design could include streamlining and standardizing budget levels and program procedures, better Veteran support to access potential workers including representatives if appropriate, and providing clear written materials to support both Veterans and Program staff in the employer role. These changes may mitigate the identified Veteran and Coordinator dislikes and address Coordinator recommendations for standardization. Survey results support the need for standardization of program implementation between and across facilities and for central office decision-making about funding.

9. Predictable, dedicated and sustained funding for VD-HCBS was requested by the majority of Coordinators. Most sites reported there were Veterans interested in VD-HCBS who were waiting to be served by this program, leading to the recommendation of expanded availability. Several coordinators also recommended that the percent effort afforded to that role be expanded to match their role and responsibility.
10. Compelling stories of Veterans’ experiences in VD-HCBS highlight its value in enhancing quality of care and quality of life. Data collected directly from Veterans and caregivers, and from a unique Program POV code is needed for research focused on Veteran/caregiver level data to demonstrate effectiveness in achieving quality of care, quality of life and longer term health-related, service utilization and cost outcomes and for communicating the value of this program to local (medical center) and national stakeholders to support sustainability.

In summarizing key points that support sustainability, in the words of one Coordinator:

“This is one of the best programs to come out for the Veterans in a very long time. It is what the Veteran and Families have been wanting for a long time – to be able to control who cares for them, to be able to pay a family member to care for them, to be “in control” and let the VA know what they need and not be dictated to. This program empowers Veterans to self-management. It is in complete alignment with our strategic goals of Patient Centered Care.”

Acknowledgements:

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VD-HCBS Program Evaluation Report

I. Introduction
The Veteran-Directed Home and Community-Based Program (VD-HCBS) began enrolling Veterans in February 2009 in Battle Creek, Michigan with the initial programs being supported by grants from The Administration for Community Livings (ACL – formerly the Administration on Aging) to states for Nursing Home Diversion and Community Living. Developed through a partnership between the Department of Veterans Affairs (VA) and the Administration on Aging (now the Administration on Community Living – ACL), this program is a purchased service where local Veterans Affairs Medical Centers (VAMCs) enter into provider arrangements with Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), or State Agencies on Aging (SAA) to provide the Veteran-Directed program. Veterans manage their own budget to hire and direct workers and purchase other goods and services that will best meet their needs. In many cases Veterans designate a family member or other close person to be a representative to handle the management functions of the program. The ADRC or AAA conducts a comprehensive assessment, and provides supports through options counseling for spending and service plan development and implementation, monitoring of the Veterans well-being, and financial management services (FMS) either directly or through a subcontract.

VD-HCBS Program Coordinators (n=27) from Medical Centers with active VD-HCBS programs in February, 2012 were surveyed about their experiences and perceptions of the VD-HCBS program, the Veterans enrolled and services they received, and outcomes attributable to the program. In addition, Coordinators were asked to submit assessment scores and current services or spending authorizations for the ten most recent VD-HCBS and Homemaker/Home Health Aide (H/HHA) program participants (includes all traditional agency-provided services such as adult day care, respite, personal care and homemaker) as well as service plans and invoices for the VD-HCBS Veterans. The major purpose of the study was to answer the question: “Should VD-HCBS be sustained?” A second purpose was to identify whether the program spending plans support the flexible Veteran-centered program philosophy. The third purpose was to compare Veterans in VD-HCBS with those in the traditional H/HHA programs in terms of case-mix assessments (acuity) and level of service to discern if service level authorizations are commensurate with individual need. Specific elements evaluated included: A) Program effectiveness; B) VD-HCBS program characteristics linked to outcomes; C) Enrollees and services; and D) VA Medical Center implications.

We are grateful to the VD-HCBS Program Coordinators who thoughtfully shared their experiences, insights and recommendations to develop the survey and to inform program sustainability and continuous quality improvement in community-based services for Veterans. Throughout this process, and in the results reported here, the commitment to Veterans and to VD-HCBS as an accessible, high quality Veteran-centered care option was highly evident.
II. Methodology

A survey instrument was developed to learn Coordinators’ perceptions of the VD-HCBS program at the local (Medical Center) level, and to identify processes and outcomes for Veterans who receive services through this program. The survey was designed to answer the question: “Should VD-HCBS be sustained?” Questions addressed Coordinators’ experiences and perceptions about the VD-HCBS program, the Veterans enrolled and services they received, and outcomes attributable to this program. Surveys were distributed and returned electronically via the Veteran Integrated Service Networks (VISNs) to the Department of Veterans Affairs Central Office (VACO), with a response rate of 100%. Data were analyzed at Boston College. A copy of the information request, including the survey is in Appendix B.

The Coordinators from each of the 27 VAMCs were also asked to submit scores from the VA Minnesota ADL Assessment (Appendix C) for each of the last ten Veterans to begin the VD-HCBS program and most recent ten to begin agency based home and community-based services (designated here as H/HHA). All Coordinators submitted data, although some sites did not have ten Veterans enrolled. The VD-HCBS sample included 247, and the H/HHA sample had 269 Veterans.

Data was requested on the initial spending plan, the most recent spending plan and the most recent detailed invoice on each VD-HCBS Veteran submission. There were 191 detailed VD-HCBS Spending Plans submitted by the Program Coordinators from 23 VAMCs. Two plans from one of the VAMCs were excluded from aggregate analysis due to being extreme outliers. There were 130 invoices submitted. Because the Spending Plans show the approved spending over a year and the invoice just shows one month utilization, the Plans were the primary source for determining the distribution of VD-HCBS spending across the sample.

III. Results

The results of this program evaluation include: A) Program effectiveness; B) VD-HCBS program characteristics linked to outcomes; C) Enrollees and services; and D) VAMC implications. Appendix A includes Coordinator quotes tied to each of these items numbered by section. Quotes use the language provided by the Coordinators and can be identified by italics.

A. VD-HCBS Program Effectiveness

Program Coordinators (n=27) were asked to identify the most important benefits they perceived for Veterans who have participated in VD-HCBS by answering the question: “What difference does VD-HCBS make?” They were also asked to rate how they thought Veterans would respond to the question: “How effective is VD-HCBS in meeting Veterans’ needs, helping Veterans remain living at home, improving satisfaction with services and care, and improving accessibility of services and goods.” Frequencies of degree of effectiveness ratings are shown in Figure 1.
Each of these perceived outcomes is discussed individually although there is also evidence of their inter-relatedness and synergy. Coordinators’ assessments of effectiveness were rated on a Likert-type scale, ranging from 1 (not effective) to 5 (highly effective). Qualitative data were analyzed using content analysis to identify themes that enrich the quantitative responses. Exemplar quotations from Coordinators are in Appendix A.

A.1. Meeting Veteran’s Needs: The perceived effectiveness of VD-HCBS in meeting Veterans’ needs was rated as effective to highly effective by 92.6% of coordinators, with an average rating (M=4.2, SD 0.9) of very effective. Case-mix data show (see Figure 2) that:

- Veterans served through VD-HCBS, as well as those served by traditional H/HHA, had a range of acuity levels; but
  - Veterans served through VD-HCBS had higher acuity levels in 24/27 sites (88.9%); and
  - The weighted case mix acuity scores for the VD-HCBS group were significantly higher ($t = -4.7$, $df = 26$, $p=.00$). (See Appendix D for case mix definitions).
“What needs are being met?” and “how does VD-HCBS help to meet the needs of Veterans and caregivers?” were questions used to gather valuable data. This qualitative data revealed a broad spectrum of functional, health, psychosocial, emotional, safety and quality of life needs that were being met; in addition to the need for personal care assistance with activities of daily living (ADLs). In the case of ADLs, Veterans in VD-HCBS were able to receive more services than those in a traditional H/HHA program, resulting in a closer match between assessed needs and services provided that several Coordinators reported. Some Coordinators noted that the VD-HCBS program was cost-effective in that Veterans could receive more hours of services for the same amount of money by hiring family or friends, compared to costs for agency services. Others indicated that VD-HCBS, by providing services matched to needs and allowing the purchase of things not otherwise available through the VA, prevented the need for more costly alternatives. Another noted that “Hospitalization and ER visits [were] reduced because of quality and frequency of care given,” and that the program has reduced the use of services by providing “better coordination of services in the continuum of care needed by the Veteran.”

Coordinators identified a broad range of basic human needs that are met through unique aspects of the VD-HCBS program. These included: socialization, dignity, empowerment, mental health, life satisfaction, self-esteem, continuity of care, comfort, safety and quality of life (see Appendix A for
Meeting or addressing Caregivers’ needs was another commonly reported benefit of VD-HCBS. Caregiver needs included a decrease in negative outcomes such as burden and stress, and also an increase in positive outcomes. Several Coordinators noted that not only did caregivers appreciate being paid, but it also enabled them to continue providing care.

Achieving a match between Veterans’ needs and service options was identified as important by several Coordinators. Comments included the adequacy of services under different care options, Veteran choice and philosophical alignment with participant-directed care, balancing the needs of many Veterans with availability of funding, differing perspectives about the skills and resources needed by individuals interested in VD-HCBS and the importance of quality of life outcomes.

**A.2. Remain at Home:** The perceived effectiveness of VD-HCBS in helping Veterans to remain at home was rated as effective to highly effective by 96.3% of coordinators, with an average rating (M=4.4, SD 0.8) of very effective to highly effective. Coordinators estimated that 62.9% of Veterans enrolled in VD-HCBS would have needed more costly care. The meaningfulness to Veterans of remaining at home, and ways in which VD-HCBS enabled this, are portrayed in exemplars (Appendix A). As one Coordinator said, “the program has allowed Veterans not to just reside in the community but to thrive in the community.”

**A.3. Improve Satisfaction:** The perceived effectiveness of VD-HCBS in improving satisfaction was rated as effective to highly effective by 96.3% of coordinators, with an average rating (M=4.2, SD 0.9) of very effective. A quote from a coordinator illustrates the importance of this finding:

> Veteran satisfaction is highly important for feedback regarding program implementation, operation and sustainability. My top priority is to present VD program outcomes to hospital leadership and demonstrate this is a cost saving program that enhances the quality of life of Veterans. The satisfaction survey results are (100%) feel VD services have improved quality of life “a lot.” Veteran family’s quality of life is also improved.

**A.4. Improve Access:** The perceived effectiveness of VD-HCBS in helping Veterans to remain at home was rated as effective to highly effective by 96.3% of coordinators, with an average rating (M=4.3, SD 0.9) of very effective. Access was described as availability of care in rural areas, availability of services when they were most needed, and safe access at home through use of services and goods.

**A.5. Top two outcomes:** Coordinators were also asked to identify what they perceived as the top two outcomes from VD-HCBS. The most frequently prioritized outcomes were Veteran satisfaction (n=13) and helping Veterans remain at home (n=13), followed by quality of life for Veterans and caregivers (n=11) and decreased health costs (n=8).

**A.6. Negative cases (n=3):** One Coordinator rated VD-HCBS as not effective in meeting Veterans’ needs or in improving satisfaction with services and care and only somewhat effective in helping Veterans remain living at home, saying that the program was: “Too unstructured, too many subjective aspects, and expensive.” This same Coordinator reported flexibility as one of the strengths of the program and satisfaction as an outcome, noted “very positive feedback from families” and “a great deal of positive feedback, related to being able to increase the amount of personal care with the same amount of money due to
A second Coordinator rated VD-HCBS as not effective in improving accessibility while very effective in the other areas. This respondent identified budget constraints, difficulty in proving the value and measuring effectiveness in preventing institutionalization, and high cost in comparison to other programs as weaknesses of the program. Another Coordinator rated the program as somewhat effective in meeting Veterans’ needs, noting that exceptions to cost guidelines for a small number of enrollees made the program costly and inaccessible to other Veterans who could benefit. Recommendations for guidelines, accountability and funding were suggested by these respondents to improve the program.

B. VD-HCBS program characteristics linked to outcomes

Coordinators were asked: “What aspects of the VD-HCBS program are most predictive of benefits?” Many of the Coordinators identified more than one aspect of the program (themes) as linked to its benefits, for a total of 71 responses addressing this question (Figure 3). Themes of flexibility, choice, person-centeredness, autonomy and support were the most frequently identified. A central issue was that of services matched to needs of Veterans and family caregivers. These themes and their interactions were linked to the effectiveness outcomes identified above through Coordinator comments throughout the surveys that are included as exemplars. They also describe what is unique about VD-HCBS and how these characteristics have been applied to address specific challenges. Remaining challenges identified by Coordinators include those specific to VD-HCBS (e.g. number of Veterans interested in the program but waiting to be served, predictable funding, support for the role of the Coordinator, guidelines for flexible spending) and those that are more general to ensuring high quality home and community-based services for all Veterans.
B.1: Flexibility: Coordinators estimated that an average of 84.3% of Veterans (range 8 – 100) used the flexibility that is possible with VD-HCBS. They thought the most valuable options demonstrating this flexibility were that Veterans could manage the type of care they received, who provided this care and that they were able to buy unique items needed to stay in the community. While the value of flexibility was nearly unanimously endorsed by Coordinators in the surveys, several of them recommended that guidelines be established for allowable expenses.

B.2: Choice: The value and effect of Veterans having choices in VD-HCBS was described as being especially valuable in the ability to choose workers who are sensitive to the feelings of those who have lost some of their independence, and in being able to select items that will help their unique needs.

B.3. Person-Centered: Coordinators identified person-centeredness as an aspect of the VD-HCBS program that is predictive of its benefits because planning is done individually, and Veterans can manage services the way they like and with more attention to identify goals important to them.

B.4. Control/Autonomy: Coordinators also identified control/autonomy as an aspect of the VD-HCBS program that is predictive of its benefits. In some cases Veterans who didn’t tolerate agency-based services were reported to do well because this program gave them control over the service management. The sense of ownership a Veteran has of one's own life was another example given of the benefit to the Veteran afforded through enhanced control and autonomy.

B.5. Support: The following quotation illustrates how support systems are a key benefit of VD-HCBS:

> Strong oversight by case managers assigned to Veterans through the Area Agencies on Aging (AAA) has helped to ensure successful and consistent placement of services in the home by providers that the Veteran helps to choose. . . Veterans are monitored closely to ensure stable health. This model creates a more personal support system by bringing providers into the home that either the Veteran had a pre-existing trusting relationship with (family or friends as caregivers) or by allowing them choices in who provides that service. . . . Case Management through AAA oversight ensures close objective oversight to ensure that services are provided and that Veteran is satisfied with the provision of services. The Case Managers are able to maintain a presence in the Veteran’s life that ensures accountability by the Provider. . . . The AAAs provide the actual case management and their oversight results in strong advocacy and accountability by providers of services.

Coordinators rated the quality of VD-HCBS program supports from excellent (5) to poor (1). Average ratings of Counseling supports (e.g. Care advisor/Care counselor) (M=3.1, SD 0.9) and Financial management (e.g. book keeping, tax paying, check writing) (M=3.8, SD 1.0) were both in the range of good to very good.

B.6 Specific Challenges: These program elements (flexibility, choice, person-centeredness, autonomy and support) as noted above were also identified by Coordinators as instrumental in addressing specific challenges and providing services that were unique to this program, not otherwise available and highly valued. Creating a safe environment for Veterans with high acuity or
special needs that supported caregivers, promoted independence, comfort, dignity and access to services where and when they were needed were the most common challenges the Coordinators identified as being addressed by VD-HCBS. These themes are likewise echoed in Veterans/families descriptions of their experiences with care before and after enrolling in VD-HCBS and Coordinators’ assessments of what they liked about the program. The most vivid testimony is provided in the stories of Veteran experiences in the program (see Appendix F).

C. Enrollees and Services

C.1. Current enrollment: Current enrollments at the surveyed sites (n=27; data as of February, 2012) ranged from 2 – 53 (M=22, SD 15.1) as illustrated in Figure 4. Since the initiation, the total number served with VD-HCBS at the sampled sites was reported as 951 Veterans. Seventy-eight percent of sites reported there were Veterans wanting to be in the program but not yet being served. As is covered in more detail below, funding availability has been a widely reported problem. It is likely to have been a major restriction on enrollment. Referrals came from the VAMC, aging network and self-referrals after media coverage or recommendation from other enrolled Veterans. The vast majority at most sites were from within the VA although a few sites reported a significant percentage of referrals from the aging network. Separate reports for each of the VAMCs were prepared that summarize the local Veteran enrollment, and sampled acuity and utilization.

C.2. Case-Mix Characteristics of Participants: As seen in Figure 5, the acuity (degree or level of disability) of the Veterans sampled from the VD-HCBS program was higher than for the alternative H/HHA program. The majority of Veterans fall in the case mix “D” category, meaning that they have dependencies in between four and six activities of daily living. Veterans who fall in the “B”, “E”, “H”, or “J” categories have significant behavioral issues, while those in categories “C”, “F” and “K” have skilled nursing needs. Specific case mix descriptions are found in Appendix D.
**C.3. Characteristics of Veterans identified by Coordinators as a “good match” with VD-HCBS:** Coordinators were asked to identify characteristics of Veterans who were most likely to choose, or perceive benefit from the VD-HCBS program and, conversely, any they thought would not be good candidates. Coordinator responses appear in Appendix E. There were some common themes and also significant differences in Coordinators’ responses.

Areas of agreement on factors that make VD-HCBS a good or likely choice:
1. Residence in rural/low access to agency services areas,
2. Philosophical alignment of Veteran/caregiver with participant direction,
3. Need for services not provided under other programs, and
4. Dissatisfaction with traditional programs, match between needs and services.

Areas of disagreement on factors that make VD-HCBS a good or likely choice were:
1. Level of acuity,
2. Age,
3. Quality of existing supports, and
4. Presence of cognitive, mental health or adherence issues.

The “match” between Veterans and VD-HCBS is determined differently at different sites. Coordinators also reported variability in the extent to which VD-HCBS is presented as an option. It is unknown to what extent these differences are based on Coordinators’ or staff experiences with Veterans, quality and availability of support services in specific locations, site-specific Veteran/family assessments, individual vs. categorical determinants, philosophy of referral sources, and/or prioritization of participants when resources are limited. Survey responses lead to the questions of who is/should be the final decision-maker, on what basis, and what are the implications.
for individualization of supports within VD-HCBS and overall planning for home and community-based services?

**C.4. Use of Services and Goods:** Data from spending plans provide a snapshot of the most recent participants’ planned spending. Survey data adds insight into how services and goods were used to provide flexibility in meeting needs. There were 191 detailed VD-HCBS Spending Plans submitted by the Program Coordinators from 23 VAMCs. Two plans from one of the VAMCs were excluded from aggregate analysis due to being extreme outliers. The remaining 189 plans were used as the data source for identifying which services Veterans planned to use. As will be discussed further, the Coordinators also reported some other specific examples of these services in their survey responses to illustrate the program’s flexibility.

Figure 6 illustrates the distribution of dollars in the spending plans by specific categories. The planned administrative category is the amount set aside for the program support services and administration. It includes Options Counseling (assessment, service planning assistance, and safety oversight), Financial Management Services (all payments, personnel paperwork, withholding, and payroll) and the aging network agency overhead to manage and invoice the VAMC for the program components. The allowed amount for the all-inclusive Administrative Fee is set by the VACO for each region. It should be noted that all traditional agency-based services such as H/HHA also have administrative and payroll costs built into their unit rates.

Figure 6: Planned Distribution of VD-HCBS Spending

![Pie chart showing distribution of spending plans.](chart)

H/HHA services comprise 4% of the VD-HCBS budgeted amounts. The distribution ranges from zero percent of sampled plans submitted from 15 VAMCs to a high of 23% submitted from one VAMC. Although agency-based services are not meant to be used as a primary method of service
delivery, they may be used in emergency situations. Home Health Agencies build in safety monitoring and supervisory costs to their rates that the VD-HCBS program pays the aging network agency to do, and this program's philosophical underpinnings are for the Veteran (or his/her designated representative) to manage the services. VD-HCBS program policy allows for a 90 day transition period for persons just moving into the program, so some of these plans may be reflecting instances where the transition is still underway.

Goods and Services comprise 6% of the Veteran Spending Plans, ranging from a low of zero percent from one location, to over 13% of the sampled budgets from two VAMCs, and include a variety of items and community-based services as illustrated in Figure 7. The miscellaneous category includes all the items that only one Veteran selected, including a cot for a caregiver to be near the Veteran, a monitored floor mat and alarms for a Veteran with dementia prone to wander in the night, and money management assistance. The most prevalent goods and services selected are ones that could be available through traditional Medicaid waiver programs, but this may be a result of the newness of the program to Veterans. Of all Veterans with submitted spending plans, 48% chose at least one item or community service other than their self-directed worker.

![Figure 7: Goods and Services Selected](image)

Qualitative data from the survey indicates that Veterans used the flexibility and unique capabilities of the program to:
1. Access personal care services when and where needed and by caregivers of their choice
2. Access home maintenance services
3. Adapt their home for safety and independence
4. Access goods and services not otherwise available (e.g. transportation, chair lift)
5. Achieve socialization and quality of life goals

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6. Plan for larger expenses

Most of the flexibility described in the survey was in the service category. This allowed access to personal care in areas where agency services were not available or prohibitively expensive, and by caregivers with whom Veterans and their Family Caregivers felt safe and comfortable and able to respond to changing needs. In many cases, Veterans were able to receive care when they needed it (e.g. at night) and according to their own schedule. Other common categories of services were home maintenance to create a safe and livable home environment and transportation. Services needed but not otherwise available were used by some Veterans in order to access care while living at home. For example, a Veteran was able to repair an automatic door so he can go outside and let workers in. Creative use of services was evident to some extent as when one Veteran was able to attend his daughter’s wedding by having his worker come with him to help with his needs while there.

Coordinators described the use of goods to increase independence, improve safety and increase socialization and quality of life. Use of goods was less frequently discussed compared to services. Some problems in this category were also noted. For example, one coordinator noted that VD-HCBS participants disliked feeling that they don’t have full control over how the money is spent, especially in the area of “goods.” One Coordinator said that whereas Veterans like the rainy day/discretionary funds (that allow participants to have funds in reserve for urgent back-up or respite needs), they do not like that the fund is not fully discretionary for any use by the Veteran and that it has a maximum amount.

D. VA and VAMC Implications

D.1. How has VD-HCBS Helped the Medical Center? Coordinator perspectives:
Themes in response to this question included: Veteran outcomes, inter-agency collaboration, reducing costs and VA image.

The over-arching message in Coordinators’ responses to this question was their perception that what’s good for Veterans is good for the Medical Center and their motivation to provide excellent care. Multiple responses echoed the effectiveness of VD-HCBS for Veterans, in helping them remain at home, access to services and satisfaction as previously discussed. Additional effects for Veterans were also identified, including a focus on prevention, empowerment, improved quality of care and quality of life. Responses also indicated high value attached to these outcomes.

Numerous Coordinators reported health-related outcomes for Veterans enrolled in VD-HCBS in response to the question of how the program has helped the Medical Center. These included both physical and mental health as well as health care utilization such as ER visits, hospitalizations, bed days. Possible reasons cited were continuity of care, more preventive focus on care, close case management, and Veterans feeling more invested in their own health care.
Inter-agency collaboration was reported by coordinators as a benefit both to the Veteran and the VAMC. This included access to community-based organizations that were previously unknown and improved understanding of national LTSS trends.

Some Coordinators said that costs were reduced as a result of the program because served Veterans were less frequently accessing hospital or nursing facility costs. Beyond increased knowledge of and respect for the VA (addressed under inter-agency collaboration), some Coordinators thought that the VA’s image was improved through media coverage and Veteran reports to peers.

Negative responses included “Not one bit that we can tell”; “Due to the cost of the two high profile Veterans enrolled, unfortunately, I cannot see other VA medical centers wanting this program”; “This is a difficult question to answer due to program funding delays. The funding that did arrive to the medical center was not sufficient to cover the expenses of the Veterans already in the program”; and “NO COMMENT”

D.2. Costs and Spending compared to acuity-based rates: The cost information requested in the program study included total Federal Fiscal Year (FFY) spending for 2011 and the monthly VD-HCBS budget amounts and monthly H/HHA service allotments for the ten most recent admissions respectively. The total from the twenty-five sites that provided the FFY 2011 spending added up to $11,349,203. Several of these sites showed that some of the spending was toward VA personnel cost to coordinate the program, but this information was not specifically requested, so we are uncertain if there were more unreported personnel costs from other sites. As would be expected, the cost ranges by VAMC from a low of $15,102 to a high of $1,180,295 correlating with the number of Veterans served over the year.

The monthly budget allowance for each of the sampled Veterans in the VD-HCBS program and the total monthly cost of authorized services for those sampled in the H/HHA program was identified and compared to a regionally adjusted case mix rate for each Veteran. Each of the case mix levels (as described in Appendix J) have established maximum rates determined by Minnesota for their Medicaid and state programs. The Minnesota rates were used as a base and adjusted by region to establish VA case mix rates. For both VD-HCBS and H/HHA, the case mix rates are all inclusive of contracted direct service and allowable overhead and administrative costs.

As illustrated in Figures 8 and 9 below, the regionally adjusted case mix rates are shown side-by-side with the current monthly authorizations for the sampled Veterans. Figure 8 shows a very large difference between current per Veteran authorization for H/HHA compared to what the functional characteristics as defined by the case mix level of the Veteran indicate may be needed. The average per Veteran per month (PV/PM) difference between current authorizations and what case mix rates would be for the H/HHA services is $1,957. Figure 9 illustrates that the current VD-HCBS budgets are very close to regionally adjusted case mix rates. The average PV/PM difference between current VD-HCBS budgets and case mix budget amounts is $44. In other words, VD-HCBS clients seem to be getting budgets commensurate with their needs, but the same cannot be said for current H/HHA clients.
Figure 8: H/HHA Current per Veteran Average Monthly Expenditure Compared to Regionally Adjusted MN Case Mix Rates

Figure 9: VD-HCBS Current Rates Compared to Regionally Adjusted MN Case Mix Rates
D.3. Coordinators’ perceptions of weaknesses, Veteran/caregiver dislikes and suggestions for improvement: Coordinators were asked to identify what they perceived as weaknesses of the program. The majority of responses were in two categories: program implementation issues and fiscal issues.

Program implementation issues included: challenges of coordination among agencies and problems with coordination/communication; time to process admissions/status changes; lack of consistency between facilities; and time required for coordination, monitoring and outreach.

Fiscal issues included: limited funding and predictability/sustainability of funding (n=7); billing and reimbursement issues (n=7); high program/administrative costs (n=5); lack of clarity/subjectivity of allowable expenses and need for rate guidelines (n=4)

Other answers to this question by individual Coordinators were that the program was limited in the number of Veterans served, that mental illness prevented participation, some families can’t handle the complexity, the service could be provided under another established program, the program is too unstructured and that it is difficult to prove value and measure outcomes.

Coordinators were also asked what Veterans/families disliked about VD-HCBS. Dislikes were recorded in 54% of the surveys, in some cases Coordinators said that a complaint pertained to one or a few participants. In some cases the responses seemed to pertain to those participating in VD-HCBS while in others seemed to be reasons someone may not choose a participant-directed model of care. The most frequent themes were:

- Difficulty managing employer related program requirements (e.g. determining wages, documentation, hiring) (N = 8)
- Time required for transition into the program and implementation of services or delay in payment (N = 4)
- Not enough resources (family availability, requests for additional services) (N = 4)
- Limits on choice and control of how funds could be used, especially in area of “goods” (N = 1)
- Number of persons involved in developing and implementing service plan (N = 1)

Some Veterans have elected not to enroll because they prefer to work with an agency that would take care of the administrative portion of the program. One Coordinator responded that Veterans/caregivers do not like that they are only allowed to utilize non-traditional model of care since some of them have a limited social network. It is not clear if this comment refers to Veterans in VD-HCBS or to those who choose a different care model, and to what extent it represents an issue that is best addressed at the programmatic or local level.

In response to the question of what Veterans dislike about VD-HCBS, one Coordinator responded “non-participating Veterans wish they could receive this service.” The majority of sites identified Veterans wanting to be in the program but not yet being served.
Coordinators were asked what suggestions they would make to increase the availability and success of VD-HCBS. These include:

- Funding that is consistent, predictable, dedicated and multiyear is needed to maintain and grow the program; need different payment structures/variety of monthly budgets would be helpful
- Guidelines for allowable expenses, both services and goods with transparency and accountability; standardization of billing; clear expectations for questions surrounding budgets; better understanding of the flexibility aspect of the program
- Eligibility based on higher levels of acuity; strict adherence to program guidelines without exception
- Expanded availability to accommodate interested Veterans waiting to be served; availability of VD-HCBS across counties in a state; outreach with other community agencies; outreach to community health nurse coordinators, social workers and discharge planners to seek referrals of Veterans who would be a “good fit,” outreach to include Veterans already in contracted nursing homes
- Expand the percent effort allocated to the Coordinator role/role of Coordinator. Coordinators noted the importance, and time commitment, involved in community outreach, education of providers and Veterans, screening of Veterans and matching a variety of programs with Veterans’ needs. Some Coordinators recommended the addition of part-time staff to allow Coordinators to devote more time to this program.
- Develop a mechanism for program specific coding to enable Veteran-specific outcome analysis so Coordinators could track and analyze their own data.

While not explicitly framed as a recommendation, a comment by one Coordinator highlights the importance of the coordinator role: “This program works due to the dedication and diligence of the VA staff who are overseeing it. The program is only as good as the VAMC staff that oversees it and the Case Managers working in the respective county programs.” Coordinators may have recommendations for preparation for these key roles that were not solicited in this survey.

**D.4. Changes that have resulted from VD-HCBS:** Coordinators were asked to identify changes that they have seen as a result of VD-HCBS. Their responses are listed in Table 1. The complete list is given to capture the range of responses as well as common themes that indicate the real difference that VD-HCBS has made.

- Has been essential for some difficult cases, found employment, positive impact on caregiver and clients
- 14 Veterans were able to remain at home
- Veterans could stay at home, VA and community resources used more efficiently/effectively
- Improved collaborations—state and federal
• More discussion among health care providers, flexibility of patient care and caregiver support
• Decreased admissions to NH’s, few complaints from Veterans about their care
• Caregiver burnout decreased
• Less complaints from caregivers
• Social Worker is referring directly to program and VSOs are asking for it as well
• Less time spent on coordinating services, greater investment by Veteran/family in services in home
• Increased access and reduction in hospital admissions/length of stay
• Improved Veteran and family satisfaction
• Veterans are very appreciative, view of VA improved
• Stability in home, reduce caregiver burden, less hospitalization
• Not sure
• Decrease in caregiver burden, increase life satisfaction for Veterans
• Fewer complaints from Veterans
• Increased services
• Getting service in areas without traditional agencies
• Excitement around program, Veterans in program have less hospitalizations
• No complaints about caregivers
• Veteran and caregiver satisfaction receiving more money
• Veterans remain in home longer
• No significant changes
• Increased number of Veterans calling about VA services, increased reported satisfaction and quality of life
• Satisfied Veterans and caregivers
• Greater knowledge and appreciation for community-based resources, AAA has stronger understanding of VA’s capabilities
D.5. How has VD-HCBS matched the expectations of Program Coordinators?

Figure 10 shows that VD-HCBS mostly met (52%) or exceeded (41%) Coordinator’s expectations. Coordinators reported in a VD-HCBS phone call that initial expectations for the program were high.

IV. Limitations of the survey

The surveys were distributed to Coordinators electronically through VACO and returned to VACO through the area VISN and the surveys were not anonymous. It is possible that this process influenced the candor with which participants responded. Coordinators reported on their own experiences and perceptions and on those of Veterans and their caregivers. While this was a strength in offering rich descriptions from an insider view, and provided insights that guide future program sustainability and development, there was a wide range of experience with the program as the total number of Veterans served by VD-HCBS ranged from 2 – 132 across the study sites. Also, closeness of direct contact between Coordinators and Veterans in the program varied from weekly to rarely. These differences may have influenced Coordinator responses in unknown ways. Invoice data from the most recent enrollees in either VD-HCBS or H/HHA resulted in a small VD-HCBS sample from some sites and overall over-representation of newer enrollees in both programs affecting the generalizability of findings. Nonetheless, the overall consistency of results across sites adds support to their external validity.

The survey was conducted at a time when VD-HCBS funding was uncertain and when there was a discrepancy between need and service levels in other programs (e.g. H/HHA vs. Case
Mix spending levels). These contextual factors may have influenced Coordinators responses in unknown ways.

V. Model of VD-HCBS processes and outcomes

A model of VD-HCBS processes and outcomes was developed based on the results of the survey and as a guide to future research (Figure 11). The match between Veteran needs and services available is central to every care delivery model. The Veteran needs that Coordinators identified as important included those that are assessed for case-mix classification and those that reflect quality of life for Veterans and family caregivers. Program characteristics represent the unique components of VD-HCBS through which this model of care is implemented that Coordinators highlighted as most important to Veterans and their family caregivers. In the model, intermediate outcomes are the short-term goals that the program was designed to achieve. These outcomes were supported by results of the survey. They are both interactive and synergistic (not depicted). The connection to long-term outcomes was supported by anecdotal data from Coordinators’ perspectives and their stories of Veteran experience. The model is included here as a way to depict the results of this survey and as a guide to future research.

![Figure 11. Model of VD-HCBS](image)

VI. Key findings and recommendations:

Results of the survey demonstrated that VD-HCBS is meeting an important special need in home and community-based services for Veterans whose level of need for care and services places them at risk for nursing home placement, but who choose to remain in their own home and maintain choice and control with their plan of care. Based on the combined results of the Coordinator Survey and quantitative data, the following key findings and recommendations emerge:
1. The VD-HCBS Veterans had significantly higher acuity than Veterans utilizing traditional agency-based homemaker/home health services. The VA Central Office (VACO) had recommended that the highest need Veterans be referred for the Veteran-Directed program and this was found to be the case. Coordinators added important dimensions to understanding “high need” as the interaction of person and environment and noted that the program has created alternatives for the Veteran with higher needs.

2. The VD-HCBS costs were consistent with acuity-based reimbursement (as measured by case mix rates). However, in comparison, current H/HHA authorization levels were significantly lower than case mix levels. It is unknown exactly what impact this low H/HHA per Veteran service level has, although higher caregiver burden and more institutional stays can be hypothesized (Gaughler, Kane, Kane & Newcomer, 2005; Miller, Rosenheck & Schneider, 2012). At the medical center level, an implication of the imbalanced funding is that costs for VD-HCBS were perceived by some Coordinators as higher when compared to the underfunded H/HHA program. Contrary to this perception, several Coordinators noted cost savings from VD-HCBS as a benefit to the medical center.

3. VD-HCBS was perceived as effective in meeting Veterans’ needs (92.3%), helping Veterans remain at home (96.2%), improving satisfaction (96.2%) and improving access (96.2%). Average ratings of very-to highly effective are supported and explained by qualitative data revealing a broad spectrum of functional, health, psychosocial, emotional, safety and quality of life outcomes. Caregiver outcomes included decreased burden and stress and improved satisfaction.

4. VD-HCBS elements linked to effectiveness include flexibility, choice, person-centeredness, autonomy/empowerment, and support. Services were matched to individual needs across spectrum of acuity.

5. Flexibility of VD-HCBS is highly valued. It has been applied primarily in the realm of services, and to a lesser extent for goods. The VD-HCBS budgets were allocated to self-directed workers (71%), administrative and support service costs (19%), other goods and services (6%) and homemaker/home health agency services (4%). The few examples of creative application suggest an untapped potential to meet special needs of Veterans. Coordinators requested policies for allowable expenses and this need for more guidelines is reinforced by apparent differences across sites in interpreting existing policies. In addition, flexible and creative use of funds to impact health, well-being and remaining in the community may be an area where specialized expertise within the VA, or from Independent Living Centers, could supplement expertise within the aging network.

6. Veterans with a broad range of physical, mental health and psychosocial needs have been served through VD-HCBS. There is some disagreement among Coordinators about the characteristics of Veterans who are most likely to choose or benefit (or be excluded) from this program. While there is agreement about the importance of a match between program philosophy and Veterans’ preferences and needs, it is not always clear who decides and on what range of criteria. Schore, Foster and Phillips (2007) found in the original Cash & Counseling Demonstration that individuals with all types of disabilities could benefit if they chose the model and had the supports needed by such possible means as having a representative decision-maker, or purchasing worker training or other services to meet their individual needs. Among Veterans who were identified as most likely to choose or benefit from VD-HCBS, the range of Veterans’ physical, behavioral health and substance use issues supports current Program referral criteria based on Veteran choice with availability of a representative as desired. The spending/service planning process by the Veteran with help from the
Aging Network and Representative, if appropriate, is the opportunity where individualized needs can be identified in order for the program to be successful.

7. Collaboration between VA Medical Centers and the aging network has been enhanced with mutual benefit in a number of sites, although there have also been a few who named these collaborations as sometimes complicated and difficult. Exemplar cases where the coordinators said the aging and VA networks work well together could provide a model for achieving this goal at all sites through peer networking. Role clarification may be helpful to maximize the complementarity of roles of VA and Aging Network Coordinators in education and outreach, assessment, matching Veteran needs with program options and preferences, development of the budget and plan of care and responsibilities for monitoring and follow-up.

8. Improvements in Program design could include streamlining and standardizing budget levels and program procedures, better Veteran support to access potential workers including representatives if appropriate, and providing clear written materials to support both Veterans and Program staff in the employer role. These changes may mitigate the identified Veteran and Coordinator dislikes and address Coordinator recommendations for standardization. Survey results support the need for standardization of program implementation between and across facilities and for central office decision-making about funding.

9. Predictable, dedicated and sustained funding for VD-HCBS was requested by the majority of Coordinators. Most sites reported there were Veterans interested in VD-HCBS who were waiting to be served by this program, leading to the recommendation of expanded availability. Several coordinators also recommended that the percent effort afforded to that role be expanded to match their role and responsibility.

10. Compelling stories of Veterans’ experiences in VD-HCBS highlight its value in enhancing quality of care and quality of life. Data collected directly from Veterans and caregivers, and from a unique Program POV code is needed for research focused on Veteran/caregiver level data to demonstrate effectiveness in achieving quality of care, quality of life and longer term health-related, service utilization and cost outcomes and for communicating the value of this program to local (medical center) and national stakeholders to support sustainability.

VII. Research Recommendations

Recommendations for research include interim “next steps” that can be done now to expand on findings from the sustainability survey, and long-term recommendations for evaluation once there is a clear comparison group. The research recommendations that emanate from this program evaluation are closely aligned with the “Veteran-Directed Home and Community-Based Services: Potential Evaluation Projects” proposed by Kemper, Sciegaj & Heier (2009).

Short Term Recommendations:

I. Gather data from Veterans/caregivers themselves and from service utilization records to answer the questions:
   a. How do Veterans define quality of care?
   b. What are the key factors guiding Veteran’s choice of community-based service options?
c. What are the reasons for discharge from VD-HCBS?

II. Access data collected by the aging network (e.g. satisfaction) and compare sites based on enrollment, time in operation, Coordinator ratings of outcomes

III. Compare service utilization of a random sample of Veterans in VD-HCBS with a random sample of Veterans in H/HHA, matched on case-mix level. This is very important in addressing the differences in perception among Coordinators or between Coordinators and Medical Center staff and leadership

IV. Follow-up with Coordinators to answer questions arising from the findings of this study:
   a. What assessments beyond acuity are helpful in individualizing support services (including support counselor, FMS, representative). These might include perceived preparedness, self-efficacy, quality of social supports

Long-term Recommendations:

A key long-term recommendation is rigorous research using a longitudinal design and clear comparison groups to evaluate the effectiveness of VD-HCBS. Proposed outcomes are derived from the Model developed from this sustainability survey and from previous research evaluating participant-directed care. Based on the results of this survey, it is essential to include a range of outcomes to capture those important to all stakeholders.

I. Research Question: What is the effect of VD-HCBS on Veteran and caregiver outcomes: (see comparison groups below)
   a. Outcomes from the model developed from this survey: Veteran health and well-being, caregiver burden and satisfaction, service utilization, quality & cost (Note: these were all identified by Coordinators, as was the need for empirical evidence to demonstrate impact)
   b. Outcomes modeled after the Cash & Counseling demonstration project: Veteran perceptions of caregiver reliability and scheduling, Veteran perceptions of their caregiver relationship and attitudes, Veteran satisfaction with care arrangements and perceived unmet needs, Veteran health (including adverse events, problems, and status), and Veteran life satisfaction, access to personal assistance services and cost
   c. Caregiver outcomes – both decrease in negative outcomes (burden, stress) and increase in positive outcomes (satisfaction, quality of relationship)

II. Compare and contrast:
   a. Veterans in VD-HCBS with those using traditional HCBS models of care
   b. Differential impacts of the program for Veterans with and without mental health diagnoses
   c. Differential impacts of the program on Veterans with additional characteristics on which Coordinators disagreed (e.g. behavioral or substance use issues, skilled care needs, degree of caregiver burden, perceived social support and self-efficacy)
VIII. Summary

The main question of whether VD-HCBS should be sustained was resoundingly affirmative. Veterans and their caregivers are receiving a level of service commensurate with their needs, and the VA Coordinators report that the program has resulted in high favorability ratings and reduced institutional care. The qualitative data revealed a broad spectrum of functional, health, psychosocial, emotional, safety and quality of life outcomes. Caregiver outcomes included decreased burden and stress and improved satisfaction.

In the words of one Coordinator:

This is one of the best programs to come out for the Veterans in a very long time. It is what the Veteran and Families have been wanting for a long time — to be able to control who cares for them, to be able to pay a family member to care for them, to be “in control” and let the VA know what they need and not be dictated to. This program empowers Veterans to self-management. It is in complete alignment with our strategic goals of Patient Centered Care.
References


Appendix A:
Coordinator Quotes Keyed to Report Section

A.1. Meeting Veteran’s Needs:

Allows them to have an enhanced life experience after suffering with many physical/medical and mental disabilities. Gives them hope of some positive experience, feeling a sense of relief for Veteran consistent/safe care. Lifts caregiver stress/burden which can be a health issue for them eventually in keeping Veterans in their home.

Same consistent caregivers, more capable caregivers due to their getting to know the Veteran and his needs versus an array of clients as a traditional homecare would be servicing. More reliable service a better buy in of staff in daily care of the Veteran. Having the same caregiver who has learned the care of the Veteran and comes daily is giving more relief to burned out spouses. That caregiver learns how to best work with the Veteran leaving the spouse to feel someone does have the expertise versus several different aides showing up weekly and spouse having to train them to the Veteran's specific needs/routine.

I can’t say for certain that this program has impacted Veterans’ physical health. However it clearly impacts their mental health by providing them with a sense of independence and choice in how they live.

One of our Veteran’s brothers was already providing care and Veteran felt guilty for taking advantage of him. This program removes that guilt from the Veteran.

Based on feedback with Veterans and caregivers the benefits include improved continuity of care, decrease in caregiver burden, Veteran feels and remains safe at home, long term placement in a nursing home no longer seen as only option, report feeling they are not at as great a risk for hospitalization, can adhere to providers prescribed plans of care, increased independence, increased socialization and quality of life. . . . Gives Veterans a feeling of purpose and control since they are so dependent on others and have so many health problems that they cannot control.

Get respite which decreases their stress and allows them to resume activities that they enjoy (but couldn’t do before program). Can take care of the Veteran in their home and not worry about the care in the nursing home because they cannot be there 24/7.

One salient example is a couple where the caregiver was forgoing purchasing her own medication in order to pay for her husband’s prescriptions and medical expenses. With this program she was able to purchase these goods for herself. She stated a number of times that the program “saved their lives.” (Note: VD-HCBS does not pay for caregiver medication – it was income from paid employment that allowed purchase of medications)

There seem to be more “relationships” between caregiver and Veteran than under HHA—whether that be actual familial relationships with paid caregivers or otherwise. This is apparently beneficial to both caregiver and Veteran.

Quality of life is enhanced for both Veteran and their family as a result. VDHC caregivers are appreciative of salary but take value in helping Veterans to stay at home.

Families that already provide high volume help have the incentive to continue and not look for other sources of income which the caregiver needs.
Veterans feel less burdensome, and the caregivers feel relief.

[Before VD-HCBS] Overwhelmed with care needs/being unable to keep Veterans safe when going to school or shopping or to medical appointments by spouses/caregivers working and not getting paid and not having any income at all. A sense of relief for safety and mounting care needs.

A.2. Remain at Home

Veteran stated he tried assisted living and moved back home. “Being on this program gave me a chance to live in my own home.” “VD services improved the quality of my life . . . I would be dead without this program.”

Veterans can remain at home longer with less caregiver and economic stress.

Added hours to assist them with their ADL’s and IADL’s. Family members that were too busy looking for work to help the Veteran were able to get paid, which helped them financially and at the same time assisting in building relationships with each other.

One enrolled Veteran has a dx of ALS. When he was enrolled in the program initially he was not yet using a ventilator, however as his disease progressed, he needed to be on a vent. His paid caregiver came to the VA to be trained along with his wife in working with the vent. The Veteran was successfully d/c from an ICU setting home on vent. And continues to do well at this time.

Several of the Veterans had been receiving care from family members that worked outside of the home. As the Veteran’s needs grew, the caregivers were getting to the point that they were no longer able to provide the level of care that the Veteran required and they were considering nursing home placement. Because of this program, they were able to avoid institutional placement.

This program enables Veterans to remain in their homes longer. Our state representatives had at one time expressed some concern that the types of patients we were placing under the Veterans-Directed HCBS program were significantly more complex and fragile than what they expected. A year plus later they came back to us, after reviewing data they were tracking through the counties, and confirmed that the program really was retaining Veterans in their community settings. We have interpreted this as perhaps our adherence to criteria being “at risk of nursing home care” originally differing from the Non-VA grant component, (our application of criteria more strictly applied), however our VA program participants showed clear evidence of program effectiveness – that Veteran participants remained in the community setting and were not institutionalized.

Veteran was in a nursing home as his wife’s health did not permit her to take care of him anymore. This program allowed her to bring him home by hiring and purchasing adequate care. She now looks 30 years younger.

I believe that access to greater personal care levels, along with mobilization of community resources reduced both Veteran & caregiver stress, and allowed participants to focus on staying healthy and out of the hospital.

. . . the program has allowed Veteran not to just reside in the community but to thrive in the community.
A.3. Improve Satisfaction

Veteran satisfaction is highly important for feedback regarding program implementation, operation and sustainability. My top priority is to present VD program outcomes to hospital leadership and demonstrate this is a cost saving program that enhances the quality of life of Veterans. The satisfaction survey results are (100%) feel VD services have improved quality of life “a lot.” Veteran family’s quality of life is also improved.

I believe when both the Veteran and the caregiver are satisfied with care there is less stress for the individuals and for the family/caregiver relationships or interactions and both maintain a higher level of overall health.

Satisfaction is extremely high with all Veterans on program. With the surveys that have been completed there is 100% Extremely satisfied and would not return to traditional services.

. . . if the Veteran and family is more satisfied there is better adherence with healthcare recommendations and plan of care and decreased use of VA higher cost services including ER and hospitalizations.

Veteran and caregiver satisfaction is important because dissatisfaction with services causes increased Veteran and caregiver stress. Many Veterans find agency services to be unreliable or don’t trust agency workers. This causes increased stress. Through this program the fact that the Veteran and family can choose their caregiver gives them a sense of connection with the caregiver and allows for more trust of the caregiver.

[Satisfaction] improves their outlook on life and elevates the VA image.

Satisfaction indicates that their needs have been met, and indicates that the VA is doing our job.

{Families say} The program has enhanced their life and relationship with the Veteran by reducing caregiver burden. The program has helped them carryout the Veteran’s wishes of staying home.

A.4. Improve Access

The most important benefit would be the ability for the Veteran to access services that fit their specific care needs (while remaining in familiar surroundings) and the opportunity for family to be involved with care. Self-Determination if that’s the patient’s wish.

VD-HCBS is also a valuable option in rural areas where there may not be an agency. This program allows Veterans to receive the assistance that they need, even when traditional services are not available.

This program is a vehicle to provide services to underserved Veterans in rural areas due to FMS component

This program provided services when availability of services was limited or non-existent. Example: Veteran had exhausted all available agency services to assist with colostomy care. VDHC help him to hire non-professional person to help him with colostomy care thus kept him from going into NH for skill services . . . Ensuring effective utilization of program benefits to address life threatening or dependent PC needs that if not provided would result in nursing home or institutional placement.
B. VD-HCBS program characteristics linked to outcomes

B.1. Flexibility

The ability to hire non-traditional caregivers and to provide flexibility with the type of care that each individual Veteran requires. Veterans in this program are able to hire employees at a significantly lower rate than traditional agency rates resulting in a higher number of care hours per week.

This program allows for more flexibility in the care it can provide; it addresses some of those areas that VA does not address (e.g. allows caregivers to purchase items VA does not provide.

[Before enrolling in VD-HCBS] they described their care as limited and inadequate at meeting their needs. With this program they describe their care as enhancing their quality of life, flexible, and meeting their family’s needs.

B.2. Choice

By offering a choice, the Veteran feels more invested in their own health care.

The ability to choose their caregivers, who “know their story” and are sensitive to the feelings they may have associated with an inability to continue to complete tasks on their own. Someone who is sensitive to the loss of independence felt by those in need of these services.

They make their own choices on services. There has certainly been a positive impact on reducing caregiver burden and maintaining safety in their community-based environment. Knowing that they are planning and directing their own health care needs is the driving force for increased satisfaction with this subset of our enrolled Veteran population.

B.3. Person-centered

Veterans get personal individual attention that they would never get in a nursing home.

This program empowers Veterans to self-management. It is in complete alignment with our strategic goals of Patient Centered Care.

I would say that although it comes with increased costs, it creates a true patient-centered, community-driven support model that strongly enables Veterans to remain in their home. Once reduced hospitalizations, reduced clinical use, perhaps even reduced medication needs are factored, this program brings much value to the larger health system.

B.4. Control/Autonomy

Appointing a caregiver who they know and trust, having backup plan so there is always someone available to Veteran, gives the Veteran the power and control over their healthcare, and ability to get equipment to increase their independence and safety.
This is one of the best programs to come out for the Veterans in a very long time. It is what the Veteran and Families have been wanting for a long time – to be able to control who cares for them, to be able to pay a family member to care for them, to be “in control” and let the VA know what they need and not be dictated to.

This program is especially helpful for very challenging cases because of the role the Veteran has in taking charge of their own care and feeling more independent and accountable.

Can stay home, flexibility, control and ownership of their own care and life

The program offers opportunities for patient and their families to receive wrap around services that empowers them to manage their own care, feel more in charge of how their care is delivered, provide services not normally within reach due to cost, enable patients to remain independent and in their own home longer

B.5. Support

The aspect of Veteran as Employer of Record. The aspect of the program that provides a Financial Management Service and/or Options Counselor to support the Veteran in his/her choices regarding mix of goods and services, and helping to manage the monthly budget.

Having the Area Agency on Aging case manager serve as liaison between Veteran/family and the VA has made a big difference for the Veterans and caregivers.

Strong oversight by case managers assigned to Veterans through the Area Agencies on Aging (AAA) has helped to ensure successful and consistent placement of services in the home by providers that the Veteran helps to choose. . . Veterans are monitored closely to ensure stable health. This model creates a more personal support system by bringing providers into the home that either the Veteran had a pre-existing trusting relationship with (family or friends as caregivers) or by allowing them choices in who provides that service. . . Case Management through AAA oversight ensures close objective oversight to ensure that services are provided and that Veteran is satisfied with the provision of services. The Case Managers are able to maintain a presence in the Veteran’s life that ensures accountability by the Provider. . . The AAAs provide the actual case management and their oversight results in strong advocacy and accountability by providers of services.

C. Enrollees and Services

C.4. Use of Services and Goods

Veterans and their families/caregivers have expressed sincere appreciation of this program. They are most happy with this unique model because they are in control of provision of care, in partnership with AAA. Family members that want to be the direct caregiver for their loved one appreciate that they can be compensated for their care so that they can afford to either care for the Veteran full-time or work reduced hours so that they can be the provider (012)

[Veterans/families like] Increased access to respite services and personal care assistance from employees that the Veteran/Caregiver trusts; ability to direct the Veteran’s care based upon the Veteran’s current needs;
having the flexibility to adjust their care plan as the Veteran’s need change has improved the quality of care that the Veteran receives.

Prior to enrolling in the program one enrollee described having to wake up earlier than his norm to be able to receive the care, as that was the only time the agency could provide him services. He now receives his care according to his own schedule and preference. Also enrollees report a greater degree of comfort with having someone they know well in their home providing services.

One SCID Veteran was able to use funding to fix his automatic door on his wheelchair van so he could utilize it. Otherwise he was homebound.

Veteran’s son who is the paid caregiver is able to finish his education on line while providing fabulous care for his father who requires total care due to his MS condition.

... able to attend his daughter’s wedding by hiring a personal attendant to accompany him and enabled his spouse to enjoy herself more at the wedding as well.

Unfortunately the picture for many of the enrollees is bleak both before and after enrollment. Most enrollees are appreciative of the services and find that their life is enhanced, but still find that there are never enough services available to provide for everything they need.

A frequent faller was able to put padded flooring down in his home. NO INJURIES since

One salient example is a couple where the caregiver was forgoing purchasing her own medication in order to pay for her husband’s prescriptions and medical expenses. With this program she was able to purchase these goods for herself. She stated a number of times that the program “saved their lives.”

Veterans purchased lift chairs, safe stool to access visual assistive device on counter, scale, carpet removal so Veteran is able to propel wheelchair, railings and installation for safety, personal emergency devices

The Veteran was able to meet their creative/artistic side through obtaining music therapy, guitar lessons and art lessons

One Veteran obtained a computer (which he would not be able to buy) so that he could start taking some online courses and start writing short stories which he has always been interested in. This increased his socialization with other Veterans as he began using email and chat rooms and also enrolled in MyHealtheVet!

Planned savings for a special mattress enabled one Veteran and his spouse to remain closer. A second Veteran was able to remain independent with his transfers through planned savings for a lift chair. A third Veteran used planned savings for respite care

Wife used part of rainy day fund to help her purchase generator which gave her a great deal of psychological relief because she feared power going off during bad weather and utilities [were] needed to take care of total care husband

D. VA and VAMC Implications

D. 1. How has VD-HCBS Helped the Medical Center?
VD-HCBS has helped the Medical Center through greater knowledge of and appreciation for the array of community-based resources available through AAA. Conversely, I believe that AAA has benefitted from gaining a stronger understanding of VA’s mission and service capabilities.

This program has allowed us the opportunity to work closely with long term care counterparts in our county and state offices and to understand their “world” better. It can be a gateway of partnership in respect to future collaborations. That is, there are many similarities and kindred spirits in terms of mission-focused staff behavior for the aging and those in need of extended care services.

We are proud and pleased to be among the earlier adopters of this program. The contacts we have made with our State and AAA partners have been invaluable in enhancing a myriad of services and resources we are collectively able to offer our Veterans.

This program was instrumental in enhancing communication and cooperation between the Medical Center and the State Government. This served as a means of sharing VA services with State services. It has brought increased referrals, particularly of OEF/OIF and female Veterans and it has saved the Medical Center money as we shift some of our costs to programs unique to the State. We have pursued other partnerships with the State with excellent results and we will certainly continue to do so to synergize our collective efforts to assist all Veterans.

Veteran’s Care Consultant located a volunteer community senior group who was willing to repair the Veteran’s leaking roof for free.

Many of the Veterans enrolled in the program are those that are eligible/entitled to the long term nursing home care benefit. Through their enrollment in the self-directed program, these Veterans have been able to remain in their own homes, thereby demonstrating a savings for the CNH program.

This program has prevented nursing home placement at the expense of the VA and has helped reduce preventable hospitalizations.

I believe it has helped the Medical Center by reducing hospitalizations, re-hospitalizations & outpatient clinic use. I believe that access to greater personal care levels, along with mobilization of community resources reduced both Veteran and caregiver stress, and allowed participants to focus on staying healthy and out of the hospital.

The participants reported increased satisfaction with the VA and sharing their stories with others, thus improving the image of the VAMC.

Media coverage of this pilot program has helped to increase community awareness of the VA.

**D.3. Coordinators’ perceptions of weaknesses, Veteran/caregiver dislikes and suggestions for improvement**

It takes time and good communication to thoroughly understand the specific need of each Veteran and his family and then to align the services that are available in the area they reside that will meet their needs.

Standardized national outcome measures should be established to assess the success of the program in reducing contract dollars spent, reducing bed days of care, increasing Veteran satisfaction, and attracting new uniques to the VA.
Appendix B: Data Request to Field

1. Cover Memo

Action Item

Selected VISNs – See Addressee List

Veteran-Directed Home and Community-Based Services Program

The Office of Geriatrics and Extended Care Policy (10P4G) is requesting the VAMC Program Coordinators of the Veteran-Directed Home and Community-Based Services (VD-HCBS) Program to provide information on 10 Veterans in VD-HCBS and 10 Veterans who are receiving Homemaker/Home Health Aide services and information on other program topics. Attached are 4 documents related to this request. The responses will form the basis of a paper on improving the program and will influence the national roll-out of the program. The documents are:

Expenditure and Case-Mix Information

VA/Minnesota ADL Form

Case-Mix Recorder Sheet

Coordinators Survey

The Expenditure and Case-Mix Information document requests workload and expenditure information and specific data on 10 Veterans in the Veteran-Directed program and 10 Veterans in the Homemaker/Home Health Aide Program. Information forwarded to VACO will not have Veteran identification. The VA/Minnesota ADL form will be used to collect the case-mix information and the Case-Mix Recorder spreadsheet is provided to record the information.

The VD-HCBS Coordinators Survey was developed by staff at the National Resource Center for Participant Directed Services, in conjunction with 5 VD-HCBS coordinators.

Both documents have been fully vetted and approved by the VAMC VD-HCBS program coordinators. The case-mix instrument (VA/Minnesota ADL form) takes 5-6 minutes to complete for each Veteran. (The form will take less time when the Veteran is well-known to staff). The survey form takes 20-40 minutes to complete, but coordinators may choose to allocate more time with their responses.

The VD-HCBS program coordinator should respond to all items in this request with the exception of the expenditure information which should be provided by the VAMC Finance Office.

All responses should be routed through the VISN GEC POC.
Responses are DUE in VACO (10P4G) on Friday 30 January 2012.

Questions on this request should be directed to Daniel Schoeps or Patrick O'Keefe in the Office of Geriatrics and Extended Care, VACO.

This Action Item on Veteran-Directed Home and Community-Based Services is assigned to:

VISN 01
  - Togus
  - Bedford
  - West Haven

VISN 02
  - Syracuse

VISN 03
  - New Jersey

VISN 05
  - Washington DC

VISN 06
  - Richmond

VISN 08
  - Gainesville
  - Bay Pines
  - Miami
  - Tampa

VISN 11
  - Ann Arbor
  - Battle Creek
  - Detroit
  - Saginaw
  - Illiana/Danville

VISN 12
  - Iron Mountain
  - Jesse Brown
  - North Chicago
  - Hines
  - Milwaukee

VISN 16
  - Fayetteville AR,
  - Little Rock

VISN 17
  - Central Texas/Temple
  - Dallas

VISN 20
  - Puget Sound

VISN 23
  - Sioux Falls
B. Veteran-Directed HCBS Program

B.1. Expenditure and Case-Mix Information

In order to complete a comprehensive analysis of the Veteran-Directed HCBS (VD-HCBS) program and funding needs, we are requesting the following redacted information. VD-HCBS program coordinators are responsible for compiling the information with the exception of question #3.

1. For each of the last ten* Veterans admitted to VD-HCBS:
   a. A completed VA/Minnesota ADL assessment (form and spreadsheet enclosed)
   b. The first and most recent submitted spending plans
   c. The first and most recent approved spending plans
   d. Most recent actual cost monthly invoice or quarterly reconciliation report (if actual expense method is used, also include back-up documentation sheet)

2. Total VD-HCBS expenditures at your Medical Center for FY 2011 (to be completed by VAMC Finance Office)

3. Total Enrollees in VD-HCBS for FY 2011

4. Total enrollees in the VD-HCBS Program (since start of program):
   a. Total new admissions:
   b. Total discharges:
   c. Total current enrollees:
   d. Total re-admissions:

5. For each of the last ten Veterans admitted to your Homemaker/Home Health Aide Agency (H/HHA) Program:
   a. A completed ADL assessment (same form and spreadsheet as 1a above)
   b. Number of authorized hours per week (indicate if Veteran is receiving VA-paid home hospice and the number of authorized hours for Community ADHC and In-Home Respite)

* If you have not enrolled ten Veterans yet please provide the information for all enrolled Veterans.

RESPONSES DUE TO VACO (10P4G) THROUGH VISN BY COB 30 JANUARY 2012. Questions can be directed to Daniel Schoeps or Patrick O’Keefe in GEC Policy.

C. Veteran-Directed HCBS Program – Program Coordinator Survey

Introduction:

We are interested in hearing your perceptions of the VD-HCBS program at the local (medical center) level, and in learning more about outcomes for Veterans who receive services through this program. We are particularly interested in answering the question: “Should VD-HCBS be sustained?”

The following questions address your experience and perceptions about the VD-HCBS program, the Veterans enrolled and services they receive, and outcomes attributable to this program.

Part I: About the VD-HCBS Program:

1. What do you see as the most important benefits you have seen for Veterans who participate in the VD-HCBS program? What difference does it make for Veterans?

2. Which aspects of the program are most predictive of these benefits?

3. What specific challenges has VD-HCBS helped to address?
4. What unique services does VD-HCBS facilitate that are not otherwise available?

5. What do Veterans like (and dislike) about VD-HCBS?

6. What do caregivers like (and dislike about VD-HCBS?

7. How do you perceive the quality of:

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Counseling supports (e.g. Care advisor/Care counselor) available to Veterans in VD-HCBS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Financial management available to Veterans in VD-HCBS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Of the participants currently in this program, what percent would have gone into a nursing home without these services, or needed other more costly care? __________
   a. How did VD-HCBS help these Veterans remain living at home?
   b. Were any Veterans able to be discharged out of a nursing home because of the VD-HCBS program?
   c. How did VD-HCBS help these Veterans return to their home?

9. How has this program helped the medical center?

10. Has VD-HCBS increased the use of VA services by Veterans?

**Part II: About Enrollees and Services**

1. What are the characteristics of Veterans enrolled in the VD-HCBS program at your medical center?

   Specifically:
   a. Are there particular characteristics of Veterans who are most likely to choose, or perceive benefit, from this program?
   b. Are there any Veterans that you think would NOT be good candidates for VD-HCBS?
   c. Do you avoid enrolling Veterans with any particular characteristics?

2. How many Veterans have been enrolled in VD-HCBS at your medical center?

   _____ # currently enrolled _______ total number served _____

3. Where do referrals to VD-HCBS come from? (E.g. VAMC, aging network)

   a. What is the approximate percentage of enrollments from each of these referral sources?

4. What types/amounts of services were enrollees receiving prior to their enrollment in VD-HCBS?

   a. Who was paying for them?

5. Are there Veterans wanting to be in the program but not yet being served?

   _____ yes  _____ no  _____ don’t know
   Comments:

6. How often do you see or personally follow-up with Veterans enrolled in VD-HCBS?
7. How do Veterans/families describe their experiences with care before and after enrolling in this program?

8. What do Veterans say are the best things of being in this program?

9. What do families/informal caregivers say?

10. How effective is VD-HCBS in: Please rate how you think Veterans would respond to each of the following:

<table>
<thead>
<tr>
<th>Not Effective</th>
<th>Somewhat Effective</th>
<th>Effective</th>
<th>Very Effective</th>
<th>Highly Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting Veterans’ needs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helping Veterans remain living at home?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving satisfaction with services and care?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving accessibility of goods and services?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

11. How important is Veteran and caregiver satisfaction? Why?

12. What percent of Veterans have used the flexibility that is possible with VD-HCBS?

   a. How have the Veterans used the flexibility that is possible with VD-HCBS? (give example)

13. What are some creative ways that Veterans have used this program?

14. Tell me a story that highlights a Veteran’s experience in the program that would portray the value of the program to others.

Part III. About Outcomes (this set of questions is your perceptions about outcomes for Veterans who participate in the VD-HCBS program)


2. What do you consider to be strengths of the program?

   What do you see as weaknesses?

3. What changes have you seen as a result of VD-HCBS?

4. What are the top two outcomes you see from VD-HCBS?

5. What would you say about the program that would make other VA medical centers say: “We have to have this program."

6. Has the VD-HCBS program: (check one)

   ___ exceeded expectations  ___ matched expectations  ___ performed below expectations

   Why/How?
7. What suggestions would you make to increase the availability and success of VD-HCBS?

Additional Comments:

If you are willing to have The National Resource Center for Participant-Directed Services contact you by phone for follow-up, please enter your contact information and best time to call:

Name:                                                    Telephone:
E-mail:                                                  Best days/times to call:

RESPONSES DUE TO VACO (10P4G) THROUGH VISN BY COB 30 JANUARY 2012. Questions can be directed to Daniel Schoeps or Patrick O’Keefe in GEC Policy.
# Appendix C: Minnesota Assessment

## G. Activities of Daily Living (ADLs)

List all sources of information for ADLS, using the following codes: Person (C), Informant (I), Medical record (R), Observation (O). Enter value of score in first box in left margin. Check as “dependence” in second box in left margin if value is asterisked.

### G.1 Dressing

How well are you able to manage dressing? By dressing, we mean laying out the clothes and putting them on, including shoes, and fastening clothes. Would you say that you:

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>can dress without help of any kind?</td>
</tr>
<tr>
<td>01</td>
<td>need and get minimal supervision or reminding?</td>
</tr>
<tr>
<td>02</td>
<td>need some help from another person to put your clothes on?</td>
</tr>
<tr>
<td>03</td>
<td>cannot dress yourself and somebody dresses you?</td>
</tr>
<tr>
<td>04</td>
<td>are never dressed?</td>
</tr>
</tbody>
</table>

### G.2 Grooming

Now I have some questions about how you manage with grooming activities like combing your hair, putting on makeup, shaving, and brushing your teeth. Would you say that you:

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>can comb your hair, wash your face, shave or brush your teeth without help of any kind?</td>
</tr>
<tr>
<td>01</td>
<td>need and get supervision or reminding or grooming activities?</td>
</tr>
<tr>
<td>02</td>
<td>needs and get daily help from another person?</td>
</tr>
<tr>
<td>03</td>
<td>are completely groomed by somebody else?</td>
</tr>
</tbody>
</table>

### G.3 Bathing

How well can you bathe or shower yourself? Bathing or showering by yourself means running the water, taking the bath or shower without any help, and washing all parts of the body, including your hair and face. Would you say that you:

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>can bathe or shower without any help?</td>
</tr>
<tr>
<td>01</td>
<td>need and get minimal supervision or reminding?</td>
</tr>
<tr>
<td>02</td>
<td>need and get supervision only?</td>
</tr>
<tr>
<td>03</td>
<td>need and get help getting in and out of the tub?</td>
</tr>
<tr>
<td>04</td>
<td>need and get help washing and drying your body?</td>
</tr>
<tr>
<td>05</td>
<td>cannot bathe or shower, need complete help?</td>
</tr>
</tbody>
</table>
G.4 Eating

How well can you manage eating by yourself? Eating by yourself means drinking and eating without help from anybody else, but you can use special utensils and straws. It also means cutting most foods on your own. Would you say that you:

<table>
<thead>
<tr>
<th>Value</th>
<th>Dep</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td></td>
<td>can eat without help of any kind?</td>
</tr>
<tr>
<td>01</td>
<td></td>
<td>need and get minimal reminding or supervision?</td>
</tr>
<tr>
<td>*02</td>
<td></td>
<td>need and get help in cutting food, buttering bread or arranging food?</td>
</tr>
<tr>
<td>*03</td>
<td></td>
<td>need and get some personal help with feeding or someone needs to be sure that you don’t choke?</td>
</tr>
<tr>
<td>*04</td>
<td></td>
<td>need to be fed completely or tube feeding or IV feeding?</td>
</tr>
</tbody>
</table>

G.5 Bed Mobility

How well can you manage sitting up or moving around in bed?

Would you say that you:

<table>
<thead>
<tr>
<th>Value</th>
<th>Dep</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td></td>
<td>can move in bed without any help?</td>
</tr>
<tr>
<td>01</td>
<td></td>
<td>need and get help sometimes to sit up?</td>
</tr>
<tr>
<td>*02</td>
<td></td>
<td>always need and get help to sit up?</td>
</tr>
<tr>
<td>*03</td>
<td></td>
<td>always need and get help to be turned or change positions?</td>
</tr>
</tbody>
</table>

G.6 Transferring

How well can you get in and out of a bed or chair? Would you say that you:

<table>
<thead>
<tr>
<th>Value</th>
<th>Dep</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td></td>
<td>can get in and out of a bed or chair without help of any kind?</td>
</tr>
<tr>
<td>01</td>
<td></td>
<td>need somebody to be there to guide you but you can move in and out of a bed or chair?</td>
</tr>
<tr>
<td>*02</td>
<td></td>
<td>need one other person to help you?</td>
</tr>
<tr>
<td>*03</td>
<td></td>
<td>need two other people or a mechanical aid to help you?</td>
</tr>
<tr>
<td>*04</td>
<td></td>
<td>never get out of a bed or chair?</td>
</tr>
</tbody>
</table>

G.7 Walking

How well are you able to walk around, either without any help or with a cane or walker, but not including a wheelchair? (If asked, clarify that independence in walking refers to the ability to walk short distances around the house. Independence in walking does not include climbing stairs.) Would you say that you:

<table>
<thead>
<tr>
<th>Value</th>
<th>Dep</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td></td>
<td>walk without help of any kind?</td>
</tr>
<tr>
<td>01</td>
<td></td>
<td>can walk with help of a cane, walker, crutch or push wheelchair</td>
</tr>
<tr>
<td>*02</td>
<td></td>
<td>need and get help from one person to help you walk?</td>
</tr>
<tr>
<td>*03</td>
<td></td>
<td>need and get help from two people to help you walk?</td>
</tr>
<tr>
<td>*04</td>
<td></td>
<td>cannot walk at all?</td>
</tr>
</tbody>
</table>
G.8 Wheeling

00 • Does not use wheelchair, or receives no personal help with wheeling.
01 • Needs and receives help negotiating doorways, elevators, ramps, locking or unlocking brakes or uses power driven wheelchair.
02 • Needs and receives total help with wheeling.

G.9 Communication

00 • Communicates needs.
01 • Communicates needs with difficulty but can be understood.
02 • Communicates needs with sign language, symbol board, written messages, gestures or an interpreter. (Do not code ESL)
03 • Communicates inappropriate content, makes garbled sounds, or displays echolalia.
04 • Does not communicate needs.

G.10 Hearing

00 • No hearing impairment.
01 • Hearing difficulty at level of conversation.
02 • Hears only very loud sounds.
03 • No useful hearing.
04 • Not determined.

G.11 Vision

00 • Has no impairment of vision.
01 • Has difficulty seeing at level of print.
02 • Has difficulty seeing obstacles in environment.
03 • Has no useful vision.
04 • Not determined.

G.12 Orientation

Orientation is defined as the awareness of an individual to his/her present environment in relation to time, place and person. See H.1 and H.4 for memory/orientation information.

00 • Oriented.
01 • Minor forgetfulness.
02 • Partial or intermittent periods of disorientation.
03 • Totally disoriented; does not know time, place, identity.
04 • Comatose.
05 • Not determined.
G.13 Behavior

Value Dep.

00 • Behavior requires no intervention
01 • Needs and receives occasional staff intervention in the form of cues because the person is anxious, irritable, lethargic or demanding. Person responds to cues.
*02 • Needs and receives regular staff intervention in the form of redirection because the person has episodes of disorientation, hallucinates, wanders, is withdrawn or exhibits similar behaviors. Person may be resistive, but responds to redirection.
*03 • Needs and receives behavior management and staff intervention because person exhibits disruptive behavior such as verbally abusing others, wandering into private areas, removing or destroying property, or acting in a sexually aggressive manner. Person may be resistant to redirection.
*04 • Needs and receives behavior management and staff intervention because person is physically abusive to self and others. Person may physically resist redirection.

Comments

G.14 Toileting

How well can you manage using the toilet? *(Using the toilet independently includes adjusting clothing, getting to and on the toilet, and cleaning one’s self. If reminders are needed to use the toilet this counts as some help.)* Would you say that you:

00 • can use the toilet without help, including adjusting clothing?
*01 • need some help to get to and on the toilet but don’t have “accidents”?
*02 • have accidents sometimes, but not more than once a week?
*03 • only have accidents at night?
*04 • have accidents more than once a week?
*05 • have bowel movements in your clothes more than once a week?
*06 • wet your pants and have bowel movements in your clothes very often?

Comments

G.15 Self-Preservation

Does the individual have the judgment and physical ability to cope, make appropriate decisions and take action in a changing environment or a potentially harmful situation?

00 • Independent.
01 • Minimal supervision.
02 • Mentally unable.
03 • Physically unable.
04 • Both mentally and physically unable.
G.16 **Special Treatments (Check all that apply.)**

- 00 No TX.
- 01 Tube Feedings
- 02 One or more TX such as:
  - Intravenous Fluids
  - Intravenous Medications
  - Blood Transfusions
  - Drainage Tubes
  - Symptom Control for Term. Ill
  - Isolation Precautions
  - Hyperalimentation/Hickman Catheter
  - Oxygen & Respiratory Therapy
  - Ostomies & Catheters
  - Wound Care/Decubiti
  - Skin Care
  - Other

G.17 **Clinical Monitoring**

- 00 Less than once a day
- 01 1-2 shifts
- 02 All shifts

G.18 **Special Nursing:** Use for Case Mix Classification Worksheet

In order to code this item “yes”, the person must receive either tube feeding only, or a combination of other Special Treatment ([02] in G.16 **and** 02 in Clinical Monitoring in G.17 above. Yes [ ] No [ ]

G.19 **Neuromuscular Diagnosis.** Also complete on page 6, E.4.

Yes [ ] No [ ]

**Comments on Functional Strengths/ADLs/Community Support Plan/Supervision Implications:**

VD-HCBS Program Evaluation 43
Appendix D:
Case Mix Descriptors and Weights

Case Mix Descriptors and Weights
Assessment Instrument: “VA/State of Minnesota Assessment ADLs Only”

Case Mix Classifications:

L: (Weight 0.85) Very low ADL needs (less than three and each can be scheduled ahead of time)

A: (Weight 1.0) Low ADL needs (up to three and one or more may need on call support such as positioning or toileting)

B: (Weight 1.3) Low ADL needs and behavioral needs

C: (Weight 1.64) Low ADL needs and special nursing needs (such as tube feeding or ventilator care on every shift)

D: (Weight 1.95) Moderate ADL needs (4-6)

E: (Weight 2.27) Moderate ADL needs and has behavioral needs

F: (Weight 2.29) Moderate ADL needs and special nursing

G: (Weight 2.56) High ADL needs (7-8)

H: (Weight 3.07) High ADL needs (7-8) and has behavioral needs

I: (Weight 3.25) High ADL needs (7-8) and requires supervision for eating to prevent choking

J: (Weight 3.53) High ADL needs (7-8), requires eating supervision to prevent choking, and has either a specific neurological diagnosis or behavioral needs

K: (Weight 4.12) Has high ADL needs (7-8) and requires special nursing

Note: Each case mix level has specific scoring criteria keyed to the VA Minnesota Assessment ADLs Only
## Appendix E:
### Coordinator Views on Veteran Characteristics for Program Success

<table>
<thead>
<tr>
<th>Site*</th>
<th>Are there particular characteristics of Veterans who:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. are most likely to choose, or perceive benefit, from this program?</td>
</tr>
<tr>
<td>(001)</td>
<td>Yes, reside in Rural areas and on Native American Reservations have benefited most from VD-HCBS program. Yes, those Veterans who do not choose to be involved with the complex FMS aspect of this program.</td>
</tr>
<tr>
<td></td>
<td>B. would NOT be good candidates for VD-HCBS?</td>
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<td></td>
<td>C) you avoid enrolling</td>
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<tr>
<td>(002)</td>
<td>Those who are homebound and alone at home, emptying their assets to avoid nursing home placement. Those with elderly spouse who are experiencing caregiver burnout or are experiencing deteriorating health. Those who cannot self-direct or do not have a representative. Those who need a lot of skilled nursing care that cannot be managed at home.</td>
</tr>
<tr>
<td></td>
<td>Develop screening processes that adhere to H/HHA NIC criteria.</td>
</tr>
<tr>
<td>(003)</td>
<td>Not specifically</td>
</tr>
<tr>
<td></td>
<td>Veteran with some cognitive impairment and designee would not be able to self-direct their care.</td>
</tr>
<tr>
<td></td>
<td>As indicated in b</td>
</tr>
<tr>
<td>(004)</td>
<td>Veterans with a stable routine are more likely to be able to manage the administrative aspect of the program. Veterans with a chronic illness or disability benefit from home modifications through the program, and can settle into a routine with the caregiver more easily. The VD-HCBS program moves slowly, and can be slow to respond to acute changes. I would avoid Veterans with compliance issues, and those with active substance abuse, due to the difficulties they would experience in managing their care. Terminally ill Veterans would be better served through Hospice, due to the slowness of the program to respond.</td>
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<tr>
<td></td>
<td>I would look carefully at Veterans with documented non-compliance, unless a responsible agent will assume coordination of the care. I would avoid a Veteran with end-of-life issues, as we can initiate Hospice Care much faster.</td>
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<tr>
<td>(005)</td>
<td>The ones that were frustrated with the traditional programs and all the rules of the program and the limited hours provided.</td>
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<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No, the program was offered and options counselors met with all those that were interested and identified by the traditional CADHC and H/HHA programs.</td>
</tr>
<tr>
<td>(006)</td>
<td>Veterans with involved family that can help manage all aspects of the program. Veterans that want to stay in their home until the end of life. Veterans living alone with cognitive capacity to manage employees and make sound decisions about care. Veterans with significant cognitive impairments living alone without family or friends to help manage care. Veterans that clearly need nursing home care and would be unsafe in the home environment no matter what services are put in place.</td>
</tr>
<tr>
<td></td>
<td>Veterans with significant cognitive impairments living alone without family or friends to help manage care</td>
</tr>
<tr>
<td>(007)</td>
<td>Veterans who have an identified caregiver already and are looking for a source to provide payment for them.</td>
</tr>
<tr>
<td>(008)</td>
<td>Younger Veterans with catastrophic disabilities</td>
</tr>
<tr>
<td>(009)</td>
<td>Yes, frail. Elderly and on limited incomes.</td>
</tr>
<tr>
<td>(010)</td>
<td>Those with mental health illness, paranoia, cognitive issues.</td>
</tr>
<tr>
<td>(011)</td>
<td>Veterans with an &quot;open-mind&quot;, and supportive social networks appear better at navigating this program</td>
</tr>
<tr>
<td>(012)</td>
<td>Veterans that have not been satisfied with agency providers and traditional services would possibly be more satisfied with this program. Younger Veterans that are disabled are hesitant to allow “strangers” into their homes to provide Respite. Having the liberty to choose a provider that they are comfortable with would result in higher satisfaction.</td>
</tr>
<tr>
<td>(013)</td>
<td>Yes, those who have very little support systems in place.</td>
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<tr>
<td>(014)</td>
<td>High need with high homemaking/driving needs that cannot be serviced with HM/HA program</td>
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<tr>
<td><strong>(015)</strong></td>
<td>Yes. All Veterans in the program have a high degree of physical dependence on others and low cognitive abilities.</td>
</tr>
<tr>
<td></td>
<td>Yes, if the Veteran is independent in care, they would not be a good candidate for the program.</td>
</tr>
<tr>
<td><strong>(016)</strong></td>
<td>Many are SCI/D Veterans, some dementia with representatives, ALS, and some with medically complex disease living in rural areas with minimal social support services. Veterans in rural counties where agency assistance and reliability is minimal or nonexistent.</td>
</tr>
<tr>
<td></td>
<td>As above – we screen the Veteran with the SW and then speak directly to the Veteran about their ability to find their own employees</td>
</tr>
<tr>
<td><strong>(017)</strong></td>
<td>Individuals who live alone, medically frail caregivers, and caregivers who need to maintain employment. Individuals who are not succeeding in traditional NIC programs due to behavioral issues or complex medical needs such as ventilator care.</td>
</tr>
<tr>
<td></td>
<td>Individuals with no community support and active substance abusers.</td>
</tr>
<tr>
<td><strong>(018)</strong></td>
<td>Possibly. Veterans who are seeking money for services for their caregivers.</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td><strong>(019)</strong></td>
<td>Veterans who require additional hours of care, not covered under other home health programs. Also, Veterans who are in need of services not currently provided by other home health programs, such as; companion or escort services and transportation.</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td><strong>(020)</strong></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>(021)</strong></td>
<td>Veterans that are homebound and need the assistance of a caregiver 24/7.</td>
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<tr>
<td></td>
<td>Seriously ill Veterans living alone without full time support. Needing 24 hr care.</td>
</tr>
<tr>
<td><strong>(022)</strong></td>
<td>1. Total care patients. 2. Live in remote areas or have limited access to agency services. 3. Not eligible for home health services due to income or no in-home caregiver or need more hours of care than what is available/authorized.</td>
</tr>
<tr>
<td></td>
<td>Yes, refer to 1b</td>
</tr>
<tr>
<td><strong>(023)</strong></td>
<td>Low level of functioning due to medical condition. They would need skilled nursing facility placement because they would lack the support system at home that</td>
</tr>
<tr>
<td></td>
<td>No, everyone is screened.</td>
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<tr>
<td></td>
<td>the VD-HCBS program provides.</td>
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<td>---</td>
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<tr>
<td><strong>024</strong></td>
<td>Veterans who wish to have close involvement with their care provider, due to their complex medical conditions and needs which require one consistent care provider.</td>
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<tr>
<td><strong>025</strong></td>
<td>Veterans and their family caregivers are motivated to stay in the home and so are also motivated to do the hiring and time sheets (employer responsibilities of the program). Many have high personal care needs and needs that occur at varied times of the 24 hour day</td>
</tr>
<tr>
<td><strong>026</strong></td>
<td>Must reside in Tarrant County, Veterans are mostly HBPC and SCIHC, Veterans are in need of at least 20 hours/week of home care</td>
</tr>
<tr>
<td><strong>027</strong></td>
<td>Many have caregivers that are on the verge of burnout and in need of assistance to continue to care for the Veteran in the home.</td>
</tr>
</tbody>
</table>

*sites in random order*
Appendix F: Veteran Stories

Veteran Stories

Veteran-Directed Home and Community-Based Services Program

One Spinal Cord Injury disabled Veteran was able to use funding to fix the automatic door on his wheelchair van so he could utilize it. Otherwise he was homebound. Another Veteran was able to go out of town and was able to pay a caregiver to go with him – attend a funeral for a family member. A third Veteran was a frequent faller – was able to put padded flooring down in his home. NO INJURIES since.

There is a young Veteran who has been part of the program since it began. He had a heart attack while he was in the military, and the subsequent loss of oxygen to his brain caused enough damage to render him impulsive, quick to anger, and almost childlike. His mother became his legal guardian shortly after his wife divorced him. His mother attempted to have him live with her, while continuing to work outside the home. She then had him placed at the State Home for Veterans, and subsequently had him placed in various Adult Foster Care Homes. None of the arrangements were satisfactory. The Veteran would wander away, become belligerent and aggressive. With the referral to the Veteran-Directed Care Program, the mother was able to quit work, become his full time caregiver and provide a stable living environment for the Veteran. The Veteran's brother lives close by and is able to take the Veteran on outings, hunting and fishing. Because of the Veteran-Directed Program, the Veteran is able to remain at home with the people who love and care about him and have his best interests at heart.

One Veteran currently served under this program had been moving to and from various (5-6) family members over the last 2 years. They juggled taking time off work and sharing the responsibility of caring for the Veteran. As he has advanced dementia, these changes totally incapacitated him. With this program, one family member has now been able to remain at home with him consistently for the past 2.5 years to both the Veteran’s and the family’s satisfaction.

One Veteran with dementia lives with his son. The son worked part time and cared for his father in the evening. The Veteran had a difficult time finding a HHA that he liked and was uncooperative with allowing the home health aide to assist with his personal care needs. He dismissed several home health aides. At times there were no other home health aides available and the Veteran would not receive care. The son felt his father was not safe at home. On one occasion, the son reported his dad was preparing something to eat and suffered a burn. There were frequent phone calls from the son complaining that the VA was not helping his father enough. Once the Veteran went on the Veteran-Directed program, and caregivers that the Veteran knew were caregivers, the Veteran became more compliant and cooperative with his personal care. He was safer at home because there was always someone available to be with him and prepare meals. The son has stopped calling and complaining that the VA was not helping his dad and is very happy with the program. Overall, the Veteran has better care and quality of life.

VD-HCBS helped a Veteran with a psychiatric diagnosis who was unable to remain in a nursing home due to his behavior. The Veteran was able to return home and hire a caregiver to provide 24-hour care.

Prior to the program, a caregiver hardly slept due to her husband wandering at night. She is now able to sleep because she hired a paid caregiver during the night while she sleeps.
Veteran was in a nursing home as his wife’s health did not permit her to take care of him anymore. This program allowed her to bring the Veteran home by hiring and purchasing adequate care.

Mr. P. is a 91 year old Veteran living alone in his home in Seattle. He had been struggling with preparing meals, safely taking showers, dressing, catheter care and was not able to manage his medications as needed. Mr. P. opted to hire an individual provider (IP) through Veteran-Directed Home and Community-Based Services (VD-HCBS) Program and now receives the help he needs. He comments, “If I didn’t have Melody [his IP], I don’t know what I’d do.” When I asked him what he thought of his IP and her performance, he commented that she is “200%! She’s really good!” Mr. P’s hygiene, diet and health have improved because the IP’s assistance. When I asked him if the VD-HCBS services he’s received have helped or improved the quality of his life, he told me with a gleam in his eye and a wide smile, “Oh, you know it!” In addition, Mr. P’s VD-HCBS care consultant was able to assist in coordinating repair of his roof through the volunteer help of Rebuilding Together Seattle. Also, Mr. P’s care consultant and IP are working to assist him in applying for a VA HISA grant to modify his basement entry to improve safety for him.

A female Veteran, age 53 with medical/psychiatric conditions, had experienced a high level of frustration and dissatisfaction with services as delivered through a traditional agency with the Home Health Aide program. There were multiple complaint calls and time spent listening and helping the Veteran to resolve issues that arose on a fairly regular basis.

This resulted in the Veteran refusing to continue with the assigned agency. It was clear to the team that the Veteran wanted more flexibility and control of coordinating her own care needs. The challenge was that the Veteran lived in a geographic location where options for alternate agencies was limited. The VA Team consulted with the Area Agency on Aging to determine feasibility to service Veteran’s geographic location. A Veteran-Directed program was presented as an option. The Veteran was very excited to learn and understand all aspects of program. The referral was sent and the process was begun for start of care. Shortly after the Veteran started in the program, the Veteran's father who has been determined to have a 100% Service-Connected disability relocated and transferred his care from a VA Medical Center in NY to Virginia. Now both the father and daughter are enrolled and experiencing a high level of satisfaction. Another Veteran suffered from depression/isolation, alcoholism, and only had use of one arm and one leg. When interviewed for services, he agreed to cut down on his drinking if he could be admitted to Veteran-Directed Care. He was able to have home cooked meals and adequate care. This resulted in an increase of self-esteem, which led to a haircut and better personal appearance. One Veteran has had his three closest neighbors cleared for being his caregiver. The primary caregiver has trained the rest and gives updates as needed. At any moment the primary caregiver should be unavailable due to emergency or illness, one of the others can step up and provide care to the Veteran. (Veteran has ALS and is nearing end stage of disease)

"I like to socialize. I've gone to the movies and I have my medical appointments.” For Frances P, a 73-year old U.S. Air Force Veteran from Syracuse, N.Y., socialization and even going downstairs in her home was difficult, if not impossible, before she started the Veteran-Directed Home and Community-Based Care Services Program (VD-HCBS). Through the program, Ms. P was able to hire her grandson and daughter to help out around the house, monitoring her diabetes and medical supplies, and help with her nails and hair. She receives meal deliveries daily and attends an adult day health care program twice a week. With help from VA's partner, the Oneida County Office for the Aging, a chair glide is now installed in Frances P's home. "You don't know what it is to sit on the chair and ride downstairs. I don't have pain in my legs. I can get from my bedroom to the first floor. I can go outside. To me that's the best part of the program. It doesn't separate me from the rest of my family," says Ms. P.
A 95yr old, 100% Service Connected disabled Veteran was in the VA nursing home for over a year. The Veteran was depressed and hopeless during the nursing home placement resulting in failure to thrive. The family was able to hire a non-traditional caregiver who was able to meet all of the Veteran's complex needs. The Veteran has not been hospitalized in over a year and his mood and physical function have improved since he has been at home. The Veteran and his family routinely state that this program has saved the Veteran's life. They report that the program has allowed Veteran not to just reside in the community but thrive in the community.

One Veteran used his emergency savings during this period. His wife was admitted to the hospital and then to a rehab facility after suffering a Transient Ischemic Attack. The veteran was admitted to a nursing facility for respite care while his wife was hospitalized. This had been their back-up plan and it worked very well. There was enough savings from the first year’s budget to pay for this without accessing the couple’s limited personal savings. The Veteran was able to return home within days of his wife with the paid caregivers back on the job providing personal care to him and homemaking services. They are now home together and very happy to be reunited.

The program allows one of the Veterans to have the aide with him when he travels.

A Veteran with a spinal cord injury living with his disabled wife was able to obtain assistance during hours that accommodated his waking and bed time. His caregivers were able to accompany him to the VA for physical therapy. The companionship and the flexibility of the workers normalized the Veterans daily routines. An Agent Orange Veteran was bound to a wheelchair after experiencing increased neurological symptoms. In addition, he was dependent on his disabled wife for rides to appointments and grocery shopping. An options counselor helped him get a handicap-equipped van and with this new freedom, he is able to get out of the house when he desires. He has also been able to participate in art, learn Spanish, and take music and guitar lessons at home.

Several of the enrolled Veterans have passed away while in the program. These Veterans were all able to live in their homes until death. Without this program, all of these Veterans would have lived their final months in an institutional setting. The families of the deceased Veterans have expressed gratitude that the VA made it possible for the Veterans to remain in their homes until death.

We have a 55 years old Veteran that is wheelchair bound and lives on an island. He is dependent on others to get up in morning and for many other care needs. Due to the remote location where he lives, there is only one home care agency that would provide services to him. That agency would charge extremely high rates for care due to this home’s location on the island and still could not meet all of his needs. The VD-HCBS program allowed flexibility for him in hiring workers and factoring in ferry fares and the other unusual needs of life on the island. If he did not have this service, he would have to go to a nursing home at his very young age.

In a fairly typical case, the Veteran had been active with the homemaker/home health aide program. He was generally happy with the service, but was restricted by policy related to tasks the worker was permitted to do. He also disliked the staff turnover. The Veteran hired several family members as his caregivers, dividing the assignment between them. He then had a group of regular workers whom he knew and trusted, available over a wide time range. The workers communicated between themselves to make certain of coverage for the Veteran. One Veteran enrolled in the program has a diagnosis of Amyotrophic lateral sclerosis (ALS). When initially enrolled, he was not yet using a ventilator; however as his disease progressed, he needed to be on a vent. His paid caregiver and his wife were both trained at the VA in working with the vent. This Veteran was successfully discharged from an Intensive Care Unit setting to his home on vent. The Veteran continues to do well at this time.