Veterans Independence Plus

Cost Benefit Analysis

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Introduction

The Veterans Health Administration (VHA) has had the opportunity to implement and expand the Veteran-Directed Home and Community Based Services Program (VD HCBS) since Battle Creek VA began enrolling Veterans in February 2009. The VD HCBS program is a partnership between the Department of Veterans Affairs and the Administration on Community Living (ACL). The program is a purchased service in which local Veterans Affairs Medical Centers (VAMCs) enter into provider arrangements with Aging and Disability Resource Centers (ADRC) and/or State Agencies on Aging (SAA). Veterans at risk for nursing home placement may be enrolled in the program in which they manage their own capped monthly budget to hire and direct workers and purchase goods and services that will best meet their personal care needs to remain in their homes. There are currently 42 operational VD HCBS programs with 6-10 sites expected to be operational in the next six months.

The Affordable Care Act section 2402a leads the national trend of balancing home and community based service (HCBS) options with current institutional care options. The VD HCBS program allows VAMCs to provide these participant-directed services to Veterans who prefer to remain in their homes while containing the cost of care. States that invest more in HCBS program have resulting lower overall long-term care costs and VD HCBS services have been shown to be a lower daily cost alternative to traditional home health services and have resulted in greater reductions of nursing facility care than the agency-based counterpart (Kaye, LaPlante, & Harrington, 2009)(Dale & Brown, 2006).

The Boston VA Healthcare System was approved to rollout the VD HCBS program in FY 11 with approval to receive Veterans Affairs Central Office (VACO) funding for fiscal years 2012 ($431,000) and 2013 (TBD). The first Veteran was enrolled into VD HCBS in August 2011.

The state of Massachusetts ADRC was recently awarded a funding opportunity from the ACL, VHA, and the Centers for Medicare & Medicaid Services (CMS) to significantly strengthen and expand their person-centered access programs and to help people learn about and access the long term services and supports (LTSS) that best meet their needs. This funding also provides access to a special opportunity being made available by the VHA to assist Veteran's

with disabilities and their family caregivers to access VHA-funded home and community-based services. The Aging and Disability Resource Center RFP also noted:

This funding opportunity provides a Special Opportunity to Expand HCBS Access for Veterans. The VHA has a long-standing partnership with the U.S. Department of Health and Human Services (HHS) through partnership agreements with the Aging and Disability networks to provide VD-HCBS. The VHA expands this existing partnership under this funding opportunity and will have expenditures up to $9 million each year over the project period in successfully awarded states. Funds will be disbursed through the Veterans Integrated Service Networks (VISNs)/Veterans Administration Medical Centers (VAMCs) to purchase ADRC Options Counseling services within the funded states (Aging and Disability Resource Center Program, 2012).

The VHA has submitted a proposal to OMB and the White House for a national roll-out. The anticipation nationally is that 35% of Veterans eligible for long term care services will be participating in VD HCBS programming within five years.

Background

The VD HCBS program provides Veterans of all ages the opportunity to avoid nursing home placement by directing their own home and community based services. Veterans may be eligible for the program if they have a Boston VA primary care provider and are determined to be in need of nursing home care as measured by functional dependency with three activities of daily living (ADL), and/or a significant cognitive impairment, or a combination of ADL with IADL dependencies that the VA determines requires ongoing in-home services. The targeted Veterans are those whose needs exceed the average number of hours available through the Homemaker/Home Health Aide (H/HHA) program and would otherwise require institutional placement and who desire to self-direct their services and supports.

The program provides Veterans with a capped monthly budget, which is determined based on the results of the Minnesota case-mix matrix model which can be found in ***Appendix A***. The matrix provides the Veterans with a level of care category, based on the number of personal care dependencies and other critical issues such as significant behavioral concerns,

special nursing needs, or neuromuscular diagnosis. The completed matrix provides a lettered score, “L” through “K” which determines their monthly spending caps

Table 1: Matrix of Lettered Scores

Urban Area	Case Mix "L"	Case Mix "A"	Case Mix "B"	Case Mix "C"	Case Mix "D"	Case Mix "E"	Case Mix "F"	Case Mix "G"	Case Mix "H"	Case Mix "I"	Case Mix "J"	Case Mix "K"
National Rate	$1,293	$1,678	$1,909	$2,240	$2,315	$2,552	$2,630	$2,714	$3,062	$3,143	$3,350	$3,904
Boston-Quincy, MA	$1,588	$2,061	$2,345	$2,751	$2,844	$3,135	$3,230	$3,334	$3,761	$3,861	$4,115	$4,795

The funds are provided by the VA and administered by the local elder services agency. The local elder services agency is responsible for evaluation of the Veteran on referral and at least quarterly, to confirm eligibility and safety with provided services. The agency also completes an evaluation on caregiver and potential care providers, which includes an administrative package, including tax forms and CORI checks. During the quarterly visits the agency monitors the Veteran’s well-being and efficacy of the program. These services are paid for by the VA as a monthly administrative oversight fee, which is included in the Veteran’s monthly budget.

The agency also provides training and support to the Veteran and caregiver regarding the development of the Veteran’s monthly spending plan. A third-party fiscal intermediary (FI) is responsible for all payroll services. For Veterans who are physically or cognitively unable to self-direct a surrogate whom is able to monitor the program services may be appointed. The Veteran or surrogate is responsible for signing and submitting timesheets to the FI for completion of payroll. The FI withholds payroll taxes and manages workers compensation insurance.

The care providers are typically family members, friends, and neighbors, although Veteran’s may hire private professionals. Homecare agencies are forbidden to be hired as part of the Veteran’s spending plan. Care providers provide personal care and complete household chores. Within their monthly spending plans, Veterans may also include the purchase of medically necessary goods and services. All spending plans must be submitted to the VA Medical Center program coordinator for approval.

Method

This review compared the costs and customer satisfaction levels of Veterans enrolled in the Boston VA VD HCBS program to a random sample of Veterans admitted to a VA contracted nursing home (CNH). All Veterans currently enrolled, as well as those who have been discharged from the VD HCBS program were included in this study (n=28). A random sample of (n=27) Veterans admitted to a CNH was compiled utilizing a list of Veterans admitted to a CNH as of March 30, 2013 and the website www.random.org.

The VA Computerized Patient Record System (CPRS) was utilized to collect demographic and diagnostic information. Only diagnostic information that would be related to the level of care needs of Veterans in need of nursing home care was collected.

Record reviews were completed for all CNH Veterans to enable completion of the Minnesota case mix matrix. All Veterans associated with the VD HCBS program had an updated Minnesota case mix matrix completed in person; all questions were answered by either Veteran or caregiver.

For all Veterans, both CNH and VD HCBS, a telephone interview was conducted to complete customer satisfaction surveys. The customer satisfaction survey for this study was developed locally utilizing preapproved questions. The identical survey questions were asked of both CNH and VD HCBS Veterans or caregivers. See ***Appendix B***.

Results and Discussion:

The general demographics of the VD HCBS Veterans, both enrollees and those on the waitlist (as of April 30, 2013), and the randomly selected Veterans admitted to a contacted nursing home can be seen in ***Table 2***.

Table 2: General Demographics

	VD HCBS Enrollees	VD HCBS Waitlist	CNH Veterans
Gender			
Male	28	64	25
Female	0	3	2
Age			
<60 years old	0	4	0
60-69	5	13	7
70-79	8	10	4
80-89	10	26	8
90-99	4	14	8
Ethnicity			
African-American	2	3	3
Asian	0	1	0
Caucasian	25	61	24
Hispanic	1	3	0
Service Connection %			
Non Service Connected	9	27	0
0-60	7	13	0
60-100*	12	27	100

*Includes 60% service connected and unemployable

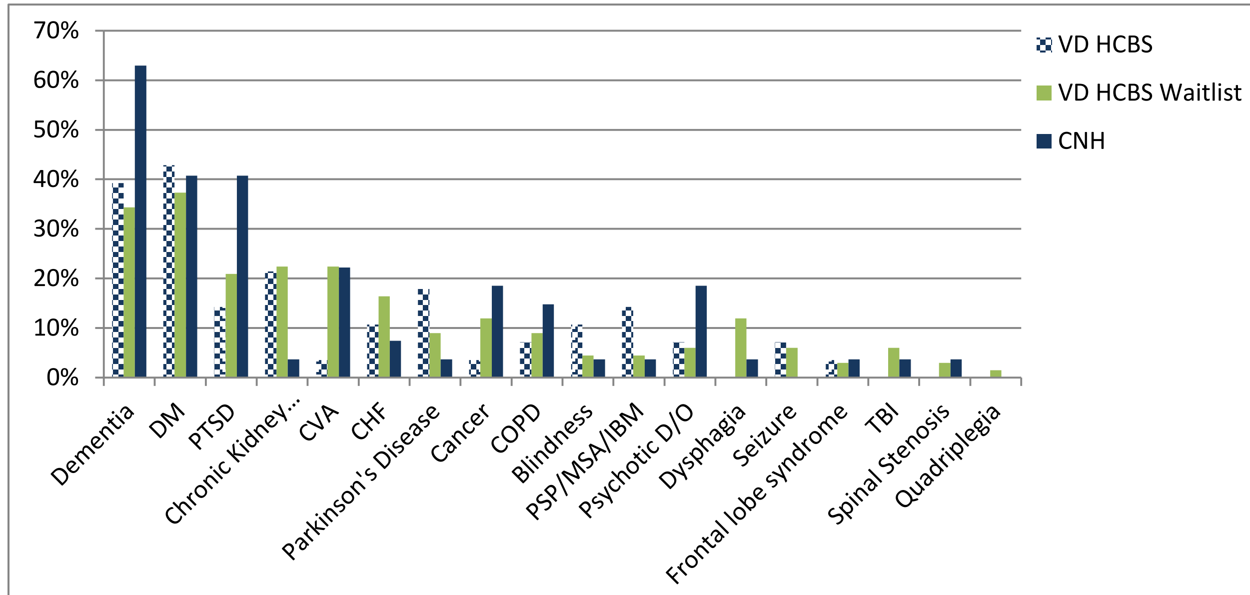
Table 3 shows the number of Veterans at identified VERA levels as of April 30, 2013. The VD HCBS Enrollees list includes all Veterans currently enrolled as well as those who have been discharged.

Table 3: Number of VD HCBS Veterans at VERA Levels

VERA Level	VD HCBS Enrollees	VD HCBS Waitlist	CNH
2	9	29	0
3	6	9	1
4	1	1	0
5	1	3	0
6	0	1	0
7	1	8	0
8	10	7	20
9	0	0	1
10	0	9	5

Figure 1 presents the frequency of severe chronic diagnosis in Veterans enrolled in VD HCBS, those on the waitlist for VD HCBS and Veterans admitted to a CNH. This information was obtained from their CPRS medical record. Of note, the majority of Veterans in all three groups have multiple chronic medical conditions.

Figure 1: Frequency of Severe Chronic Diagnosis in Veterans Served



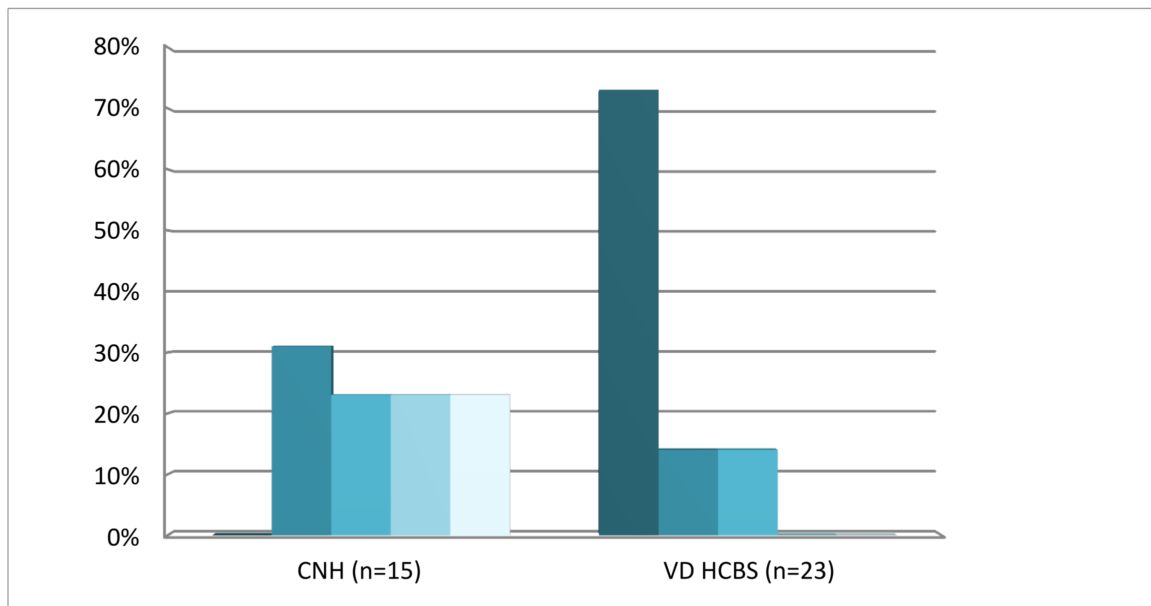
***PSP/MSA/IBM: Progressive Supranuclear Palsy/Multiple Systems Atrophy/Inclusion Body Myositis**

A customer satisfaction survey was given to a sample of Veterans or their care providers both currently and previously enrolled in VD HCBS. The surveyor completed 23 surveys with these Veterans. The survey was also conducted with a random sample of Veterans admitted to

a contracted VA nursing home. These surveys were completed via telephone by the Veteran's health care proxy. The surveyor attempted to contact 27 individuals, but was able to complete 15 surveys.

VD HCBS respondents reported a much higher rate of satisfaction in regards to ability of choosing their own providers as presented in ***Figure 2***. This is one of the motivating factors of offering the VD HCBS program as Veterans are able to choose people they are most comfortable with to assist them with activities of daily living.

Figure 2: How Do You Rate Ability to Select Providers



The survey also revealed that individuals receiving VD HCBS services reported higher quality responses to their personal wants and needs (87% v. 67%) and personal care needs (74% v 47%). This is shown in ***Figure 3.***

Figure 3: Rate Handling of Wants, Needs, and Personal Care Needs

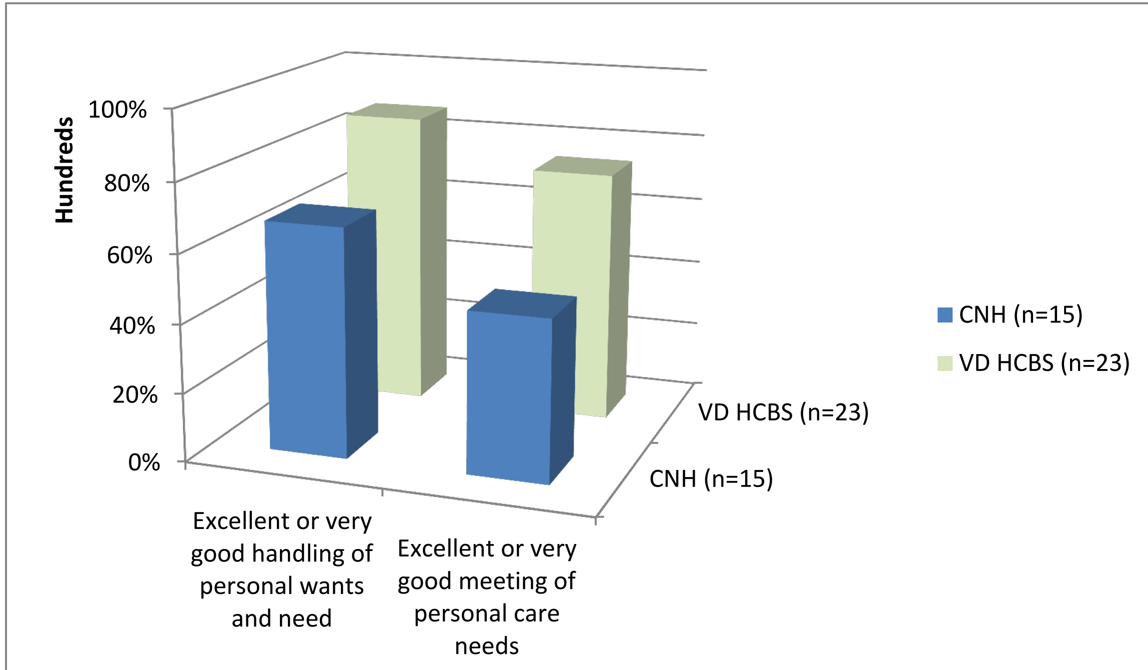
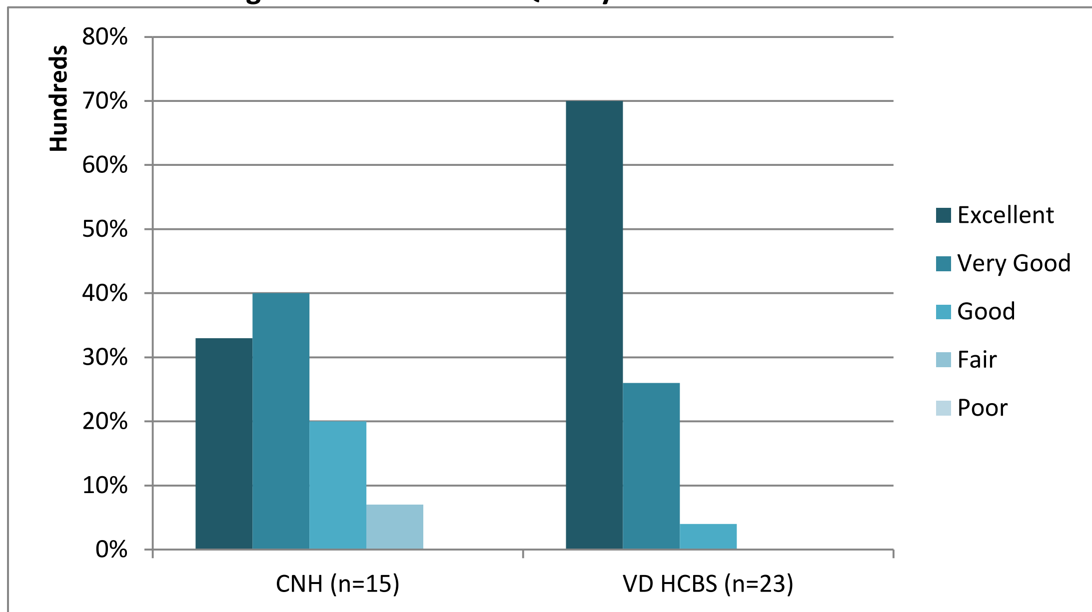


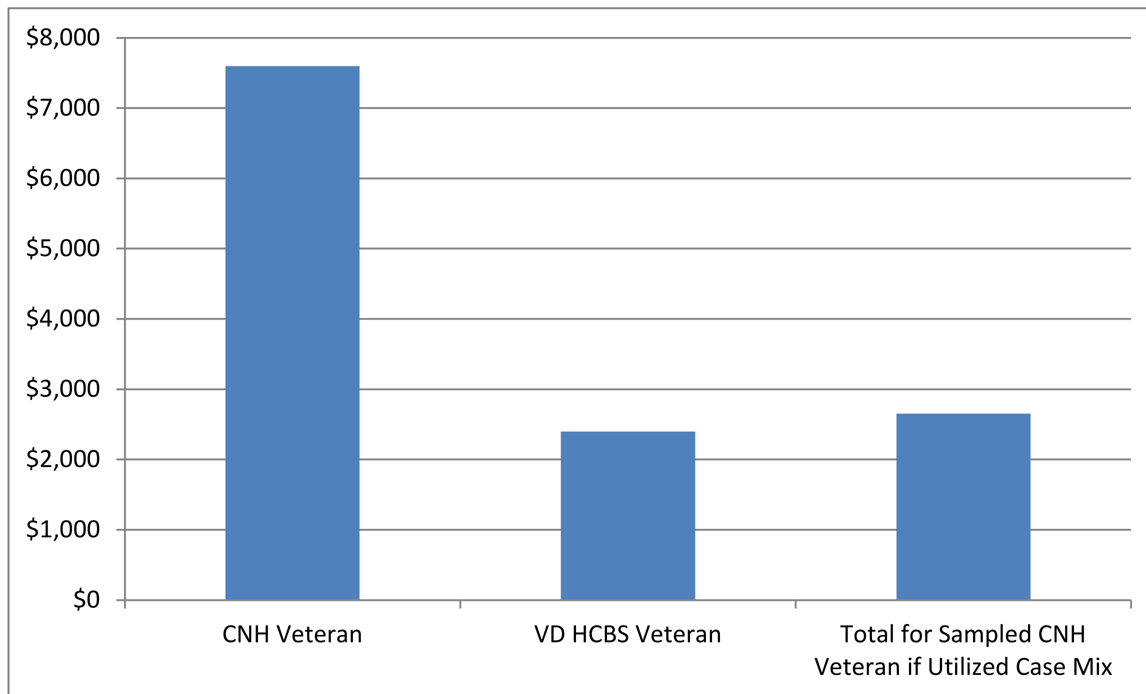
Figure 4 shows that respondents enrolled in VD HCBS services reported a higher level of overall quality of care and services received in the program compared to those received at contracted nursing facilities.

Figure 4: Rate Overall Quality of Care and Services



The final graph, ***Figure 5***, shows the average per month cost comparison per Veteran receiving VD HCBS services compared to CNH services. The CNH data is based on the average basic daily rate for the VA Boston Healthcare System ($250.74). The VD HCBS average monthly cost is the average of all 28 Veterans who have been enrolled in the VD HCBS program during the previous two years. Finally, the hypothetical average monthly costs for the CNH Veterans who were sampled for this analysis, if they were receiving VD HCBS services. This data was developed through a record review of each Veteran and the completion of a Minnesota Case Mix assessment.

Figure 5: Average Monthly Cost per Veteran



Conclusion

This report supports previous findings that VD HCBS programs appear to be less expensive than CNH care however, overall cost benefits will be seen on a case by case basis (A Comparison of Veteran Directed Health Care Programs vs. Community Nursing Home Placement, 2013) (Kayala & Mahoney, 2012). Nursing homes are necessary for individuals, requiring twenty-four nursing care due to the nature of their medical needs, safety concerns or risk for harm of self or others, but the VD HCBS program is a viable alternative to Veteran's who

may otherwise be admitted to a nursing facility, offering an option to remain in their homes and receive a more substantial level of care compared to other in-home support programs offered by the VA. The VD HCBS program also offers younger Veterans an opportunity to remain at home with more supports compared to being admitted to a facility where populations are typically elderly individuals.

The VD HCBS program has served 28 Veterans since the inception of the program in August 2011. The average length of time of the program is currently 374 days, with a range of 32 to 618 days. Of the ten Veterans who have been discharged, five were related to death, four were admitted to long-term care and one went to a rehabilitation facility following an acute medical condition.

As of April 30, 2013 there are 68 Veterans on the waiting list to receive services. This list works on a strictly first come first served basis. The next Veteran on the list to receive services was referred on April 12, 2012, making for a wait of 384 days. There have been 16 Veterans removed from the waitlist, 13 due to death and 3 were admitted to long-term care.

With an extensive waiting list along with the requirement for the VA Boston Medical Center to include VD HCBS within the medical center budget for FY 14, determination of funding levels and future eligibility criteria need to be determined.

Recommendations

- Should VA Boston VD HCBS continue to accept referrals for all Veterans or should eligibility be restricted to Millennium Bill eligibility Veterans?
- Should all Veterans enrolled in VD HCBS within the Home Based Primary Care (HBPC) coverage area, be required to receive HBPC services?
- What will the VA Boston VD HCBS budget cap be for FY 14?

References:

A Comparison of a Veterans Directed Health Care Program vs. Community Nursing Home Placement. Milwaukee VA Healthcare System. (2013).

Aging Disability Resource Center Program (May 31, 2012). OMB: 0985-0018

Dale, SB and Brown, R. (2006). Reducing Nursing Home Use Through Consumer-Directed Personal Care Services. *Medical Care*, 44, 760-767.

Kayala, Dianne and Mahoney, Ellen. (2012). “VD HCBS Program Evaluation,” National Resource Center for Participant Directed Services.

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APPENDIX A

Minnesota Case Mix Activities of Daily Living (ADLs) Only Assessment

[Note: Asterisks(*) denote dependency]

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

00 • can dress without help of any kind?

01 • need and get minimal supervision or reminding?

*02 • need some help from another person to put your clothes on?

*03 • cannot dress yourself and somebody dresses you?

*04 • are never dressed?

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:

00 • can comb your hair, wash your face, shave or brush your teeth without help of any kind?

01 • need and get supervision or reminding of grooming activities?

*02 • needs and get daily help from another person?

*03 • are completely groomed by somebody else?

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:

00 • can bathe or shower without any help?

01 • need and get minimal supervision or reminding?

02 • need and get supervision only?

03 • need and get help getting in and out of the tub?

*04 • need and get help washing and drying your body?

*05 • cannot bathe or shower, need complete help?

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:

00 • can eat without help of any kind?

01 • need and get minimal reminding or supervision?

*02 • need and get help in cutting food, buttering bread or arranging food?

*03 • need and get some personal help with feeding or someone needs to be sure that you don't choke?

*04 • need to be fed completely or tube feeding or IV feeding?

G.5 Bed Mobility

How well can you manage sitting up or moving around in bed? Would you say that you:

00 • can move in bed without any help?

01 • need and get help sometimes to sit up?

*02 • always need and get help to sit up?

*03 • always need and get help to be turned or change positions?

G.6 Transferring

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

00 • can get in and out of a bed or chair without help of any kind?

01 • need somebody to be there to guide you but you can move in and out of a bed or chair?

*02 • need one other person to help you?

*03 • need two other people or a mechanical aid to help you?

*04 • never get out of a bed or chair?

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:

00 • walk without help of any kind?

01 • can walk with help of a cane, walker, crutch or push wheelchair?

*02 • need and get help from one person to help you walk?

*03 • need and get help from two people to help you walk?

*04 • cannot walk at all?

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

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.

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?

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, Hyperalimentation/Hickman Catheter, Intravenous Medications, Oxygen & Respiratory Therapy, Blood Transfusions, Ostomies & Catheters, Drainage Tubes, Wound Care/Decubiti, Symptom Control for Term. Ill, Skin Care, Isolation Precautions, 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

Yes No

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

APPENDIX B

Customer Satisfaction Survey

How would you rate your ability to choose your health care providers?

□ Excellent □ Very Good □ Good □ Fair □ Poor □ Refused/Not Applicable

How would you rate the handling of your personal needs and wants?

□ Excellent □ Very Good □ Good □ Fair □ Poor □ Refused/Not Applicable

How well are your personal care needs such as, bathing, dressing, or toileting being met?

□ Excellent □ Very Good □ Good □ Fair □ Poor □ Refused/Not Applicable

How would you rate the level of courtesy and respect you are given?

□ Excellent □ Very Good □ Good □ Fair □ Poor □ Refused/Not Applicable

How would you rate the amount of peace and quiet?

□ Excellent □ Very Good □ Good □ Fair □ Poor □ Refused/Not Applicable

How would you rate the overall quality of care and services?

□ Excellent □ Very Good □ Good □ Fair □ Poor □ Refused/Not Applicable

Have you experienced any problems or concerns?

□ Yes □ No □ Refused/Not Applicable

Was your problem or concern settled to your satisfaction?

□ Yes □ No □ Refused/Not Applicable

Would recommend this type of healthcare to my family or friends who need care?

□ Yes □ No □ Refused/Not Applicable