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Long-Term Services and Supports Scorecard
Promising Practices

No Wrong Door: Supporting Community Living for Veterans

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Greater Choice and Control for Veterans


ROBERT

Robert is an 80-year-old Veteran who served in the Vietnam War. Robert is a huge Boston Red Sox fan with a kind and gentle heart, always willing to help people in need. He has a special love for all animals, especially his beloved dog, Fenway.

When Robert fell and broke his spine, requiring a stay in a nursing facility for rehabilitation, Robert and his wife, Carole, wanted him to return home after his therapy. Robert needed assistance with dressing, bathing, and transferring from a chair to bed. Carole, with health issues and limitations of her own, was not able to do any heavy lifting.

A social worker at the Veterans Affairs (VA) Medical Center referred Robert to the Veteran-Directed Home- and Community-Based Services (VD-HCBS) program. In VD-HCBS, Veterans utilize a flexible service budget to purchase care from family, friends, and neighbors; control how much they pay for that care; and decide when care is provided. In Robert's home, Lisa, the VD-HCBS counselor at the local Area Agency on Aging, facilitated a person- and family-centered process with Robert and Carole, as well as another family member, to establish a plan of support. Through a church bulletin, Robert and his wife hired multiple personal care attendants. Robert and Carole set up a schedule for personal care and meal preparation, as well as assistance with housework and shopping to allow Carole some respite and time to tend to her own health and medical appointments. Robert also identified home modification as a need. Lisa worked with the VA social worker to set up a consult for home modifications through a VA grant program to widen doors, add rails, and assess for any other modifications that would be beneficial for Robert and Carole. Finally, Robert also enrolled in the VA Home-Based Primary Care program that offers primary care supported by an interdisciplinary team that travels to him to provide health monitoring, therapies, mental health care, and nutrition as needed.

Carole feels much calmer now that Robert is home with her. Robert notes that his mood is better since his discharge, stating, "I'm just happy to be home." By setting their own goals and developing their own plan, Robert and his wife can maximize their independence and remain in their own home together.

About This Paper

This paper describes promising practices on how aging and disability network agencies, Veterans Affairs Medical Centers (VAMCs), and Veteran Benefits Offices in seven states (Connecticut, Minnesota, Missouri, New Hampshire, Nevada, Utah, and Washington) have forged partnerships to better support Veterans in community living. This paper begins with a checklist for these local organizations to enhance collaboration and truly create a "no wrong door" for Veterans and their family caregivers to receive services in the community. The checklist summarizes key tasks described in the paper and links to promising practices and national- and state-developed tools in three key programs: Veteran-Directed Home- and Community-Based Services, Connecting Older Veterans (Especially Rural) to Community or Veteran Eligible Resources, and the Ask the Question initiative. It also includes some opportunities for potential collaboration between aging and disability network agencies, VAMCs, and Veteran Benefits Offices regarding home-based care and care transitions.

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Introduction

THE NWD SYSTEM

Almost 20 percent of people ages 65 and older are Veterans, and nearly one-third (30 percent) of Veterans live with disabilities, compared with 14 percent of the non-Veteran population.[1] Roughly 4 out of 10 (42 percent) men over age 65 are Veterans.[2]

The US Administration for Community Living (ACL), Centers for Medicare & Medicaid Services (CMS), and Veterans Health Administration (VHA) have partnered for several years to support states' efforts to make it easier for individuals and their families to learn about and access long-term services and supports (LTSS) through Aging and Disability Resource Centers (ADRCs), sometimes called No Wrong Door (NWD) Systems. If people contact an organization within this system, they can be connected with information, referrals, and supports, resulting in "no wrong door" to services regardless of their age, income, or disability.

The NWD System comprises an array of organizations serving Veterans, older adults, and individuals with disabilities. It involves aging and disability network agencies including Area Agencies on Aging (AAAs), ADRCs, Centers for Independent Living (CILs), and state agencies that administer programs for people with disabilities, along with state units on aging. The system also includes agencies such as state departments of military and Veterans affairs, state Medicaid agencies, and state mental health and substance abuse authorities.

A state NWD System can help older adults, people with disabilities, and their family caregivers navigate the array of LTSS essential for community living. Access to timely, accurate, and relevant information on LTSS also supports family caregiving and can prevent or delay admission to a nursing facility.[3] This paper provides a follow-up to the AARP "No Wrong Door: Person- and Family-Centered Practices in Long-Term Service and Support" promising practice paper published in March 2017, which detailed how high-performing states promote person- and family-centered practices in NWD Systems.[4]

THE DEPARTMENT OF VETERANS AFFAIRS: A KEY NWD PARTNER

VHA is one of three administrations within the Department of Veterans Affairs, and stands as the largest integrated health care system in the United States, with 1,200 health care facilities, including 170 VAMCs and more than 1,000 VHA outpatient clinics.[5] VHA has a long history of being at the forefront of medical innovation, with staff involvement in developing the cardiac pacemaker and the CT scan, as well as conducting the first liver transplant and identifying new treatments for tuberculosis, schizophrenia, and high blood pressure.[6] VHA innovations also include the Home-Based Primary Care (HBPC) program, which brings a team of health care professionals into Veterans' homes to monitor their health status and well-being. The mission of VHA's Office Geriatric and Extended Care is to "honor Veterans' preferences for health, independence, and well-being in the face of aging, disability, or illness by advancing expertise,

1 US Census Bureau, 2016 American Community Survey one-year estimates, Veteran Status Subject Table, https://www.census.gov/acs/www/data/data-tables-and-tools/subject-tables/.

2 US Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, https://www.va.gov/vetdata/veteran_population.asp.

3 Administration for Community Living, Centers for Medicare & Medicaid Services, and Veterans Health Administration, *Key Elements of a NWD System of Access to LTSS for All Populations and Payers* (Washington, DC: 2015), https://nwd.acl.gov/docs/NWD-National-Elements.pdf.

4 Christina Neill Bowen and Wendy Fox-Grage, "No Wrong Door: Person-and Family-Centered Practices in Long-Term Service and Support," AARP Public Policy Institute, Washington, DC, March 2017.

5 Veterans Health Administration, About VHA, accessed October 4, 2017, https://www.va.gov/health/aboutVHA.asp.

6 Department of Veterans Affairs, *VA History in Brief*. Department of Veterans Affairs, accessed October 4, 2017 https://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf.

programs, and partnerships."[7] This mission overlaps with the goals of the NWD System.

The VA Benefits Administration stands as a second arm of the Department of Veterans Affairs and administers a variety of benefits and services that provide financial and other forms of assistance to service members, Veterans, and their dependents and survivors. Each state has a Veterans affairs office and regional offices to help connect Veterans to benefits.

BENEFITS OF COLLABORATION: GREATER CHOICE FOR VETERANS, REACHING MORE VETERANS, AND EFFICIENT USE OF RESOURCES

The Department of Veterans Affairs, in collaboration with ACL and CMS on the NWD System, supports two major priorities—greater choice and focused resources—articulated by David Shulkin, the secretary of the Department of Veterans Affairs (exhibit 1).

VHA recognizes the value of aging and disability network agencies in helping Veterans to develop person- and family-centered plans and direct their own care. VHA enters into formal funding agreements with aging and disability network agencies to serve as its designated entity for delivering the Veterans-Directed Home- and Community-Based Services (VD-HCBS) program. Veterans in VD-HCBS can manage their own budgets and caregivers. VD-HCBS supports choice and control in the lives of Veterans, helps balance LTSS spending, and provides greater access to HCBS for Veterans, particularly in rural areas, which is described in more detail later in the paper.[8]

In addition to these positive outcomes, aging and disability network agencies and VAMCs also report that the partnerships built through startup and implementation of VD-HCBS provide a gateway to greater coordination and collaboration among VAMCs, VA Regional Benefit Offices, and aging and disability network agencies. This remains consistent with positive outcomes reported in past analysis of collaboration between VAMCs and aging and disability network agencies.[9] This collaboration has many benefits, including the ability to reach Veterans who would not otherwise connect to VA services. Aging and disability network agencies serve as a potential access point for many Veterans unable or willing to travel to VAMCs or who may not have otherwise known they are eligible to use or receive VA health care and benefits.

With a better understanding and knowledge of each other's mission, programs, and services, VAMCs, VA Benefit Offices, and aging and disability network agencies can work together and focus resources to serve Veterans more comprehensively. This paper, beginning with the checklist in the next section, provides a starting point for initiating or enhancing these partnerships.

EXHIBIT 1
Veteran Priorities

Greater Choice. Veterans and their families deserve greater access, choice, and control over their health care. VA is committed to ensuring Veterans can make decisions that work best for them and their families.

Focused Resources. Veterans and taxpayers deserve to know that VA resources are spent on the care and services that Veterans need most.

Source: 2018 Veterans Affairs Oversight Hearing *(May 2017), (statement of David Shulkin, Secretary of the Department of Veterans Affairs),* https://appropriations.house.gov/calendar/eventsingle.aspx?EventID=394841.

7 Department of Veterans Affairs, Geriatrics and Extended Care Mission, Vision, Goals, accessed October 4, 2017, https://www.va.gov/GERIATRICS/GEC_Mission_Vision_Goals.asp.

8 Aimee Milliken, Ellen K. Mahoney, and Kevin J. Mahoney, "'It Just Took the Pressure Off': The Voices of Veterans' Family Caregivers in a Participant-Directed Program." *Home Health Care Services Quarterly* 35, no. 3–4 (July–December 2016): 123–36.

9 Kali S. Thomas and Susan M. Allen, "Interagency Partnership to Deliver Veteran-Directed Home and Community-Based Services: Interviews with Aging and Disability Network Agency Personnel Regarding Their Experience with Partner Department of Veterans Affairs Medical Centers." *Journal of Rehabilitative Research and Development.* 53, no. 5 (2016): 611–18, http://dx.doi.org/10.1682/JRRD.2015.02.0019.

Collaboration Checklist

This checklist—created specifically for this project—provides a road map for NWD Systems to promote collaboration between aging and disability network agencies and the local entities of the Department of Veterans Affairs. The items stem from lessons learned from the programs featured in this paper as well as promising practice interviews with representatives from leading states. The final column links to national- and state-developed resources to enhance collaboration in each area.

CHECK	AREA OF COLLABORATION	COMMON CHARACTERISTICS	TOOLS/STATE OR NATIONAL RESOURCES
	Identification and recognition of Veterans	✓ NWD System recognizes Veterans as a key target population—almost 20 percent of people ages 65 and older are Veterans. ✓ Asking if individuals have served in the military becomes part of standard NWD System protocol.	Ask the Question Initiative (*page 14*)
	Shared vision	✓ VA and aging and disability network organizations have conversed about key shared values for LTSS and how to work together to accomplish shared goals. ✓ The aging and disability agency leverages its expertise and resources to support an area of need identified by the VA.	Geriatrics and Extended Care website (*page 18*) NWD Key Elements (*page 18*)
	Veteran direction	✓ VAMC leadership embraces self-direction as a way to control LTSS costs and promote Veteran choice and control. ✓ The aging and disability network agency supports self-directed models by ensuring staff capacity and recognizes value in partnership with VA.	NWD VD-HCBS Resources website (*page 18*) Washington Participant Spending Plan Tool and Self-Assessment (*page 8*) Minnesota VD-HCBS Orientation Pamphlet (*page 9*) Billing and Invoicing Methodology Guide (*page 11*)
	Communication	✓ The organizations have regular check-in meetings for ongoing collaboration.	Missouri FAQ for Program Administrators (*page 10*) Connecticut and New Hampshire strategies (*page 10*)
	Cross-training	✓ The organizations hold trainings on the services each network offers Veterans. Potential topics include the following: • Veterans Benefits 101 • Older Americans Act and Rehabilitation Act • Understanding Military Culture • Suicide Screening and Prevention • Energy Assistance Programs	Utah COVER to COVER website and training materials (*page 12*)

PROMISING PRACTICES

CHECK	AREA OF COLLABORATION	COMMON CHARACTERISTICS	TOOLS/STATE OR NATIONAL RESOURCES
	Family caregiver support	✓ Aging and disability network organizations and VAMCs are aware of what each has to offer to family caregivers and make referrals to appropriate programs and supports.	Shared Decision Making Toolkit - Caregiver Worksheet (*page 8*) Caregiver Supports (*page 7*)
	Evaluation	✓ NWD System organizations work together to track outcomes in Veterans lives as a result of collaboration between entities.	National Recommended Survey Satisfaction Tool and Procedures for VD-HCBS (*page 7*) Connecticut Case Study on VD-HCBS (*page 9*) Missouri VD-HCBS Quarterly Report (*page 9*)
	Future opportunities	✓ VA care transitions, home-based primary care (HBPC) programs, and medical foster home programs utilize the LTSS expertise of aging and disability network agencies for referrals and ongoing support.	C-TraC materials (*page 15*) Geriatric and Extended Care HBPC Website (*page 15*) VA Medical Foster Homes Fact Sheet (*page 16*)

Identifying Promising Practices

The 2017 LTSS State Scorecard, published by the AARP Public Policy Institute in collaboration with AARP Foundation, The Commonwealth Fund, and The Scan Foundation,[10] measured states' progress in developing high-performing LTSS systems. AARP fielded the following two state surveys to capture information for the Scorecard, which provided the basis for this paper.

- ***NWD State Survey.*** The LTSS Scorecard team collected information for the NWD indicator from states through a detailed self-reported survey. The survey included a question on establishing contractual agreements with VAMCs to implement VD-HCBS. Connecticut, Minnesota, Missouri, New Hampshire, and Washington have statewide VD-HCBS implementation or plans for statewide expansion. They also scored within the top 10 states overall in the Scorecard. Although Utah ranked low on the overall NWD indicator, it demonstrated commitment to statewide expansion of the VD-HCBS program in the NWD Survey question about provider agreements. It was also the first state to implement the COVER to COVER initiative.
- ***Medicaid and Aging and Disability Network Agencies State Survey.*** The Scorecard team fielded a second state survey that included an open entry field for states to report promising practices, through which Nevada highlighted its work with Veterans.

ACL, VHA, and The Lewin Group interviewed experts within those states to inform the promising practices in this paper (exhibit 2). VHA also provided an inventory of existing promising practices,[11] and The Lewin Group cross-walked those practices to identify existing or potential connections with NWD Systems.

EXHIBIT 2
Promising Practices States

STATE	OVERALL NWD FUNCTION RANK IN THE SCORECARD	RATIONALE
Connecticut	5	Statewide VD-HCBS implementation
Minnesota	2	Plans for statewide VD-HCBS expansion
Missouri	9	Plans for statewide VD-HCBS expansion
Nevada	28	Submitted promising practice with AARP scorecard survey; COVER to COVER
New Hampshire	2	Statewide VD-HCBS implementation and Ask the Question initiative
Utah	46	Statewide VD-HCBS implementation; COVER to COVER
Washington	1	Statewide VD-HCBS implementation

10 Susan C. Reinhard et al., *Picking up the Pace of Change, 2017: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, June 2017).

11 John A. Hartford Foundation and US Department of Veterans Affairs, *Next Steps 2016: A Post-Summit Report: Non-Institutional Healthcare Transformation Initiatives for the 21st Century within the Veterans Health Administration* (August 2016).

Promising Practice I: Veterans-Directed Home-and Community-Based Services

VHA and the ACL developed the VD-HCBS program in 2008 to provide Veterans with greater choice and control of their LTSS and enable them to live at home and engage in their community. The VD-HCBS program leverages a nationwide network of aging and disability network organizations within state NWD Systems to offer a self-directed home- and community-based option for Veterans at risk of nursing home admission. Modeled after the US Department of Health and Human Services– and Robert Wood Johnson Foundation–funded Cash and Counseling demonstration, VD-HCBS is an evidence-based program that enables Veterans to plan for and direct their LTSS and meets the needs of the most vulnerable Veterans at lower cost than would be possible through traditional approaches.

Prior to VD-HCBS, Veterans with LTSS needs had two options: (a) access a traditional service delivery model in which the Veteran and his or her family had to fit care needs into provider agency policies and procedures, or (b) live in a nursing home. With VD-HCBS, Veterans work together with staff from the NWD System to design their care to fit their life rather than making their life fit the care. Veterans in VD-HCBS manage a flexible budget, schedule their care at the times and hours that work for them, and hire and supervise their own caregivers (exhibit 3).

VHA purchases VD-HCBS from aging and disability organizations within a state NWD System. These VD-HCBS providers facilitate a person- and family-centered assessment and the development of a plan with the Veteran, as well as provide fiscal management services (FMS) and ongoing person- and family-centered counseling for Veterans and caregivers.

As of September 2017, the VD-HCBS program operated in 34 states, the District of Columbia and Puerto Rico, 62 VAMCs, and 182 aging and disability network agencies. Additionally, as of September 2017, VD-HCBS providers in the NWD System serve more than 2,079 Veterans and have cumulatively served 6,570 Veterans since the start of the program.[12]

The VHA Office of Geriatrics and Extended Care announced a national rollout of the program with plans for implementation in the remaining 92 VAMCs within the next three years. This rollout coordinates with an evaluation conducted by VA Health Services Research and Development investigators to understand the impact of this program on Veterans' health, health care utilization, costs, and well-being. Additional evaluation criteria will focus on the impact of VD-HCBS on Veterans' caregivers and the implementation of this program from the vantage points of the VAMCs and NWD System organizations.

EXHIBIT 3

Veteran-Directed Home- and Community-Based Services

This is a program that enables Veterans to manage a flexible service budget and hire family, friends and neighbors to provide care and purchase goods to help them live in the community. Key components include the following:

- Veteran-directed model
- Flexible budget for services
- Ability to hire friends and family
- Person- and family-centered counseling provided by the NWD System
- Fiscal management services to process workers' payroll and taxes

Source: *"Veterans Directed Home and Community Based Services," No Wrong Door, accessed October 4, 2017* https://nwd.acl.gov/vd-hcbs.html.

12 The Lewin Group Technical Assistance Monthly Report: September 2017.

The following sections detail benefits of the VD-HCBS program, including supporting community living, shared decision making, cost savings to the VHA, building sustainable partnerships, and enhanced business capacity of aging and disability network agencies.

SUPPORTING COMMUNITY LIVING WITH CHOICE AND CONTROL

Veterans report high levels of satisfaction with the foundational elements of the VD-HCBS program—choice, control, and community living. Sixty-nine percent of Veterans (n = 164) reported the likelihood and near certainty of nursing home placement without VD-HCBS.[13] Measuring participant satisfaction and outcomes remains important for ensuring the delivery of a quality VD-HCBS program. The national toolbox includes resources for VD-HCBS programs to measure satisfaction. The Veteran Experience Tool, developed by the national evaluation team, serves as a guide for VD-HCBS programs rolling out in the remaining 92 VAMCs. This section highlights some of the state promising practices to support Veterans at home.

National Toolbox:

Recommended Survey Satisfaction Tool and Procedures for VD-HCBS

Veteran Experience Tool

Missouri—Flexible Spending to Keep Veterans at Home

The VA St. Louis Health Care System reported that VD-HCBS allows the VAMC to provide more services to Veterans as a result of the flexible spending budgets provided through VD-HCBS. Veterans can buy or receive more services when compared with traditional home health programs by negotiating their own prices for private pay, which results in lower rates than traditional agency care. Through these types of purchases, which include support with personal care needs and other goods and services, the Veteran maintains a level of functioning that facilitates community living. For example, a Veteran struggling with hoarding used his flexible spending to hire someone to help declutter his house to reduce the risks of tripping and falling in his home.

Caregiver Support Toolbox:

VA Caregiver Support Website

Zarit Caregiver Burden Interview

NH Caregiver Training Resources

Washington, Missouri, and New Hampshire—Supports for Family Caregivers

The VD-HCBS program not only benefits Veterans, it also provides important support for family caregivers. The person- and family-centered assessment process for VD-HCBS includes consideration of caregiver well-being in addition to that of the Veteran.

- The Washington VD-HCBS program provides a break from caregiving by paying for respite for the family caregiver as well as education and support for the caregiver to continue providing care. In addition, if the Veteran hires the family caregiver to perform certain personal care tasks, the family caregiver is compensated for the care he or she provides.
- The Missouri VD-HCBS program tracks family caregiver burden by incorporating evidence-based Zarit caregiver burden interview questions as standard protocol and tracking family caregiver burden quarterly. The program also tracks the family caregiver's perception of the ability of the VD-HCBS program to keep the Veteran at home.
- The New Hampshire VD-HCBS program provides caregiver training information to its

13 The Lewin Group, *The Veterans Directed Home & Community Based Services Program: Veteran Experience Analysis* (Falls Church, VA: The Lewin Group, 2014), https://nwd.acl.gov/docs/Veteran%20Experience%20Analysis%20Exec%20Summary.pdf.

FMS provider. The FMS provider distributes the training packet, including topics such as understanding post-traumatic stress disorder, suicide risk, traumatic brain injury, and understanding military culture, to all new hires.

The Department of Veterans Affairs hosts a comprehensive website for caregivers including diagnosis specific resources and a 1-800 number for support.

Minnesota—Solution to Limited Rural Providers

Prior to VD-HCBS, Veterans living in the service area covered by the Minnesota River AAA in rural Mankato found it challenging to find home care agencies willing to travel to provide support. Veterans can now hire family, friends, and neighbors who live in proximal distance. Veterans report that this ability to hire local support workers increases their satisfaction with services as well as helps keep them at home. Additionally, through VD-HCBS, Veterans choose when they need a worker, rather than relying on a home health agency's availability or minimum number of hours. For example, if a Veteran needs assistance for an hour at the beginning and at the end of each day, he or she can split time between two people or have one person split his or her hours to accommodate the Veteran at the needed times.

SHARED DECISION MAKING

The participant-directed component of the VD-HCBS program includes budget authority for the Veteran and emphasis on greater choice and control in LTSS decisions. NWD System organizations support Veterans in self-directing their care by providing person- and family-centered counseling as part of the VD-HCBS program. The counselor supports Veterans in the development of a plan that identifies their preferences, strengths, needs, goals, and who will provide care and services. VHA offers a toolkit on supported decision making to help Veterans enrolled in VD-HCBS and their families in the planning process. The toolkit includes an overview of the definition of shared decision making; a worksheet for Veterans to help identify goals, preferences, priorities, options, and actions steps; a worksheet for the caregiver to help prioritize support needed; and several short videos on shared decision making.

National Toolbox:

Shared Decision Making Toolkit

Washington—Facilitating Participant Self-Assessment

The Washington VD-HCBS program developed a tool for Veterans to help plan their supports. The tool provides a chart for the Veteran to record needs and identify how to best meet them, including through paid and unpaid supports. The tool links to the formal state assessment, but primarily serves as a self-directed planning tool. After the Veteran uses the self-assessment to identify needs, the NWD counselor reviews the formal assessment and adjusts it to include services/items the Veteran identifies. The Washington VD-HCBS program also developed a spending plan tool to help Veterans manage their flexible budgets. The NWD counselor supports the Veteran as he or she designs a plan that will work for his or her unique situation. These tools are included with other program support documents in a VD-HCBS program manual provided to all participating sites. All NWD counselors receive a manual to ensure the program principles and operating practices remain similar across the state. The manual represents a collaborative effort between Washington state and its local VAMC partners.

Washington Toolbox:

Participant Self-Assessment Planning Tool

Participant Spending Plan Tool

Minnesota—Harnessing the Expertise of the Centers for Independent Living for Participant Direction

When designing the VD-HCBS program in Minnesota, the state unit on aging (SUA) knew it needed counselors skilled in person- and family-centered practice, as well as an agency close to the rural counties where some of the Veterans lived. The SUA contracted with Southwestern Center for Independent Living (CIL) to provide person- and family-centered counseling to Veterans in the program. CILs have extensive expertise in delivering participant-directed services; this expertise, paired with the location of the Southwest CIL, made this organization a good match to serve Veterans living in rural areas who were enrolled in the Minnesota VD-HCBS program. The Southwest CIL also developed educational materials that explain the participant-directed nature of the program.

Minnesota Toolbox:

VD-HCBS Orientation Pamphlet

INCREASING ACCESS: SERVING MORE VETERANS FOR THE SAME AMOUNT OF MONEY

VD-HCBS provides support to enable Veterans with nursing home level of care needs to continue living at home. A number of programs at local VAMCs have seen trends in reductions in emergency room use, hospital utilization, and skilled nursing facility admissions for Veterans enrolled in VD-HCBS. A study at the Boston VAMC compared the costs of Veterans living in a community nursing home with those Veterans with a nursing home level of care who are enrolled in the VD-HCBS program. The study found that the VD-HCBS program could serve three Veterans at home for the same cost of serving one Veteran living in a nursing home.[14] The VD-HCBS programs in St. Louis, Missouri; Milwaukee, Wisconsin; and Chillicothe, Ohio, performed similar evaluations with their programs and community nursing home care and also found cost savings associated with participation in VD-HCBS.[15]

Connecticut—Documenting Cost Savings

The West Haven VAMC has seen cost savings from enrolling Veterans in VD-HCBS, which has totaled over $600,000. For example, 80 percent of Veterans in VD-HCBS would otherwise be in a nursing home without VD-HCBS for disabilities and conditions, such as amyotrophic lateral sclerosis, mental illness, spinal cord injuries, Parkinson's, or multiple sclerosis. Veterans would incur these costs had they stayed at a nursing home for a 12-month period. (The $600,000 includes the nursing home costs minus the VD-HCBS plan of care costs.)

Connecticut Toolbox:

VD-HCBS Case Study

Missouri—Reduction in Emergency Room Visits

The VA at the St. Louis Health Care System documented its success in reducing emergency room visits for Veterans enrolled in VD-HCBS. Emergency room visits were studied for six months pre-enrollment in VD-HCBS and six months post-enrollment in VD-HCBS for 155 Veterans. There was a 50 percent reduction in emergency room visits six months postenrollment in VD-HCBS. Additionally, hospital admissions were reduced by 48 percent, and bed days of care were both reduced by 63 percent. A sample quarterly report appears in the toolbox detailing the types of information tracked over time.

Missouri Toolbox:

VD-HCBS Quarterly Report

14 Local VD-HCBS sustainability studies are available at https://nwd.acl.gov/vd-hcbs.html.

15 Ibid.

BUILDING SUSTAINABLE PARTNERSHIPS

Sustaining and growing the VD-HCBS program demands a high level of coordination and collaboration between VAMCs and NWD Systems. Partnerships with the NWD Systems expand the VA to a larger network of providers and individuals. The promising practices below provide examples of strategies to grow and sustain these critical partnerships.

Missouri—Collaborative Decision Making Key to Success

The Mid-East AAA and the St. Louis VAMC maintain a strong collaboration through the VD-HCBS program. From the beginning, decisions involved a broad array of stakeholders on e-mails, conference calls, and in-person meetings, if possible. Collective decision making occurs through engaging multiple levels of VA staff, including VAMC leadership and case managers. The AAA and VAMC collaboratively develop operational forms and reporting mechanisms. They utilize a cloud-based Frequently Asked Questions (FAQ) document for ongoing communication. Staff and supervisors can view, add, and share information as needed on the shared server. They cite the cloud server as a work in progress. The FAQ supplements the policy manual, and most answers result from joint discussion with VAMC staff. The FAQ appears in the toolkit as an example of the types of issues logged, not as specific guidance for other programs. The VAMC provides an annual report to VA leadership incorporating data provided by the ADRC on the benefits of the program. The process has made the VA more aware and more knowledgeable about other services provided through the ADRC, such as specific disease-related groups, legal services, non-VA health insurance assistance, nutrition, housing, energy assistance, home-delivered meals, transportation, and state health and senior services.

Missouri Toolbox:

FAQ for Program Administrators

Connecticut—Quarterly Meetings Facilitate Successful Partnerships

The NWD System in Connecticut meets quarterly in person with its VA partners to promote open communication. Attendees include AAA counselors who support Veterans, AAA executive directors, and VA program directors. They discuss topics such as challenging situations, billing, strategies to keep Veterans out of the hospital, and creative options for services. The meetings ensure that the partners have a forum for discussion of what's working and what's not working in the program.

New Hampshire—Joint Home Visits

In New Hampshire, the VAMC and the ServiceLink ADRCs conduct the Veteran assessment and planning jointly with the Veteran and his or her family. The assessment takes a little over an hour, during which the Veteran and his or her family and staff from ServiceLink and the VA discuss LTSS benefits, housing, VA benefits, and VD-HCBS. The collaborative assessment covers services that a Veteran may need both within the VA and in the broader community. The joint home visit allows the ServiceLink and the VA to work better as a team. The ServiceLink serves as the entry point and full access partner for New Hampshire within its NWD System of Access called NHCarePath. NHCarePath provides guidance, support, and choice for older adults and people with disabilities of all ages and income levels. The VA leverages ServiceLink to customize supports for the Veteran and his or her family caregiver to ensure additional information and access about community-based services and supports that the VA does not always know about.

BUILDING BUSINESS ACUMEN OF THE NWD SYSTEM

NWD Systems operating VD-HCBS programs must develop expertise in management of cash flow and coordination with contractors such as fiscal management services. Building this capacity opens up many opportunities for the NWD System to work in other health care

markets, such as managed care and accountable care organizations. ACL has worked with states to synthesize best practices from local programs into a billing and invoicing guide as well as a VD-HCBS spending report.

VD-HCBS providers use the following two delivery models to serve Veterans within the VD-HCBS program:

- *Sole proprietor/single agency model.* In this model, the VD-HCBS provider performs all administrative functions of the program, as well as person- and family-centered counseling services.
- *Hub and spokes model.* In this model, the VD-HCBS provider (the "hub") performs all administrative functions of the program and potentially person- and family-centered counseling services and also manages subcontractual agreements with other organizations (the "spokes") to deliver person- and family-centered counseling services. This is an innovative model because it allows smaller agencies without the cash flow capability or administrative capacity to participate in the program. From a Veteran's perspective, VD-HCBS is exactly the same regardless of the business model used by the VD-HCBS to deliver the program.

National Toolbox:

Billing and Invoicing Methodology Guide

Connecticut–Hub and Spokes Model

Some NWD organizations in Connecticut have come together to build operational efficiencies to more effectively deliver VD-HCBS. In this model, one NWD organization—the Southwestern CT AAA—serves as the VD-HCBS provider (or "hub") and performs the administrative functions for other AAAs involved in the program (North Central CT AAA, Senior Resources AAA, and Western CT AAA—the "spokes"). Southwestern CT AAA has ultimate responsibility for the delivery of the program, including managing the person- and family-centered counseling subcontracts with the spokes. The Southwestern CT AAA then enters into subcontracts with four other NWD organizations (also "spokes") to deliver person- and family-centered counseling services to Veterans in areas that Southwestern CT AAA does not cover.

Promising Practice II: COVER-to-COVER

Connecting Older Veterans, Especially Rural, to Community or Veteran Eligible Resources (COVER to COVER) represents another initiative that the NWD System is using to increase access to VA benefits, which includes training NWD staff as Veteran Benefits Specialists. The COVER to COVER program began as a pilot in Utah that operates in partnership with the VHA Office of Rural Health, the Utah Aging & Disability Resource Center/NWD System, the Utah Department of Veteran and Military Affairs, and the Salt Lake City Veterans Benefits Administration Regional Office. The COVER to COVER program asks a specific question of everyone who connects with the NWD System: "Have you or a loved one served in the military?"

The program is expanding to Colorado, Idaho, Nevada, and Oregon, and 10 additional states are planning on implementing or are interested in the COVER to COVER program.

Approximately 5.2 million Veterans in the United States live in rural communities. Within this group of Veterans, 2.9 million are enrolled in VA health care and 57 percent are ages 65 and older.[16] Veterans living in rural areas often have difficulty accessing VA resources in their community.

COVER to COVER addresses this access challenge by training NWD staff in VA benefits and building VA partnerships to assist Veterans in connecting to the VA, and by helping Veterans apply for benefits or enroll in VA health care. In COVER to COVER, VA experts in benefits and health care services provide in-person training to improve NWD System staff knowledge of VA programs. ADRC/NWD designates an options counselor as the Veteran Benefits Specialist, who can educate Veterans on VA benefits, assist with collecting documents needed to apply, connect to VA partners, streamline services between agencies, and follow up to ensure the Veterans' needs were met. Training NWD System staff to become Veteran Benefits Specialists through COVER to COVER expands the reach of VA and creates a new access point via the NWD System for Veterans in the communities.

UTAH—ENHANCING STAFF COMPETENCY TO CONNECT VETERANS

The Utah COVER to COVER program found that 64 percent of the Veterans contacting the ADRC were not connected to VA benefits and 16 percent of the people they served were widows of Veterans. ADRC staff reported that having a personal contact at the VA promoted confidence about talking with individuals about VA benefits. Through the training ADRC staff received from COVER to COVER, they now offer the following supports to Veterans:

- Information on VA benefits, and public and private programs;
- Education on required documents needed to apply;
- Support in navigating the VA benefit enrollment process;
- Assistance with filling out VA applications or with public programs; and
- Follow-up ensuring services were received.

Utah Toolbox:

COVER to COVER Website

Presentation on Lessons Learned

Data and Outcomes Poster Presentation

16 Jennifer Morgan et al., "Connecting Rural Aging Veterans to VA Benefits," C2C Conference Poster. Accessed October 4, 2017, http://www.utadrc.org/uploads/3/6/5/1/3651244/grecc_c2c_fy17_poster_update__1_.pdf.

NEVADA–SERVING VETERANS MORE COMPREHENSIVELY

In Nevada, the implementation of the COVER to COVER initiative has strengthened the NWD System's ability to provide person- and family-centered counseling for Veterans. Prior to COVER to COVER, NWD System organizations always asked individuals if they served in the military, but did not have the knowledge or training to connect Veterans with VA benefits. Through COVER to COVER, the Nevada NWD System organizations now counsel Veterans on all the benefits available through the VA. COVER to COVER has become an opportunity to provide Veterans comprehensive options available at the state, federal, and private levels. Nevada uses the presentation in the toolkit to help staff understand military language and culture, a foundation topic for serving Veterans. Additionally, they developed the VA Benefits Quick Facts sheet to assist staff in understanding the breadth and scope of state and federal VA offices and benefits.

Nevada Toolbox:

Presentation on Military Language and Culture

VA Benefits – Quick Facts

Promising Practice III: Ask the Question

NEW HAMPSHIRE–COLLABORATIONS TO INCREASE ACCESS FOR VETERANS

Through connections made in implementation of VD-HCBS statewide, New Hampshire transformed its NWD System for Veterans by initiating a number of access strategies. The state leveraged US CMS Balancing Incentive Program[17] funding to develop an educational outreach social media campaign to train all potential access points within its NWD System—also known as NHCarePath—such as social service agencies, schools, faith-based organizations, and vocational services. They encouraged the organizations to "Ask the Question": "Have you or a member of your family ever served in the military?" With this knowledge, the organizations identify potential benefits and services available to individuals. The VAMC reports an influx of referrals as a result of the initiative.

The New Hampshire NWD System also partnered with the National Alliance on Mental Illness (NAMI) New Hampshire to initiate the Military and Veteran Family Initiative, which empowers families to secure the mental health support that they need by engaging and educating the community and providers, including organizations in the NWD System. The NWD System also obtained funding from the New Hampshire Department of Health and Human Services to fund military liaisons at 10 Community Mental Health Centers (CMHCs).

This first-in-the-nation initiative also incorporated the Ask the Question campaign within all 10 centers. Through the initiative they discovered that 15 percent of all individuals served through the CMHCs are military connected. The liaisons connect Veterans and military families with services and support they qualify for and may not otherwise know about. Finally, New Hampshire participated in an ACL and Substance Abuse and Mental Health Services Administration (SAMHSA) project that trained ADRC staff on behavioral health and suicide prevention among older adults. The toolkit includes additional information about the training and a resource guide, developed in collaboration across ACL and SAMHSA.

New Hampshire Toolbox:

Ask the Question NH

NH Military & Military Initiative – "Key Project Elements"

NAMI/NH Military and Veteran Family Initiative

Community Mental Health Center Military Liaison Initiative – Fact Sheet

ACL and SAMHSA Behavioral Health Initiative

17 Medicaid Balancing Incentive Program, Incentive Payment Program website: "The Balancing Incentive Program provided financial incentives to States to increase access to non-institutional long-term services and supports." For more information, see https://www.medicaid.gov/medicaid/ltss/balancing/incentive/index.html.

Future Collaboration Opportunities

The VA programs highlighted in this section offer ideas for how NWD Systems can forge additional partnerships and/or promote an awareness of key VA initiatives to support community living. Care transition programs offer a natural connection point for the workforce of aging and disability network agencies and local VA sites to work together to prevent hospital readmission. As NWD System staff work with Veterans and their families to provide person-and family-centered options counseling, the following programs should be potential options discussed to promote community living.

CARE TRANSITIONS

Some VAMCs participate in evidence-based care transition programs with the goals of supporting Veterans posthospitalization and preventing readmission. These programs offer a natural connection point for coordination around LTSS. The Coordinated-Transitional Care (C-TraC) model serves as one example of such a program. Developed by University of Wisconsin-Madison School of Medicine & Public Health and the Geriatrics Research, Education and Clinical Center at the William S. Middleton Memorial VA Hospital, the model offers Veterans at high risk of readmission in-hospital meetings with nurse care managers, inpatient team integration, and phone calls from a registered nurse to support transition from hospital to home 48 to 72 hours after discharge. Telephone-based support continues as necessary, typically weekly, for up to four weeks. Support includes medication management and identification of "red flags" for problems that may lead to readmission. An 18-month pilot demonstrated a reduction in readmission rates as well as a cost savings of $1,225 per participant.[18] C-TraC tools and a companion toolkit for transition from hospital to nursing facility, called COMPASS, provide an excellent starting point for aging and disability organizations and VAMCs exploring potential network partnerships

National Toolbox:

C-TraC and COMPASS Tools

C-TraC Promising Practice Issue Brief

HOME-BASED PRIMARY CARE

VA offers a program of home-based primary care (HBPC) for Veterans with complex needs such as skilled care needs or limitations in activities of daily living. The program also serves Veterans whose family caregivers experience burden. Annually, HBPC services 55,000 Veterans at 300 VA sites. The interdisciplinary team supervised by a physician includes nurse practitioners, social workers, physical therapists, occupational therapists, psychologists, pharmacists, and nutritionists. The team makes home visits to the Veterans to provide services based on need. Aging and disability organizations could play a key role in the team approach to supporting Veterans in their homes by offering information and options counseling on LTSS.

National Toolbox:

Geriatrics and Extended Care HBPC Website

18 Agency for Health Care Research and Quality, *Nurse Case Managers Offer Low-Resource Transitional Care Services, Reducing Readmissions for At-Risk, Community-Dwelling Veterans in Remote Areas* (Rockville, MD, Agency for Health Care Research and Quality, July 2014), https://innovations.ahrq.gov/profiles/nurse-case-managers-offer-low-resource-transitional-care-services-reducing-readmissions.

ALTERNATIVES TO NURSING HOMES: VA MEDICAL FOSTER HOMES

For selected Veterans who need a nursing facility level of care and no longer can safely live independently, VA Medical Foster Home (MFH) provides an alternative to nursing homes in a personal home at lower cost. MFH is for Veterans of any age who have serious, chronic, disabling conditions. MFH brings together a person willing to open his or her home and serve in the role of a MFH caregiver; the VA MFH coordinator, who manages the program; and a VA interdisciplinary HBPC team. The HBPC team provides care in the MFH to the Veteran, training to the MFH caregiver, and oversight for the safety and well-being of the Veteran. VA MFH currently operates in 43 states, including Medicaid waiver partnerships with two states.

National Toolbox:

Medical Foster Homes Fact Sheet

Conclusion

This paper details how aging and disability network agencies can partner with the US Department of Veterans Affairs to support Veteran access to LTSS across the country, so the men and women who have so honorably served our country can live in the community. Implementing the VD-HCBS, COVER to COVER, and Ask the Question initiatives requires intentionally cultivating partnerships, and expanding and enhancing capacity and business practices. The checklist and associated tools provide a road map to initiate, build, and sustain these important partnerships. The following section of the paper contains more resources and expert contacts for administrators, providers, and advocates who want to learn more and even replicate these promising practices.

Contacts

The following experts contributed to this paper, and they can be contacted for support and guidance.

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Resources for More Information

ACL NWD SYSTEM WEBSITE – VD-HCBS RESOURCES

This ACL-supported website offers the most up-to-date information about the VD-HCBS program, including technical assistance documents such as sustainability studies, provider agreement guidance, case-mix information, and educational webinar slides.

VA GERIATRICS AND EXTENDED CARE VD-HCBS PAGE

This VA Geriatrics and Extended Care website offers Veterans information about VD-HCBS, shared decision making, and home-based primary care.

VA OFFICE OF RURAL HEALTH COVER TO COVER DESCRIPTION

This VA Office of Rural Health fact sheet details the COVER to COVER program.

NWD KEY ELEMENTS

The NWD Key Elements offer a guide to states in providing the necessary leadership to effectively develop and implement a NWD System of access to all populations and all payers. These elements include guidance and indicators that states can use to assess their progress in transforming their multiple LTSS access programs and functions into a single statewide NWD System.

NWD SYSTEM PERSON-CENTERED COUNSELING TRAINING PROGRAM

ACL offers complimentary access to Course 1: *Introduction to NWD of the Person Centered Counseling Training Program*. The training program was developed with extensive stakeholder support and piloted by 13 states. This competency-based training program uses a blended learning design with six online courses and a one-day in-person course. The courses are designed to build knowledge and skill among anyone working in a NWD System and can support a state's efforts to advance person-centered planning and practices. When using the link above for the *Group* field on the registration page, please select the default response of "NWD PCC." Course 1 will automatically be assigned to you upon your first log-in to the program, and will be available for six months.

www.longtermscorecard.org

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