VA LONG-TERM CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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VA LONG-TERM CARE

THURSDAY, APRIL 22, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, in room 334, Cannon House Office Building, at 9:30 a.m., Hon. Cliff Stearns, (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Bilirakis, Gutierrez, Peterson, Snyder.

Mr. STEARNS. Good morning. The subcommittee on Health Care will come to order. Over the years that I have been in Congress, the VA has repeatedly been challenged to articulate plans for addressing the long-term care needs of aging veterans. To-date, it has failed to meet that challenge.

As we approach a new millennium, almost 55 years after the end of World War II, the need to chart such a course for veterans' long-term care could not be more pressing. When asked several years ago about his plans for meeting that challenge, Dr. Kizer told this committee he would create a Blue Ribbon Advisory Committee to help him.

Today we have that committee's recommendations and we look forward to the testimony of its distinguished chairman. Last November, Dr. Kizer testified that those recommendations were to be woven into "a comprehensive long-term care strategy". Judging from VA's testimony however, the Department has yet to adopt that strategy.

The Advisory Committee on the Future of VA Long-Term Care did not go as far as some would like. Its charge for example, constrained it to provide advice for an era of no-growth budgets. Even under that constraint, however, the advisory committee gives us a framework to identify and address VA's most pressing priorities.

For one, it highlights glaring, regional disparities in access to long-term care. Consider the fact that in both upstate New York and the network serving Chicago, for example, VA provides long-term care services to about one-third of Category A veterans in need, while in Florida it meets only 13 percent of that need.

The report also highlights the fact that some network directors have simply closed costly, long-term care programs. It highlights how much more can be done even under constrained budgets, and it highlights areas in which the Congress can foster needed changes.

As that report points out, long-term care is a major strength and a crucial part of the VA health care system. Just 2 days ago I visited the Washington, DC, VA Medical Center and its Nursing Home Unit and discussed with staff many of the issues we will hear about today.

I hope that in the weeks ahead our subcommittee can move legislation to improve veterans' access to long-term care services. I hope that legislation will reverse the troubling decline in VA's long-term care programming, and I think it is critical that we make it clear for example, that long-term care is not a discretionary mission and that long-term care programs must expand, not shrink.

Any legislation must recognize that one of the strengths of VA's long-term care program is that it covers a broad spectrum that includes home-based services, community-based care, and State-run programs. State veterans' homes are valued partners in serving aging veterans and I hope to develop legislation to make more equitable the criteria for awarding federal grants for needed State Home construction and renovation.

This morning we look forward to hearing testimony on the Advisory Committee's report, VA Long-Term Care at the Crossroads, as well as testimony on the State Home Program and contractor-provided services. This hearing will not end our focus on long-term care and we hope to hear from veterans' organizations at a follow-up hearing next month.

I thank again, Dr. Kizer and our other witnesses for their participation. Many have come some distance to be with us today. But before going further I would like to call on my good friend, Luis Gutierrez, the ranking member, for an opportunity to make an opening statement.

Mr. GUTIERREZ. Mr. Chairman, I would like my complete opening statement inserted into the record if there are no objections.

Mr. STEARNS. So ordered.

[The prepared statement of Congressman Gutierrez appears on p. 36.]

Mr. GUTIERREZ. And I think we can proceed with the testimony of our witnesses.

Mr. STEARNS. All right. Dr. Kizer, the floor is yours.

STATEMENT OF KENNETH W. KIZER, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JOHN W. ROWE, M.D., CHAIRMAN, FEDERAL ADVISORY COMMITTEE ON THE FUTURE OF VA LONG-TERM CARE

STATEMENT OF KENNETH W. KIZER

Dr. KIZER. Thank you, Mr. Chairman. Mr. Gutierrez, good morning. I likewise have a statement that I would ask would be included in the record.

Mr. STEARNS. So ordered without objection.

Dr. KIZER. And I would note that I appreciate this opportunity to discuss long-term that the VA provides, as well as our strategy for developing potential solutions for the growing demand for long-term care.

I think as you well know, VA has a very long and distinguished history of providing care for older citizens, for providing long-term care, and VA is widely recognized throughout the world as being the leader in the area of care for older citizens.

I actually am going to divert from what I was going to say because I want to respond to your opening comments at least in brief, and then hope we will have time, to get into a discussion of this important issue.

During the debate about eligibility reform and the development of the Eligibility Reform Act of 1996 there was discussion—mostly on the Senate side as I recall—of getting long-term care and acute care on the same footing. And as you know the outcome of that process was that Congress continued to view them differently, and today under the law, long-term care is considered a discretionary program, not on the same footing as acute care service. In an era of severe budget limitations and constraints, some of the changes that have been seen with regard to the provision of long-term care should really come as no surprise given the inequity between how long-term care and acute care are viewed under the law.

We hope that as a result of this, and continuing dialogue, we will achieve parity between long-term care and acute care, and statutory recognition that these are merely different points along a continuum of care that should be provided for, not only our veterans, but by all health plans.

I think I will stop with that. As I said, hopefully we can get into this in more detail during the discussion.

[The prepared statement of Dr. Kizer appears on p. 70.]

Mr. STEARNS. Dr. Rowe.

STATEMENT OF JOHN W. ROWE

Dr. ROWE. Thank you, Mr. Chairman, Mr. Gutierrez. I have submitted, on behalf of the committee, a detailed statement that I would ask be included in the record.

Mr. STEARNS. Without objection, so ordered.

Dr. ROWE. I appreciate the opportunity to discuss the future of VA long-term care. I am Jack Rowe. I serve as president and CEO of the Mt. Sinai and NYU Medical Center and Health System in New York City, and president of the Mt. Sinai School of Medicine, and I served as chairman of the Advisory Committee of Long-Term Care, which issued its report, Long-Term Care at the Crossroads.

We found long-term care to be one of the VA's major strengths and a crucial component of veterans' care. I am a geriatrician and I have substantial experience through my career in the VA. I would say that geriatrics is perhaps the finest component among an array of fine programs in the VA and it is nationally and internationally recognized as such.

There were four major reasons that we felt that VA long-term care was in trouble. The first is that access to care has not kept pace with demand and in some cases, has been rather sharply curtailed, and this just follows on Dr. Kizer's statements that he just made, which was a predictable consequence of some of the other changes that have been made.

Secondly, VA long-term care needs to respond rapidly to the changes in the dynamics of the administration of long-term care

with less emphasis on nursing homes and more emphasis on home care and community-based care.

VA spends $2 billion in long-term care; 1.7 of that in nursing homes. There is a direct consequence of previous traditions and trajectories but really needs to remodel itself into a more modern structure.

Thirdly, at many VA facilities long-term care is not fully integrated into the delivery system. It is not coordinated with the unified set of services for the veteran.

And lastly, at the network level, we found that long-term care was really not adequately integrated into the VISNs. One of the problems is that VISN directors see long-term care as under-funded, and basically see themselves as having a financial disincentive to provide long-term care, and that is one way to kill it over the long run.

And that may not be an intended consequences, but that is at least a view of some VISN directors and we think that needs to be changed.

We approach our recommendations in the full knowledge that the VA was operating with a no-growth budget. Dr. Kizer, in his charge to us, made that clear, and as a CEO of a very large health care institution that provides a continuum of care, I can appreciate the issues of responding to changes in the marketplace and the need in a no-growth budget situation.

But we considered a number of models as to what the VA should do in long-term care: everything from no change to outsourcing everything, to some sort of a mix. And the community had members across the continuum of this field and we are very sophisticated.

We came out unanimously suggesting a model in which the VA should emphasize home and community-based care, minimize capital investment, i.e., don't build any more nursing homes unless it is absolutely required, and place much greater reliance on contract care. We feel there is a competitive market in contract care out there and it can be advantageous to the veterans and be very high quality.

So we have three key recommendations that we would like you to consider, Mr. Chairman. The first is, we think that we need to provide some strong incentives to managers to improve the quality and the amount of long-term care.

The VA has been successful under Dr. Kizer's leadership in using incentive programs to improve efficiency, quality, and access. We think that long-term care should be included in this.

Secondly, don't build any more nursing homes. Please.

Thirdly, invest in home and community-based care. The committee called for tripling. I know we're not supposed to triple anything these days, but it is a very small number that we are tripling. We call for tripling the investment in home and community-based services from a current 2.5 percent to 7.5 percent of the VA Health Care budget.

For long-term care as a sub-piece of the budget, this would increase community and home care to about 35 percent; which we think is still a low number but much more reasonable than the current balance.

In addition, we have three targeted legislative proposals which are in the committee report: one on respite care where we feel that respite care, while it is provided in the nursing homes, should also be expanded to other settings.

Secondly, assisted living. This is a setting in which long-term care is now provided. It is not currently in the regulations. And thirdly, we recommend a limited nursing home benefit. In a no-growth budget situation we recommended a middle course of 100-day post-hospital benefit.

Finally, let me say that back in 1975, and I was involved in the VA at that time, the VA was at a crossroads. There was recognition of the aging veteran problem and the VA took some very bold moves under the leadership of Paul Haber and developed what is really the Nation's best geriatric care system, currently.

I think that now, almost 25 years later, we are in a situation where that kind of crossroads is now being reached again, that kind of crisis. You have made a terrific investment in geriatrics in the VA and for the country, as well as veterans. I think now is the time to renew that investment in this period of long-term care.

Thank you, very much.

[The prepared statement of Dr. Rowe appears on p. 82.]

Mr. STEARNS. Thank you, Dr. Rowe. I hear what you're saying about not building any more VA nursing homes. Are you also saying the States should not do the same thing?

Dr. ROWE. No, I think the State Homes—in our committee we came to a recognition of the quality and the important partnership of the State Homes. And there are a number of State Homes that are built in collaboration with the VA.

Recognizing the various pressures for construction of nursing homes by the State or the VA, we just feel that while there may be some that need to be built, Mr. Stearns, I think we just want to raise the hurdle, we just want to make sure that the requirements are very, very stringent. And we would increasingly rely on the partnership of the State Homes.

Mr. STEARNS. I guess a logical question is if you don't want the Federal Government to build more nursing homes then you're saying here this morning you want the States to build them?

Dr. ROWE. Well, no. I think that the State Home Program does—there are some foci with where there are needs and they can be built with them. But in general, I think what we should be doing is not building more beds but finding ways to migrate the patients even in the current beds, particularly the new patients.

I mean, I think we have a commitment to the patients who are there, and that's very strong and that came through in the committee. And we're not trying to dislocate patients who are there and there for a long time.

Mr. STEARNS. I understand.

Dr. ROWE. But the new ones who are coming in to the pipeline of long-term care, they should be very carefully assessed and placed in community-based, long-term care settings. It's often better for them and it is less expensive.

Mr. STEARNS. Dr. Kizer, I think you said publicly that you agree with the Advisory Committee recommendations. I think that is true, isn't it?

Dr. KIZER. That is correct, and as you may recall my testimony, I think before this committee, I know before a number of other committees, about the need to substantially increase the amount of both spending and infrastructure we have in community and home-based care.

Mr. STEARNS. Well then, I guess the next question is, where is this long-term care strategy? Have you put it in place?

Dr. KIZER. This document actually is one that you will very soon, I suspect it will be delivered to your offices this afternoon. It was a little delayed in getting out because of a variety of unexpected things that have occurred recently.

Mr. STEARNS. The traffic on the 14th Street Bridge.

Dr. KIZER. Something like that.

Mr. STEARNS. Well, you know, I'm from Florida and my colleague, Mr. Bilirakis is from Florida, and Mr. Gutierrez is from Chicago. Dr. Rowe, you know a veteran in Chicago or New York seems to have a far greater likelihood of receiving VA long-term care services than someone in Florida, or Arizona, for that matter.

So how would we go about getting equal access for these different groups? What do you suggest?

Dr. ROWE. Dr. Kizer doesn't want to hear my suggestion.

Mr. STEARNS. We want to hear your suggestion.

Dr. ROWE. I know you do.

Mr. STEARNS. What's your suggestion?

Dr. ROWE. Well, I am a geriatrician and so I have some experience in this. I think that what the VA should do is try a number of various models of linking with various community-based organizations that are providing long-term care.

The VA is not the only subset of health care that has this problem. And long-term care has changed dramatically and it can be effectively and efficiently delivered. We don't have to invent the wheel here. I think that one of the things we have to avoid is having the VA try to invent the wheel when in fact, many patients who need long-term care in rural settings or in other settings are getting it by established models.

In many cases you would have a couple where the woman is getting long-term care from a variety of community and home-based agencies, and the VA just needs to link with that agency to provide the care to her spouse as well; things like that.

Mr. STEARNS. Dr. Kizer, do you agree with him?

Dr. KIZER. I do agree with him, however, his comments omit a threshold issue. The threshold issue is that until acute care and long-term care are on the same footing and are required in the same way, then you are not going to have that.

You have provided in law, on the one hand, a package of mandatory services that we have to provide. On the other hand, you have some discretionary things that we can provide if funding is available. In an era when our budgets are severely strained we are providing the mandatory things that you have said have to be provided.

It should come as no surprise that things in the discretionary category may not be getting the same attention.

Dr. ROWE. And if I could——

Mr. STEARNS. But you know, I think members of Congress though, assume that long-term care is mandatory, I mean, if you ask them. When they go back to their constituents they feel that that is pretty important. And I think that VISN directors evidently, get the message it is not as important, so the tradeoff between the acute and the long-term care, they make a decision that is discretionary for the long-term care.

Dr. KIZER. That is because that is what the law says.

Dr. ROWE. Yes, it is clinically mandatory; it's not legally mandatory.

Mr. STEARNS. What does that mean: clinical versus legal?

Dr. ROWE. It means that it is required for the appropriate care of the patient, but the VISN director is not legally bound to provide it, and if they have a limited number of resources they have to provide them first to the things that they are legally bound to provide.

Mr. STEARNS. So they would actually turn people down?

Dr. ROWE. Well, that is right, and it turns out to be more costly for the VA because if I have a patient with heart failure who I can manage at home, Mr. Stearns, with nursing care and with proper diet and with close monitoring, I can keep that patient out of the hospital.

If I don't have good home care the patient gets re-admitted to the hospital recurrently, and that increased the acute care costs of the VA.

Mr. STEARNS. I just don't understand how we are going to reverse this, then.

Dr. KIZER. As a point of fact for the record, it should be noted that the number of patients that are receiving long-term care in the VA today is substantially more than it was a few years ago.

The length of stay and the amount of care that is being provided per patient is less, and it is clear that there is a shift to other payers, particularly Medicaid.

Mr. STEARNS. Okay, going back one step, why should there be such a wide variability in access to long-term care, such as I cited between Chicago and Florida, for example?

Dr. ROWE. Well, I think this is a heterogeneous system of 172 medical centers and they each come with different leadership and traditions. And in some of them, particularly those who have had GRECCs, there has been more—Geriatric Research Education Clinical Centers, which are centers of excellence in geriatrics—there has been more emphasis in some of your medical centers on geriatrics and on hospital-based home care programs that have gotten very large and very successful.

Other medical centers have gone in different directions and have not developed hospital-based, home care programs. Now you look, you come in at 172 different programs; some have very well-developed geriatric programs, some don't. And you see that veterans in the areas where they have well-developed programs, have more access.

And I think that what we need is to even this out by providing the resources to develop the home care and community-based programs in those places that have not yet had the opportunity to do that.

Dr. KIZER. That may well be part of it, but I think there also have been some other fundamental issues at play, as we have discussed before here; e.g., the historical funding inequities that have existed throughout the country.

In Florida, for example, veterans were under-funded compared to veterans in the northeast. And so now those differences are being equalized under the VERA, but that is a recent phenomena, and there is still a lot of catch-up to do.

There is different infrastructure, there is a whole lot of other different variables in the different networks that account for where the funding is going and where it has to go to support ongoing need and changes that are underway.

Mr. STEARNS. I thank you. My colleague, Mr. Gutierrez.

Mr. GUTIERREZ. Thank you. Well, first of all, thank you for being here this morning. I wanted to particularly thank Dr. Rowe for his many years of service to the veterans, dating back a quarter of a century. Thank you very much for being here again.

I think we understand what is mandated and what isn't mandated and what you legally have to do and what you are going to do in a budgetary situation

So what do we have to do so that those who meet the objective criteria for needing long-term care established by the medical profession, are going to get it? What do we have to do so that every veteran who meets an established objective criteria for needing long-term care, is going to get it?

Dr. KIZER. I think there are two things that are obvious at the outset. One is that under the law, what have been historically viewed as different types of care have to be put on an equal footing. There has to be parity.

Just as there should be parity between mental health and other types of health care, there should be parity between long-term care and acute care. And we have to get away from this notion of thinking that long-term care is something that is an extravagant, extra service that's being provided.

It is a fundamental part of the continuum of care that should be provided. So providing that legal or statutory basis for it is necessary, and then second, you have to fund it.

Mr. GUTIERREZ. How much more money would it cost, Doctor?

Dr. KIZER. Well, that gets a little bit more difficult to answer in a straightforward manner because it depends on exactly how quickly we go there, the types of services and other factors.

For example, we would support the notion of tripling the amount or the proportion of funding that is currently spent on community and home care. That will have a different amount than say, what you put in a nursing home, or if you put it in State homes versus contract homes.

I am not prepared to give you a figure at this time, but I would say that it is going to be very substantial.

Mr. GUTIERREZ. Given the current budget presented by the current administration, as for a flat-line budget, no increases; which if I recall correctly would entail also the elimination of 7,500 employees at different levels, is that correct? The no increases and one of the ways to reach the goals is eliminating 7,500 employees?

Dr. KIZER. Approximately, yes.

Mr. GUTIERREZ. Then we have another budget, the one that was approved by the House of Representatives, that increases the VA budget $900 million for next year, and then reduces it by $3½ billion the subsequent 6 years.

So under those scenarios we wouldn't be able to meet long-term care objectives for people. And so I think that what we have to do is two things. I think you are absolutely right.

If we wish to serve the veterans appropriately, I think we are going to have to be honest with ourselves and say, well then let us mandate it so that there is no discretion, there are no areas of fuzziness between one VISN and another and the 172 medical directors. I think that is one way of guaranteeing it; saying you are all going to have to do it.

Secondly, going back and looking at that budget, because if we're going to reduce the VA budget by $3½ billion over the next 6 years, I don't see how you are going to be able to do it.

So I think those are important areas to look at, because I know that at Hines for example, because even if there are 18 percent availability in Florida and 30 percent availability in Chicago, there is still some 70 percent of people who are not getting, even in the best-case scenario, are not getting the service that they need.

And particularly Hines. I visited Hines last week. I visited the long-term care facility there, right in the medical center, and I saw patients getting served their lunch and the plate open. And I asked the director if she needed additional personnel and she said no, she was doing just fine. And I said, well the food is going to get cold.

And her response was simply that they will reheat it once again; which only made me think that maybe we should always try dinner one day with our hands tied behind our back with the food hot in front of us and just tell everyone, don't worry about it. We'll get around to it, we'll just reheat your food. Which is no hyperbole; it's exactly the way it happened.

And she said it with, very dismissively, so why is this even a concern? So I think that as we visit our centers I think we need to look at where we are today in terms of—because we may be providing long-term care but what is the quality of the long-term care we are providing today and the need for additional care?

Would you like to comment, Dr. Kizer? I am sorry.

Dr. KIZER. I was going to comment on one thing.

Mr. GUTIERREZ. Sure.

Dr. KIZER. The VA is faced with what we call a demographic imperative. We simply have a very large population of elderly veterans who need this care, and that need is going to continue for some years. But it is qualitatively not unlike what is going to confront the rest of the American public in just a few more years down the road.

Quantitatively, it is significantly different because 20 years from now there is going to be a much larger demand for long-term care, and I would hope that we would not overlook the tremendous potential that we have here to put in place programs that serve the needs of veterans today, but also create new knowledge, new models, and experience that will be vitally important in serving the larger number of Americans who will need long-term care, not that long from now.

Mr. GUTIERREZ. We know, if we keep having five month waits for patients that are seniors, and they have a five month wait to see an orthopedic surgeon or any doctor—which is not uncommon in the VA system—you are going to have even more need for long-term care because if you don't get the care when you need it you are going to have to substitute it subsequently with other kinds of care which is much more costly.

So I agree with you, Dr. Kizer, and I am not coming here this morning to say that all of the blame is on your shoulder. I think the Congress needs to take responsibility also, both at making it clear legislatively, mandating it if that's what we wish to do, and secondly, providing the additional dollars that are going to be required in order to provide that care.

Dr. KIZER. If you mandate it and don't provide additional funds, you will create an impossible situation.

Mr. GUTIERREZ. You will just make other choices. Instead of 5 months for waiting to see the orthopedic surgeon, it will turn into 12 months. I mean, somewhere in the system——

Dr. KIZER. It will be unmanageable.

Mr. GUTIERREZ. It will be unmanageable.

Dr. ROWE. You will pit the younger veterans against the older veterans.

Mr. GUTIERREZ. Right. I think that is a very good point, Dr. Rowe.

Dr. ROWE. That is what you will do if you do that.

Mr. GUTIERREZ. Thank you.

Dr. ROWE. Thank you.

Mr. STEARNS. The gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Good morning, Dr. Kizer, Dr. Rowe, Ms. Salerno. The State veterans homes kind of grab me a little bit because we are talking about a solution. It's a solution obviously, that is not going to cover 100 percent of everybody, but could improve the situation.

We recently opened as you know, the Land o' Lakes State Home in Florida, which was a partnership as all State VA nursing homes are.

The grants, are they up to 65 percent or—does it vary, when a request comes in from a State for construction of a State nursing home?

Dr. KIZER. That is my understanding; that they are 65 percent.

Mr. BILIRAKIS. So they are 65 percent; they are not up to but they actually are 65 percent?

Dr. KIZER. They are 65 percent, yes.

Mr. BILIRAKIS. All right. Now, according to this briefing material that I have seen here, VA's per diem operating cost—let's see, VA supports the program for per diem payments for each eligible veteran receiving care and then up through the award of the grants for construction.

VA's per diem operating cost for these beds is much lower than those for VA's own beds and contract beds. I am trying to get that clear. Does that mean that the operating costs are probably roughly the same but that the VA only pays a smaller percentage of the full per diem operating costs? Or is there better efficiency, or is this maybe a wrong statement, an incorrect statement?

Dr. KIZER. I am going to ask Dr. Salerno to comment on that as well, but I think part of the issue is that State homes take care of different types of patients. For example, in the VA nursing homes we typically take care of a much higher acuity patient that has higher needs, a higher demand for services than what might commonly or typically be provided in a State home or in a community nursing home.

Dr. SALERNO. As part of the partnership between with the States and the veteran for this care, we now provide approximately 30 percent of the per diem, so the State Home per diem costs are, on average across the country, somewhat less than the cost of a VA nursing home.

Mr. BILIRAKIS. So you are providing 30 percent of the actual per diem costs?

Dr. SALERNO. Approximately. And our goal is to provide up to a third of the total average per diem over the next few years.

Mr. BILIRAKIS. All right, so when this says, supporting through per diem payments, you mean through a partial per diem rather than a full per diem?

Dr. SALERNO. Yes.

Mr. BILIRAKIS. And the rest of it is incurred by the States. And also, in terms of qualifications, a veteran who wants to qualify to get into a VA nursing home, pure VA nursing home versus the State/federal partnership nursing home, was there much of a distinction there?

Dr. SALERNO. The States set specific eligibility criteria for their homes. In VA nursing homes enrolled veterans are prioritized, with service-connected veterans having first priority as beds become available in VA-operated homes.

Mr. BILIRAKIS. Would you say though, even though the States might set them, but the Federal Government, the VA has no input into all that, in spite of the fact that they share a good portion of the costs?

Dr. SALERNO. We require, of course, that patients have served for the military and documentation that they were honorably discharged and are eligible for and in need of nursing home or domiciliary care.

Mr. BILIRAKIS. And that is about it. So the rest of it is criteria set by the States?

Dr. SALERNO. Yes.

Mr. BILIRAKIS. Now, is there a large variety would you say, in the setting of criteria amongst States? Is there a large variety from one State to the another, number one, and number two, is there a large variety between the criteria of States versus the VA, pure VA nursing homes?

Dr. SALERNO. We don't have very specific demographics on patients in State homes, but our assumption is that they are somewhat different. They are different in terms of, as Dr. Kizer said, their care needs. They tend generally to require longer, continuing care, rather than short-term nursing home care as we provide in many of our VA nursing homes.

But there are opportunities to have spouses and Gold Star parents be admitted to the State facilities, at the discretion of the State.

Mr. BILIRAKIS. I see. Well, just one last question because my time is almost up. In terms of paying for this care, in the VA nursing home does the patient share the cost in any way?

Dr. SALERNO. No.

Mr. BILIRAKIS. All right. In the State homes they do, isn't that correct?

Dr. SALERNO. In some States they do. They are——

Mr. BILIRAKIS. So there is a distinction, there is a difference, State-by-State, as far as that is concerned?

Dr. SALERNO. Yes. Some of the State homes are serving Medicaid patients and Medicaid picks up part of the costs. Many States provide——

Mr. BILIRAKIS. But the patients themselves, also pick up part of the costs?

Dr. SALERNO. Yes.

Mr. BILIRAKIS. I know at Land o' Lakes that is the case. Well now, there are two in Florida, if I might get a little parochial here just very quickly. There are two in Florida and I know a third one has been proposed—but if the State of Florida is able to convince the legislature to appropriate, let us say the 35 percent of the construction costs, is it likely that the VA will put up the other 65 percent?

I mean, how do things kind of stand in that regard, in general?

Dr. KIZER. I wouldn't want to disappoint you and give you an answer. There is a methodology which is for assigning that, that has recently been reviewed. We are seeking some further, additional comment on the new methodology for assigning what the priority of State's requests for grant funding would be.

Mr. BILIRAKIS. Well, would the fact that the market share in Florida, 13 percent, be a factor in that formula, that methodology formula, conceivably?

Dr. KIZER. It would depend ultimately, on what option is chosen; there are a number of different options that are proposed.

Mr. BILIRAKIS. You should have been a lawyer in addition to a doctor. Thank you very much.

Mr. STEARNS. Thank you, gentlemen.

Mr. GUTIERREZ. Mr. Chairman?

Mr. STEARNS. Yes.

Mr. GUTIERREZ. I am going to regrettably, leave. I think this hearing is very timely and I thank the chairman for it. I will leave Mr. Peterson and Dr. Snyder. There is a Kosovo briefing for members only, and given the fact that if we do commit ground troops they will be directly sent to the VA facilities after their service, I am going to go over there right now.

But I think this hearing is important and I want to thank the chairman.

Mr. STEARNS. I thank the gentleman. The gentleman from Arkansas?

Dr. SNYDER. Thank you, Mr. Chairman. I appreciate you doing this hearing also. I think it is very important, as well as the one yesterday on VA research.

Dr. Kizer, in your statement—I am sorry I missed your oral comments this morning—but you talk about the 333 percent increase in veterans over the age of 85 over the next 21 years. What are

those actual numbers? What kind of numbers are you talking about?

Dr. KIZER. As far as how many people that are over the age of 85.

Dr. SNYDER. Yes.

Dr. KIZER. We estimate that there were 327,000 in 1998 and this number will increase to about 645,000 in 2003, and peak at about 1.3 million in 2013.

Dr. SNYDER. You are talking about a troubling——

Dr. KIZER. Yes. It is a dramatic increase.

Dr. SNYDER. And you also talk about, in that same period of time you are going to have about a 12 percent decrease in number of veterans over the age of 65. As you look ahead in your long-term planning, do you anticipate therefore, that there would be able to be a shift in resources from your acute care to the long-term care, or will it not work out that way because of the medical needs of your over-85 population?

Dr. KIZER. Well, it really goes to the heart of what we were discussing before you came in; that under the law we are mandated to provide acute care services. Long-term care is a discretionary item. Insofar as our budgets are strained right now, priority is given to the mandated services.

Dr. SNYDER. Well, I understand the legality. My guess is we have 21 years—in term of your long-term policy planning though, as you look ahead would you anticipate that there would be an ability shift resources as your 65-and-under veterans decrease and your 85-and-under veteran decrease by your over-85 increase?

Dr. KIZER. If I understand your question correctly, and if we take an assumption that there is parity between acute and long-term care, what I would expect is that over the next several years there would be a substantive shift from—or a substantive increase in the amount of funding that would go into long-term care.

I think we have to recognize that these are also individuals who have acute care needs because of their age and so just because they need long-term care does not mean there's going to be a diminution in the need for acute care.

Dr. SNYDER. I think that is really the crux of my question. There would not be any savings there.

Dr. KIZER. Right. No, the essential point that I think has to be understood is that the pot needs to grow.

Dr. SNYDER. Yes. There are kind of some subtle concerns, too. I mean, you have looked over the legacy of the long-term care I think, in your report, but as we look ahead 21 years we are going to have a whole lot smaller family size, our family connections are going to be much more disconnected, we are not going to have the family support in 21 years from now when the baby-boomers retire, like we did 20 years ago for your veterans.

Is that something you all looked at in your report also? Did you look at urban/rural differences? Tell me your thoughts about urban/rural differences of the veteran population in terms of provisions for long-term care needs.

Dr. ROWE. Do you want to?

Dr. SALERNO. It is a far more difficult situation when you are thinking about options like home care, to think about patients who

are far-flung, perhaps 100 miles away from a medical center. And I think that is where partnerships with community providers become critical in filling in the gaps and getting that network connected.

And the role the VA must take on in those situations is care coordination, so that we don't lose track of what is happening to the patient when another provider is taking care of them; and we maintain that primary care responsibility.

Dr. SNYDER. Pattern for these kinds of services as you know, for the rest of the population has been, and for health care changes has been, let us try it in urban areas first where all the people and the money is; then see if some of it will swap over in the rural areas. I know that you all would be interested in over the long run, not seeing that accrue the VA serves.

Dr. ROWE. The growth of home care services in rural areas over the last several years has been very, very substantial. In fact, something the HCFA and the Medicare program has been concerned about.

I think one way to look at this, Dr. Snyder, if I may, is that if this were not the House Veterans' Affairs Subcommittee on Health but you were the Board of Trustees at my institution, a not-for-profit, academically-based institution, and we were talking about how to take care of our older patients now and in the future, what we would say is, how can we match the care with the need?

I can walk down the ward of one of our hospitals with you and look at each patient and say, does this patient need to be in the hospital or could they be better treated in a less costly, more efficient, less restrictive environment?

And a lot of the patients who are in the hospital could migrate to home care, but there is no home care for them to migrate to, so they are in the hospital getting expensive care.

I would have, with you as my Board of Directors, a seamless system. There would be no legal or other barrier for moving a patient, one to the other, and I would have "X" number of dollars to spend. That is not the system you have; that is the system you have to get to.

But if you get to that system, you would not necessarily then say, let us start 200 more home care programs, because there are home care programs out there in the community taking care of the women and taking care of the disabled Medicare beneficiaries. And there is a competitive market out there which is making it efficient, and I think, high quality.

So the advantage the VA has is because we are a little late in making this change, the marketplace has developed capacity to provide care in the rural areas, etcetera, and all the VA has to do is find some money and freedom to link with those resources.

That is basically the situation as I see it. I think it is good that we are slow, not bad, because we don't have to invent the home care system.

Dr. SNYDER. I understand. May I ask one more question, Mr. Chairman? Would you give some examples of the incentives that you were talking about that managers would benefit from having incentives to deal with this——

Dr. ROWE. Sure, from the committee's point of view. What we felt was that there was a financial disincentive; that the $35,000 a year for special care veterans did not meet the costs that some VISN directors feel it costs them to provide that care in a nursing home, so they are obviously going to dial that down because they are losing on that "product line".

And we just think that a careful analysis of that should lead to something which would provide a level playing field. We don't need advantage long-term care but we shouldn't disadvantage it.

I would say also that this is an unintended consequence; that Dr. Kizer has done as much if not more, for older veterans than I ever have, or anybody I know has ever had. So I mean, I don't think that this is—this is, we built the new system, he built the new system, he implemented it, it had a lot of great effects, and now it is time to recalibrate it in some areas that we developed disincentives that we didn't expect.

Dr. SNYDER. Thank you.

Mr. STEARNS. I thank the gentleman. Mr. Peterson.

Mr. PETERSON. Thank you, Mr. Chairman. Thank you for calling this hearing and apologize for being late. I may be coming into this and asking something that has already been made clear.

Dr. Kizer, can you explain to me exactly what kind of long-term care veterans can expect? I mean, what they can expect to be considered part of their benefits that they can receive from the VA? Is it written out someplace?

And then along with that, how does the decision-making work that people either get placed into a long-term care facility within the VA hospital—I have one in my district—or a nursing home, a private nursing home or a State nursing home or assisted living or home health care?

How would that decision get made? Is there some kind of process that goes on that you could actually follow, or is it somewhat kind of first-come, first-served until we run out of money?

Dr. KIZER. The placement decisions are a combination of decision, as you would expect; on clinical grounds, on family desires, patient desires, as well as on resource issues.

Certainly, many of our patients who go into a nursing home are considered heavy care or heavy need patients, either because they have dementia or dementia and a combination of medical conditions. Those patients are often very hard to place in a community nursing home.

Community nursing homes, depending in which community you are in, may or may not have availability for that type of patient, so that VA patients may be skewed to go to a VA nursing home in the first place.

The family may live 100 miles away and say we really want father/grandfather in our community as opposed to the VA nursing home which is attached to the facility, in which case you would do your best to place the patient closer to them.

Depending on the resources of the network, that may come to bear as well, as far as whether there is space in the nursing home. In some places they are filled. All of our nursing homes run at a very high occupancy rate so there just may not be space there, and the only option is a community nursing home or a State Home.

So it really is a combination of those things that will determine, and is made on a patient-by-patient basis.

Mr. PETERSON. Who has the final decision-making, then? Ultimately, the VISN director? If it has gotten to that level. Who has the authority to make that decision?

Dr. KIZER. Yes, I suppose it is theoretically possible, but these are decisions that are made by the physician and patient/family, and the local management, typically. I mean, these would rarely ever go to the facility management.

Mr. PETERSON. Yes, but you know, but they do run out of money, I would guess. I mean, my sense is that there is more demand for these rooms than there is rooms or resources.

Dr. KIZER. No question.

Mr. PETERSON. So then my question is, how does that decision get made? Who gets to be included and who doesn't when you run out of resources? Is it basically, first-come, first-served, or is it whoever has the most——

Dr. KIZER. We would go according to the prioritization. For example, a 100 percent service-connected veteran would get the top priority and would find placement, and those who are on a lower priority level on the priority scheme may not have the same options available to them; again, recognizing that this is a discretionary item under the law and under the benefit package.

Mr. PETERSON. Dr. Rowe or Dr. Kizer, either one, I was involved somewhat in these discussions about home health care and some of the things that are going on under the Medicare system. You know, it seems to me that whenever we set up a program where the government is paying for it, you have a whole, you know, industry that develops and sometimes they go overboard and abuse the system.

I think that has happened in home health care to some extent, and we tried to correct that and probably went too far the other way. But what you are saying is that you think that the VA could open up to this system?

My concern is if we opened up the VA and maybe tried to push things that direction, are we going to create a situation like we had with Medicare where we are going to—or, how are we going to avoid that, I guess? Are we going to put the controls on it before we get into it?

Dr. ROWE. I can comment on that, Ken, if you would like. Mr. Peterson, I am a member of the Medicare Payment Advisory Commission which reports to Congress and has some oversight with respect to HCFA in the Medicare program. So in that context I have some experience also with respect to this issue.

We knew there was too little home care and that patients should be treated more at home than they were in the hospital. And we implemented changes in Medicare to stimulate that and it was, to put it mildly, successfully, and there was a tremendous growth in home care and concerns about fraud and abuse.

Payments for home care have reduced substantially under Medicare in the last couple of years, and regulations have improved. I believe that in most markets in the United States there is now a healthy competition between not-for-profit and for-profit home care providers.

We have a home care agency at Mt. Sinai NYU Medical Center, which is obviously not-for-profit,and many States have for-profits as well. I believe that the efficiency, quality, cost is now getting in the range which is appropriate. And again, we are at a relative advantage in the VA because we weren't out there stimulating the growth of home care and therefore, paying too much.

I think at this point the competition in the marketplace is such that the VA could avail itself of these resources in a cost-effective, high quality way.

Mr. PETERSON. Do you agree with that, Dr. Kizer?

Dr. KIZER. I do. I also don't think we should overlook the different economic incentives and how, certainly within the VA, where we have essentially a global budget and where we are managing our budget and where whatever savings we can achieve on the one end gets plowed back into patient care, there is a different dynamic at play than in the marketplace, where it goes into profit and a executive benefits.

So there is a different set of incentives at play, and even where we are contracting for it is a different milieu than what we see in a market-based approach.

Mr. PETERSON. Well, I would just say, you know, it is hard for me to figure what exactly is going on, but I represent a rural district that is kind of remote, and I am not sure about the competition in those areas.

I mean, there was a bunch of stuff that developed that was basically babysitting, and you know, they got so they could bill all this stuff and built basically, a business on that where they would actually go out and tell the patient, well we can come twice a day, 6 days a week because the government will pay for it.

And when we clamped down it created a hue and cry out there like you can't believe. But I don't think from my—I have met with these people and met with the patients and so forth. Out in these remote areas I am not so sure how much real competition there is.

Dr. ROWE. I accept that. I come from the rural, Upper East Side of Manhattan and we even have locales where we wish there were more competition. But let us not forget the VA, as part of its strength in long-term care, has hospital-based home care programs which are very strong. And so we wouldn't be entirely reliant on others; we could build our own in those areas in which we didn't——

Mr. PETERSON. All I was concerned about is that the VA don't contribute to this what we had go on as we expanded the home health care. I mean, I am all for it. I think it is a cheaper way to do things, but it did get carried away. I mean, there was services provided that were provided because the government did it.

Excuse me, Mr. Chairman.

Mr. STEARNS. I thank the gentleman. I thank the first panel for their time, Dr. Rowe and Dr. Kizer. And we will take now the second panel.

The second panel is Mr. Robert Shaw, president of the National Association of State Veterans Homes, Pamela Zingeser, principal, Birch and Davis Associates, and Kathleen Greve, chief, State Home Construction, Department of Veterans Affairs.

If you folks will come to the desk? And Mr. Shaw, we'll start with you for your opening statement.

Mr. SHAW. First I would like to ask that my written statement be included in the record.

Mr. STEARNS. With unanimous consent, without objection.

Mr. SHAW. And I have a few, brief, comments.

STATEMENTS OF ROBERT SHAW, PRESIDENT, NATIONAL ASSOCIATION OF STATE VETERANS HOMES; PAMELA ZINGESER, PRINCIPAL, BIRCH & DAVIS ASSOCIATES, INC.

STATEMENT OF ROBERT SHAW

Mr. SHAW. The National Association of State Veterans Homes appreciates the opportunity to appear before this distinguished committee to express our views pertinent to the issue of long-term care for our Nation's veterans.

Your understanding of our program and generosity you have provided over the years to carry out our mission of "caring for America's Heroes" is greatly appreciated.

We feel our involvement is extremely important with the increasing demands being made upon our Federal Government for funding and taking care of our veterans, particularly those increasing numbers of elderly veterans who have reached that time in their life when such care is needed.

And it should be noted I believe, and it has already been noted by the VA, that the number of veterans 85 and over will continue to increase well into the next two decades.

Currently, our Nation is faced with the largest aging veteran population in its history. We believe the State Home Program should continue and even expand, its role as an extremely vital asset to the Department of Veterans Affairs in meeting this great challenge.

State Veterans Homes, where feasible and on their own initiative, have already undertaken innovative steps in providing services to meet a broad range of veterans' needs. What we need is recognition of those efforts through a greater commitment of resources and support by those who share responsibility for our veterans' care.

Without the integration of all available resources, we will fail to meet our moral obligations to our Nation's veterans. With this in mind, the National Association has gone on record and shared their thoughts pertinent to the following legislation initiatives with the Veterans' Affairs Committees, Department of Veterans Affairs, and Veterans Organizations.

The first being, the increase in VA per diem to State Veterans Homes in an amount equivalent to one-third of the national average cost of providing care in a State Veteran Home.

Number two, to obtain sufficient federal dollars to fully fund the backlog of approved grant applications to the VA State Home Construction Grant Program.

And I found out just last night, just since last August the VA has received 24 new grant applications with a total request of $189 million; and that is in just the last few months. The States have spoken, if you would ask me.

The third one is, adequately staff this program inside the VA. It is not adequately staffed. They do not have the resources to manage the number of homes that are wanting to be built by the States. They need help or it will not happen.

Number four, modify the methodology for awarding State Home construction grant funds to a concept that incorporates elements of both first-come, first-served and VA's current "needs formula".

Number five, establish State-Home-based Personal-Care Services through the State Home Program utilizing a funding formula with VA assuming one-third of its average national cost of providing such care through VA hospital-based programs.

And the last, number six, be included as a true partner with the VA in long-term care solutions for veterans.

We, in the National Association of State Veterans Homes, stand ready to meet the challenges that lie ahead feeling confident that we can continue to be a valuable resource for the Department of Veterans Affairs and the Nation in providing long-term health care services for the Nation's chronically ill, handicapped, aging veterans, keeping in mind service, efficiency, and economy.

Thank you, Mr. Chairman and members of the committee.

[The prepared statement of Mr. Shaw appears on p. 87.]

Mr. STEARNS. I thank Mr. Shaw.

Pamela Zingeser.

Ms. ZINGESER. I have also submitted written testimony I would like in the official record.

Mr. STEARNS. By unanimous consent, so ordered.

STATEMENT OF PAMELA ZINGESER

Ms. ZINGESER. Mr. Chairman and members of the committee. Thank you for the opportunity to appear before you today to discuss the work that Birch and Davis has done recently for the VA State Veterans Home Construction Grant Program.

I am Pam Zingeser. I am a principal of the firm and served as project director for our effort. I am accompanied today by Paul Grimaldi who is responsible for the technical portion of the analysis, and also Kathleen Greve who is with the VA's program.

Birth and Davis was asked to help the VA to determine various options to consider in redesigning the methodology and priority system used to fund the grant requests. In addition, we provided descriptive information about the facilities, the patient population, and the services provided in the homes.

Our work focused exclusively on outlining possible options for change or elements to consider in making a change. Key policy decisions by the VA will be required, as well as possible legislative changes to implement some of these options.

To conduct our effort we reviewed the current methodology; visited several State Homes; spoke with State Health Planning Organizations; and also analyzed data that were collected by the National Association of State Veterans Homes.

The State Veterans Home Program as you know, provides States with up to 65 percent of the cost for acquiring, constructing, or renovating homes that provide nursing home care, hospital care, adult day health care, and domiciliary care.

Although the funding for this program has increased steadily since its inception and now amounts to more than $90 million, the requests for the funds have far outpaced availability of funds and currently there is a backlog of just under $260 million.

Initially, these grants were awarded on a first-come, first-served basis, and in 1986 the VA moved to establish its first priority system for awarding the grants. In our review of the current methodology we found that one of its major advantages was its simplicity and requires answers to just a few basic questions.

Those questions are basically: Have States provided their matching funds? Have they received any kind of a grant before for a State veterans home? Is there an unmet bed need at or above 91 percent? Is the grant for a nursing home or is it for a domiciliary project? Is it a bed-producing project or renovation; and if it is a renovation, Is it life safety-related or not?

Virtually 90 percent of the requests that were received by the VA were for bed-producing projects and 97 percent of those that were actually awarded went to create additional nursing home beds.

A number of VA stakeholders and other interested parties have expressed concern about the methodology and would like to see it revised. For example, projects that receive a low priority level often remain at the bottom of the list and never get funded, which poses a particular problem for States in trying to determine when and if these projects will be funded.

While simplicity, of the current method, is a major strength it is also a key weakness in that it overlooks a variety of factors that could be used in improving the methodology.

In reviewing the consent method, talking with a number of interested parties, and reviewing some of the positions that have already been put forward, we identified a number of areas in the current method that could be addressed in a revised method. And I will just briefly review what some of those might be.

Using better demographic data to predict long-care needs such as the aging of the veteran population and their functional status and perhaps, insurance status; considering the availability of pertinent community-based resources; recognizing leasing arrangements as an alternative to new-bed construction; ensuring that existing State Homes do in fact, meet VA quality of care standards; expanding the definition of types of projects to not only look at whether it is a nursing home project or a domiciliary project, but perhaps other types of program expansions; looking at unmet needs perhaps on a continuum; and perhaps earmarking a portion of the funds for renovations as well as new bed construction.

And these are all discussed thoroughly in the report. In our report we presented three hypothetical options; that sequenced a number of variables the VA might consider in redesigning its methodology.

But clearly, there are a multitude of other options that could be considered as well. The point that we need to make is that in our view there is no single, best priority method that is independent of VA's policy goals and strategic direction.

And to make any changes in the current methodology will require that the VA address a number of these key policy issues,

such as: Will quality of care in existing State Veterans Homes be a prerequisite to future funding?

Will higher priorities be assigned to different types of projects, whether they be life safety-related, ADA compliance related, privacy-related, or certain types of program expansions?

How will unfunded projects be handled from year to year? Will the list just continue on for the following year or will the projects be rescored each year according to priority and then funded accordingly?

How will the transition to a new method be handled? What approaches will the VA take to do that? Will they clear out the backlog, will they have some type of phased-in approach? Will a minimum threshold for projects be revised? Will the VA consider lease-arrangements?

Will a certain portion of the VA funds in fact, be separated into two pots; in essence for renovation versus new bed construction? And how will the definition of need be expanded to include veteran age, functional status, and other elements?

As many have said before, the VA veteran population is expected to decline considerably over the next 25 years and the ages of the veterans in the short run will also increase. As a result, the VA needs to re-examine the way in which it is spending its limited funding to ensure that veterans do in fact, receive the long-term care services they need.

The work that Birch and Davis did represented a first step in revising the VA's methodology by laying out what the options might be. But important policy decisions must be made to ensure that revised methodology reflects VA's overall, long-term care objectives.

A copy of our report, I understand, has already been provided to the Hill.

Thank you.

[The prepared statement of Ms. Zingeser appears on p. 92.]

Mr. STEARNS. As I understand, Kathleen, you don't have an opening statement? And would you identify, Ms. Zingeser, the individual on your right?

Ms. ZINGESER. Paul Grimaldi is with Birch and Davis. He is also a Principal of the firm and he was responsible for the technical portion of the report that Congress received.

Mr. STEARNS. All right. Ms. Zingeser, it is my understanding that VA construction grants are available to States which have a need for nursing home beds for veterans. Does it make sense for VA to ignore the community nursing home bed availability in determining this need?

Ms. ZINGESER. Well, our opinion is, is that should be taken into consideration. I think it goes in line with a lot of the VA's direction in terms of expanding its relationship with the local community and looking at services on a continuum; both VA services and community-based care.

And so in our laying out of the options we felt that it would be a good recommendation to take a look at those resources and make them available.

Mr. STEARNS. Mr. Shaw, would you agree?

Mr. SHAW. No, I would not.

Mr. STEARNS. Okay.

Mr. SHAW. I believe, depending on the situation, and it has to be looked at on a case-by-case basis, it may make the most economical sense if there is not a large enough catchment area of veterans in a specific, small community. That it might be better to contract with private facilities with the VA to provide care to Veterans contract.

But over the long-term, no. I think the quality of care in State Veterans Homes is much higher, and it is also all-inclusive because of the VA rate which includes many things which are not included in private nursing homes.

Mr. STEARNS. So you are saying that the quality is higher——

Mr. SHAW. Yes, that is my opinion.

Mr. STEARNS (continuing). In Veterans than in the community nursing home?

Mr. SHAW. Yes, that is my opinion.

Mr. STEARNS. So you would not agree that when the VA construction grants are available to States that this need should be modified at all to reflect occupancy rates in the community nursing home facilities in the area?

Mr. SHAW. As I said, it would be case-by-case and it would depend on the situation, but I think it would play a very minor role. The care that's provided in State veterans homes is structured toward veterans. The care in community homes is not.

The typical population in a State Veteran Home is going to be 80-plus percent male. The typical population is going to be at least inverse in a private community nursing home, with 80-plus percent female. And they are not structured with programs and such to meet those needs of many of those men.

Mr. STEARNS. Ms. Zingeser, do you believe that there are major weaknesses in the system for determining whether a State needs more bed?

Ms. ZINGESER. I think that is a question I would rather have directed to Kathleen Greve.

Mr. STEARNS. All right. Kathleen? Ms. Greve?

Ms. GREVE. Well, certainly it is one of the things that we asked Birch and Davis, when we requested this study, to look at as well. Geriatrics and extended care encompasses a lot of different programs and whole continuum of care.

The State Home Program is just one of those programs, and so for our purposes, and from a national perspective, I think we do need to look at what is happening in the local communities where State homes are being requested.

Mr. STEARNS. Mr. Shaw, let me put you on the spot. What is the case, when you say case-by-case, what is the case where it should be considered? Can you be more specific?

Mr. SHAW. There may be some environments where you do not have a catchment area of veterans, and if someone were to want to build a veteran's nursing home where there is no veterans, that would not make a lot of sense.

Maybe there is a few and maybe it would be better served then, to provide that care by contract with local nursing homes and/or offer alternative placement into an area that already has a State Veterans Home or a VA nursing home.

I am an attorney and that is as close as you are going to get me there.

Mr. STEARNS. You know, earlier we talked about the role of the States. Mr. Shaw, if VA sees a need to increase its spending on home health care and other non-institutional care, is there a role for the State Homes in this area?

Mr. SHAW. Yes, I believe there is. We already had the apparatus to provide care. We are already in many rural areas, and we are already interested and have made that known to the VA and other committees, that we think we could also extend our care to home-based, which would bring continuum closer to where they want to be. And we also agree on the continuum of care.

Mr. STEARNS. Ms. Greve, should Congress take VA's long-term care strategy into account in developing legislation to change the State Home Program?

Ms. GREVE. Well, yes sir. I think there will be some legislative changes necessary if we are going to change the prioritization methodology at all. Yes sir.

Mr. STEARNS. All right. Mr. Peterson, my colleague.

Mr. PETERSON. Thank you, Mr. Chairman. I guess Mr. Shaw, I think in your testimony you say there is $189 million backlog, or is that what it is?

Mr. SHAW. Last night I was told that new applications just since last August—there has been 24 new grant applications requested, and that total requested in these new applications which aren't of record anywhere yet, is $189 million. This is in addition to the numbers that they gave you a little bit ago of $260 million. So we probably have $450 million backlog looking at us.

Mr. PETERSON. Is that everything? That is everything that has been put in? Or is it more than that?

Mr. SHAW. I would say that is——

Ms. GREVE. May I answer that question since I do the program and I do the list?

Mr. PETERSON. Right.

Ms. GREVE. The 24 applications are brand new. They were not included on last year's list. Last year's list, which is actually for fiscal year 1999 funding—we had 88 projects. Of those 88 projects, 59 of them were priority-one, and those are the only ones that we usually consider funding in a given year.

Those were the $241 million dollar's worth of projects.

Mr. PETERSON. How much of the other ones that were not priority-one?

Ms. GREVE. I think the total was 348-something. To be honest with you I don't have the number in my head because I don't fund those.

Mr. PETERSON. And then we have $189 million besides?

Ms. GREVE. Being added to the list next year, yes sir.

Mr. PETERSON. So we are at $500-and-some million?

Ms. GREVE. Yes. How many of those will be eligible for funding I am not sure at this particular point in time.

Mr. PETERSON. Would it be——

Ms. GREVE. We also have to consider though, of the $241 million that were on this year's list, we did get $90 million funds, so you can subtract the $90 million.

Mr. PETERSON. And in order for them to be eligible they have to go through your process or something?

Ms. GREVE. Basically, to be eligible for funding and priority-one with the current methodology, they have to have an application requesting what it is that they want to build or what they want to construct. And then their State matching funds.

Mr. PETERSON. And that puts them in priority-one?

Ms. GREVE. That puts them in priority-one, yes sir.

Mr. PETERSON. And these other ones, what are they missing? The State funds?

Ms. GREVE. Yes, exactly.

Mr. PETERSON. Now we pay a third or 29 percent or——

Ms. GREVE. No, in our program we can pay up to 65 percent, and I believe the question earlier from the Congressman from Florida, was whether or not we always fund 65 percent. The only time we do not fund 65 percent is if the State is including in the construction something that we do not participate in.

Mr. PETERSON. Oh, this is the construction, okay. I am shifting gears here.

Ms. GREVE. Oh, you are talking——

Mr. PETERSON. Once it is built then it is a third?

Ms. GREVE. Well, that is what our goal is; to get up to a third of the costs of care.

Mr. PETERSON. With your 29 percent or 30 percent or whatever it is?

Ms. GREVE. Thirty percent, yes sir.

Mr. PETERSON. So this is much cheaper than anything else? I mean, as far as we are concerned this is the cheapest way we can go, right? So it looks to me like if we spent $500 million we would save a lot of money.

And I just tell you, we just built a State Home in my district; we just opened it about a year ago.

Ms. GREVE. Which one is your district?

Mr. PETERSON. In Northwestern Minnesota, in Fergus Falls.

Ms. GREVE. Fergus Falls, right.

Mr. PETERSON. It is a wonderful facility. The people in there are happy, they have got a little mall. I mean, it is amazing what they have done with this thing. So, you know, I guess maybe by increasing it to $90 million last year we were maybe responding or understanding that we could save this money.

Maybe the question is to the chairman here, or I don't know whoever, if we can save this kind of money, why aren't we funding all of these facilities? Does anybody know the answer to that?

Mr. BILIRAKIS. States may not be able to fund their portion.

Mr. PETERSON. Well, but apparently we have got $258 million where they can raise it, you know. Can you get me, if you don't have it on top of your head, can you get me how much money we would save if we built these facilities? Compared to what it would cost us if we put these people into a community nursing home or into the VA nursing home itself? Has anybody computed that?

Ms. GREVE. Well, I think in part it would be somewhat difficult because we are talking about different patients and different needs and different lengths of stay. Typically, the State Homes have been

longer-term stays than in community-based nursing homes. So we are talking apples and oranges here.

Mr. PETERSON. Well, I understand. I guess I would like if somebody could give me information about——

Ms. GREVE. Well, we might be able to delineate different programs and what they provide and costs associated with them.

Mr. PETERSON. Well, I mean, in reality the reason that people don't stay as long in the community nursing home is because there is pressure to get them out of there because of the money. You know, or to get them other on the Medicaid budget.

My last question because my time is going to run out is, how much role does political pressure play in building these facilities?

Ms. GREVE. Absolutely none. I mean, when I say absolutely none it is only——

Mr. PETERSON. I find that hard to believe.

Ms. GREVE. I guess that was the wrong answer.

Mr. PETERSON. So we can just disband and go home?

Ms. GREVE. Well, no, no. The critical role that Congress plays is in providing the funding. The way the methodology is set up, as Ms. Zingeser pointed out, it is a simple methodology but it is a very straightforward application of certain principles that have to be applied for every application.

So when I say there is no political pressure applied here, the political piece of it is the funding of the program.

Mr. PETERSON. Right.

Ms. GREVE. When we come to the methodology though, it is very straightforward, it really——

Mr. PETERSON. I understand that, but——

Ms. GREVE (continuing). It really is a cookbook-approach, you apply——

Mr. PETERSON. We have $260 million in projects and we have $90 million in money, so somebody isn't going to get their money.

Ms. GREVE. That is true but it is——

Mr. PETERSON. And there is political pressure. I know that because we just went through this, getting—I mean, we tried to put as much pressure on and the State did and everybody else did. You are telling me that that is completely ignored and——

Ms. GREVE. Well, basically what it creates is a lot of letter-writing, explaining how the methodology really is pretty tight, so that there isn't any room to move or shuffle projects around——

Mr. PETERSON. In other words, I could look at this list, this $260 million list, and I could right now tell exactly how each one of these is going to get funded because it——

Ms. GREVE. Yes.

Mr. PETERSON (continuing). Is based on a formula and——

Ms. GREVE. Yes.

Mr. PETERSON (continuing). It is absolutely go that way no matter what?

Ms. GREVE. Exactly.

Mr. PETERSON. Well, I would like to see——

Ms. GREVE. And it is done once each year and it is always as of August 15th. So once the list is signed off on by the Secretary that is the list we use——

Mr. PETERSON. So you just go down the list until you run out of money?

Ms. GREVE. Exactly, and then we go to next year's list and then it starts all over again.

Mr. PETERSON. Oh, it starts all over again?

Ms. GREVE. Yes.

Mr. SHAW. A new list is generated.

Ms. GREVE. Every year.

Mr. SHAW. And that is why the repair and renovation projects get pushed to the bottom every year, which is a concern to many people in many districts.

Mr. PETERSON. Oh, I see.

Mr. SHAW. Because the new bed construction takes priority, even above life safety.

Mr. PETERSON. Right. Thank you, Mr. Shaw.

Ms. GREVE. And that is one of the——

Mr. STEARNS. I thank my colleagues. Mr. Bilirakis?

Mr. BILIRAKIS. Well, thank you for being here. It is established that a partnership type of nursing home—State, federal—would cost the Federal Government at least, less dollars. Now, there are 24 applications in total that you are considering now, or just those are 24 new ones?

Ms. GREVE. Those are just 24 new ones.

Mr. BILIRAKIS. All right, in addition to how many?

Ms. GREVE. In addition to the 88 that are on this year's list. Of the 88 on this year's list we'll fund approximately 15, and a portion of one additional project. So you subtract out 15 from 88 and add 24.

Mr. BILIRAKIS. But all of those, let's say the total of those figures comes out to say 100 or whatever it turns out to be. Even if all of those were granted—well, let me ask you first about the quality of the applications.

If you had the dollars, and could fund all of those you feel really qualify—in other words, in terms of needs and etcetera, etcetera—what would be the quality of them?

Would you say that if you had the dollars you probably would fund them all because they all meet the need requirement and the other criteria?

Ms. GREVE. Oh, yes sir. I would say yes.

Mr. BILIRAKIS. You would say so?

Ms. GREVE. Yes.

Mr. BILIRAKIS. So you are not really getting many applications of the types that Mr. Peterson mentioned where, you know, new industry has created a thing. The dollars are there so let us start a State nursing home?

Ms. GREVE. Well, no, I wouldn't—I think the States give a lot of thought before they submit an application and it is quite a lengthy process within each State.

Mr. BILIRAKIS. And I know he was referring to private and this is public, right, State, so that would not be applicable. So if then, all of these were funded, and again, hitchhiking on Mr. Peterson's questioning, if all these were funded, right now we have a 21.4 percent market share based on long-term care needs of veterans in 1997.

In other words, there is approximately, what, 69 percent of needed veterans nursing home beds are not available for them. How much of that would be satisfied by virtue of funding?

Mr. SHAW. Very, very small numbers, percentage-wise. The thing is, it is not today's need that scares me; it is the need 5 and 10 years out. Because it is a tidal wave of aged, frail veterans. Some of them will be able to be dealt with with home health care, but many of them are going to have to have alternative placements and long-term care settings.

Mr. BILIRAKIS. And there is certainly a need for the community-based nursing——

Mr. SHAW. Yes, there is.

Mr. BILIRAKIS. And I am not trying to belittle them in way.

Mr. SHAW. I am not either, sir.

Mr. BILIRAKIS. And I hope that they realize that. But I guess the bottom line here is the veteran and their needs. And you are never going to ever reach 100 percent, I don't care how much need there is out there, in any issue, in any respect.

But much of the solution, too, is the fact that it is costing the Federal Government less money if they were to encourage, if you will, more of these State nursing homes.

Even more so than the community-based, would you say, Mr. Shaw?

Mr. SHAW. I will give you——

Mr. BILIRAKIS. In terms of dollars. And I am not talking about the——

Mr. SHAW. Right, I will give you the dollars. On page 4 of my sheet, I believe it is, we have nursing care comparison figures for FY98, where the VA per diem was 45.63; the average VA contract nursing home care per diem cost per day was 148.84; and the average VA nursing facility cost was 255.25.

So if you are comparing those costs I would say it is greatly different.

Mr. BILIRAKIS. Yes. Of course, if you had the 65 percent construction cost cranked in there somewhere that would be higher——

Mr. SHAW. If you amortize that over the number of years, 20 or 30, it would be——

Mr. BILIRAKIS. But still, I guess maybe an intelligent answer without going right into the specifics right now would be, it still would cost the federal taxpayers less dollars if we went this route, right?

Mr. SHAW. I believe so. It shifts the burden to the State.

Mr. BILIRAKIS. The next question, again we don't have the States here to respond, but the next question is, would the States have the dollars? Now obviously, the applications have gone in. They apparently feel that they have the matching dollars.

But in terms of applications that have not been submitted where there is need out there, would the States have the dollars? If we sweeten the pot in some way, were able to raise more dollars to make up the federal share, and provide additional per diem dollars or something of that nature, would we see a higher number of States' applications coming in?

Mr. SHAW. I think there would be much more involvement than there is now and that is what I have heard from members inside

the Association; that we look at 40-plus States, and I would think you would see much higher participation than it even is now, because the demand is there.

Mr. BILIRAKIS. The States right now, first of all we hear that many of them have surpluses, and then we're talking about, you know, tobacco dollars have been discussed in this committee quite often lately. But that is quite a, I guess I will call it a windfall for the States if they are able to keep those dollars; if we can keep the administration from getting their hands on it, which is what they are trying to do.

But those would be dollars, Mr. Chairman, those would be the tobacco dollars would be dollars that could be available for this particular purpose.

Mr. STEARNS. Yes, and we have a bill to that effect, that some of the tobacco dollars will actually accrue to the veterans in the final settlement. So I think it is a good point.

Mr. BILIRAKIS. Thank you very much.

Mr. STEARNS. Well, I thank the witnesses for coming. I know how valuable your time is too, and now we will have the third panel come forward.

Mr. Steve Watson. He is administrator with the Ocala Harborside Healthcare Nursing Home. I am particularly pleased to welcome Steve who is a constituent who I know, who is also a veteran. And Mr. Richard Jelinek, a senior vice president of Managed Care Solutions.

So it is indeed an honor to welcome a constituent and Mr. Watson, we would be glad to have your opening statement. You can proceed at your pleasure.

STATEMENTS OF STEVE WATSON, ADMINISTRATOR, OCALA HARBORSIDE HEALTHCARE NURSING HOME ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION; RICHARD JELINEK, SENIOR VICE PRESIDENT, MANAGED CARE SOLUTIONS, INC.

STATEMENT OF STEVE WATSON

Mr. WATSON. Chairman Stearns and members of the subcommittee, my name is Steve Watson. I am the administrator of Harborside Healthcare in Ocala, Florida, where we care for 180 residents. I am here today representing myself and the American Health Care Association.

AHCA's membership has worked with the VA in providing long-term care for veterans. We are eager to continue working with the VA to serve the growing long-term health care needs of veterans. We appreciate your invitation to testify on the Federal Advisory Commission Study on the Future of VA Long-Term Care.

I come to you today, both as a nursing home administrator and a veteran, having served 18 years in the United States Navy. This combined experience allows me to see the issue from both sides. I believe when a veteran needs long-term care they need and want quality care as closely as possible to home.

As your society ages, we have been hearing more and more about strains being put on our long-term health care system by our growing aging population. We understand that the VA is truly at the

crossroads in trying to meet the demands for services by coping with limited resources.

I commend the work of this commission in recognizing that solutions must be found to the problems of providing and paying for care. We are an active participant on the Federal Advisory Commission. Generally, we support the report's findings and I would like to highlight some of them

AHCA supports the recommendation that the VA should retain its core of VA operated, long-term care services and improve the efficiency of operations. We especially agree with the recommendation that most new demand for care should be met through contracts and existing State Veterans Homes.

The VA may not need new construction to fulfill its obligation to our veterans when the needed beds are available in the community. We believe that the VA will make better use of the limited dollars by expanding its community contract nursing home program.

AHCA members, nursing home coordinates with VA in this successful program. The VA initiated the Multi-State Program in 1996 to allow veterans to access nursing home care in the communities near their families.

Through a best value competition, the VA awarded contracts to seven companies and this year will expand the program to local and regional long-term care providers as well. We help the VA by helping to care for the veterans in their own communities.

This is not only the best thing for the veteran but it saves the VA money. You don't have to be a veteran home provider, a home at best.

For instance, there is a nursing home in Napoleanville, LA, that has created its own veterans wing and holds its socials every Thursday in the mall over in New Orleans. They also provide nursing home care to veterans to programs that offer grants to States for facilities construction and renovation through the State Veterans Nursing Home Program.

It pays up to 65 percent of construction home costs. AHCA agrees with the commission's recommendation that the VA should continue this program. However, we are concerned that the funding formula does not consider the availability of care in existing nursing homes in the community.

We believe the VA should use its limited resources to build in an area only where there is a demonstrated need. Let me give you an example.

In Louisiana, the State government is considering three additional State veteran nursing homes at a time when Louisiana's private nursing home industry is operating with an average annual occupancy rate of only 81 percent.

The same is true for Minnesota. The State legislature authorized three new State veteran nursing homes to be built even though there is a moratorium on new construction because this excess capacity exists in nursing homes.

In California, the State continues to send grant requests to the VA to build more homes despite 80 percent occupancy rate. In fact, I know of many homes in my own State around the country that would be proud to honor and serve the vets.

I want to commend the commission on the development of the long-term care quality index that would standardize and measure the quality of care delivered to the vets. The process would include an assessment of patients over age 70 who may need long-term care service.

AHCA strongly supports the use of outcome measures, quality indicators. We are proud to see the VA at the forefront. Thank you for inviting me to testify. We look forward to the policy solutions of the committee and the VA will recommend for providing long-term care for vets.

We want to continue to be actively engaged in developing these solutions and we offer our full assistance.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Watson appears on p. 109.]

Mr. STEARNS. Thank you, Steve. We appreciate again, as a constituent, coming forward.

Mr. Richard Jelinek, senior vice president, Managed Care Solutions, for your opening statement.

STATEMENT OF RICHARD JELINEK

Mr. JELINEK. Thank you, Chairman Stearns and members of the Health Subcommittee. Thanks for inviting us here to talk about our company, Managed Care Solutions, this morning.

We have been asked to describe our experience assisting government agencies, such as Medicaid, in assisting them to improving access to long-term care and other medical care services, specifically as it relates to frail, elderly, and disabled individuals.

I would ask that my full hearing statement is entered into the record.

Mr. STEARNS. By unanimous consent, so ordered.

Mr. JELINEK. Managed Care Solutions is a national health care company specializing in the administration of long-term care services. Currently, we provide health care management and other services to over 170,000 people in eight different States—50,000 of which are chronically ill or disabled, and some of which are veterans.

There are three reasons why we believe our experience is relevant to the work of this subcommittee and the mission of the Department of Veterans Affairs.

First, States are grappling with a demographic challenge similar to that facing the VA; namely, a population at risk for long-term care services that is expected to increase five-fold in the next 4 years.

Second, key elements in our tested care management approach mirror that of the recommendations of the Federal Advisory Committee on the Future of the VA Long-Term Care.

And third, by putting this approach into practice in States such as Arizona and Texas, we have found success by increasing access to long-term care services, improving quality, controlling costs or the escalation of those costs, and improving patient satisfaction.

In addition to these benefits these programs also allow for a more predictable outcome of growth and demand for services. The critical success factors in our care management approach match

many of the Federal Advisory Committees recommendations to the VA and I would like to touch on a few of those.

The first element contributing to our success is the comprehensive, coordinated continuum of bundled services, and you have heard a lot about that this morning. What we do is take behavioral health care, prescription care, institutional care, social care, and acute care and blend them all together so there is one entry point for all services for individuals using our systems.

It cannot be overstated enough that unless all services in the continuum are available and coordinated it is going to be impossible to manage effectively, each individual's needs.

The second success element in our programs are highly trained care coordinators. We use nurses, social workers who work directly with the family, the patient's family—excuse me—the patients, the patient's family and the physicians, to develop individual care plans and do ongoing assessments as it relates to their needs.

And the third element is, we use information systems to track data critical to managing the care of that individual. Our care managers actually carry laptop computers with them to do the assessments in the home or in the nursing home, and enter this. We are able to not only monitor the provision of care that is being rendered to that individual but look at outcome studies over a period of time.

The fourth success factor, and I will speak more about it in a moment, placing the patient in the least restrictive setting in which to care for that individual. Sometimes we have to create alternatives where there is no care available, such as in rural markets.

And the final critical element in our success is a quality assurance oversight. We continuously monitor quality outcomes, utilization, and cost of services of our patients and assure we are meeting our internal requirements as well as those of the programs that we contract with.

I want to re-emphasize the fourth element, and it again was discussed in detail earlier today, and that is, developing alternatives to nursing home care, because that is undoubtedly one of the most important components of implementing a sound and affordable long-term care policy.

Our experience is that unless a full range of long-term care services and settings are available, it will not be possible to stretch the current resources we have in the Medicaid business and in the veterans market.

We therefore, agree with the Federal Advisory Committee in recommendation to the VA to broaden the provision of respite in all settings, allow for the payment of assisted living and residential care, expand the VA benefit package to include nursing home care when that is the most appropriate setting.

We also want to talk about the expansion and agree with the recommendation for home and community-based services to make them available, if that is the preferred placement site. We look at clinical outcomes and clinical need to determine if a better setting might be in a home setting versus in an institution.

And lastly, a way that was asked earlier about who makes the decisions about the care placement, we'd recommend that the VA look at care coordination a bit more and using care management

as an oversight mechanism to help work on individual care plans for the veterans.

Based on our experience and these recommendations of the Advisory Committee, we suggest that this subcommittee direct the VA to undertake several long-term care demonstration programs in order to test the impact of care coordination on the VA's ability to deliver long-term care services to more veterans out there.

I thank you for your time.

[The prepared statement of Mr. Jelinek appears on p. 114.]

Mr. STEARNS. I thank both of you. I really just have one. Your testimony will be part of the record, of course, and we appreciate what you have provided. Steve, you heard the second panel?

You heard Mr. Shaw who is the president of the National Association of State Veterans Homes indicate that States want to build more homes. And maybe the two of you could just comment on what the second panel said as sort of a basis for your testimony.

Mr. WATSON. Well, if I heard him correct, he said something like there were 24 applications. Is this correct?

Mr. STEARNS. Yes.

Mr. WATSON. In reference to the 24 applications for new construction. It is my understanding they have been requested not necessarily granted. My district is governed by the state North East Health Planning Council which controls the number of new community beds allotted to our district. We submit letters of intent in case we decide at a later date to apply for a certificate of need. Those that do apply are then selected by the Health Care Finance Administration.

And so if you look at our district you would see probably that there are 15 or 20 applicants in there, but only two or three of them are serious about it. We do that so we won't miss the deadlines on them. Later on we may change our mind.

So I am not saying this is what happened. I am telling you this is the way we usually work it in the community-based institutions.

Mr. STEARNS. Mr. Jelinek, do you want to add to anything that was in the second panel in terms of the criteria for, and generally the decision to build more State veterans homes?

Mr. JELINEK. I think that there are two things. One is each geographical area will have to look at what the capacity is and what the needs are for that area, but I would like to focus this group on that there are cheaper alternatives.

We found that up to 35 to 40 percent of people in a nursing home today don't necessarily belong in a nursing home, and they can better be seen in a home and community setting if the appropriate resources and networks are established to support their needs in a home.

For example, we will in certain instances, hire a family member to stay at home because that is more appropriate than putting them in a $35,000-a-year nursing home. We can pay an individual what is necessary to make the bills and to stay at home because they are working for minimum wage elsewhere, we can pay them a little bit more and train them to take care of their elder one or the one that needs services, and those are alternatives.

So I can't comment because I don't know the individual needs on beds, but I can say that there are other alternatives for placement

in a nursing home that might be more appropriate, and better utilize the existing beds that are in place today.

Mr. STEARNS. I thank you. My colleague, Mr. Bilirakis.

Mr. BILIRAKIS. We have a vote on the floor, Mr. Chairman, and I know we certainly don't want to keep these good people here for an undue period of time. So I guess I will hold off.

The thought that I would have is as I have already indicated, there is certainly room for and a need for, the community-based nursing home; there is no question about that. And what we have got to kind of consider here is the bottom line being the veteran and their needs, and the best way to get it done.

And in the mix of course, would be you guys, a community-based nursing home. But you have made a comment, Mr. Watson, in your written statement something about, you talked about more efficient and quality and all that. Then you also said something about cheaper, less costs, and I think you used the words "if needed".

Well, obviously less cost is always needed. So I know you are communicating with Mr. Stearns but I would suggest that we've got to take into consideration all of these things and the more information you can furnish us in terms of the role that you all play and the costs ultimately to the taxpayers, and also not excluding obviously, quality and efficiency and you know, really taking care of the veteran, the better we can do our job up here.

It looks like no matter how many State nursing homes we add in the mix it is not going to really bite into the needs as much as we would hope. So community-based would always be there.

I know for instance, there is a veteran in my area who is down in a community-based nursing home. I am not really sure what degree the VA is contributing towards him. He wants to transfer to Land o' Lakes, the new State nursing home there—which by the way has not gotten its license from the State yet even though it is a State home.

It has supposedly been open for a few months now, or at least a few weeks because I was there for the dedication. But in any case, he wants to transfer because he wants to be with his fellow veterans. I guess he feels he would be more comfortable there.

But I don't know for instance, what the costs will be to the VA, what the costs will be to him, what the costs will be to the State if he transfers versus the costs today when he is in a community-based nursing home.

These are all things I think that we all need to get in our minds in order that we can make our decisions. Thank you very much.

Mr. STEARNS. I thank the third panel, particularly Steve for coming this distance and helping out. We have a vote and we have about 5 minutes to get to our vote so we are going to conclude the hearing and adjourn this. And again, I thank you for your time.

[Whereupon, at 11:15 a.m., the subcommittee was adjourned.]

APPENDIX

Statement of Congressman Christopher H. Smith
Thursday, April 22, 1999
Veterans' Affairs Health Subcommittee Hearing on Long-Term Care

The Need for Respite Care

Thank you, Mr. Chairman, for convening this hearing on a topic that is of great interest and importance to our nation's veterans as well as their children and grandchildren. As Congress discusses the future financial solvency of Social Security and Medicare, we must also face the fact that as Americans live longer, their health care needs will continue to increase. Medical advances are prolonging lives but also providing new challenges as we strive to provide quality long-term care services for America's senior citizens, many of whom are veterans.

Today's hearing seeks to find answers to the long-term care needs of America's veteran community. The report issued last November by the Federal Advisory Committee on the Future of VA Long-Term Care was very timely and contains a number of worthwhile suggestions and recommendations to improve the VA health care system. Clearly, Congress needs to ensure that our VA system will continue to provide quality long-term care for our veterans.

I have been a strong advocate for finding ways for people to prepare for and meet their family's long-term care needs. For example, this year I have reintroduced legislation -- the Long-Term Care Advancement Act (HR 275) -- to help American families prepare for their future, long-term care needs. Under my proposal, families who are taking care of a disabled spouse or parent in the home can obtain desperately needed tax relief in the form of a $500 refundable tax credit. In addition, HR 275 makes long-term care insurance policies more affordable by allowing taxpayers to withdraw a portion of their money from their IRAs or 401 (k) plans tax-free and penalty-free.

I want to draw attention to one of the 24 recommendations contained in this report, which concerns the subject of respite care. The facts about long-term care are that the vast majority of LTC services are already being provided in the home. This is important to recognize, because if it were not for the millions of compassionate and courageous spouses and adult children caring for their loved ones at home, the costs of providing these services financially would be overwhelming. So the key is to find ways to enable these care givers to continue providing care in the home for as long as they want to and it is feasible. That is where respite care comes in.

The premise of respite care is that it enables the spouse, adult child, or other care giver of a veteran to be given a break from their duties. Many senior citizens who are diagnosed with a long-term, debilitating illness choose to reside at home because of the independence that it affords as well as the intangible and tangible benefits of living in familiar surroundings.

However, the day-in and day-out care that is needed by a dependent person, whether it is providing meals, doing laundry, or administering medication, while willingly and lovingly provided, do take a toll on the care giver over time. Before you know it, the veteran is not the only one with a health problem because their care giver may often find their own well being deteriorating from neglect. Respite care provides time off for a family member so that he or she may take a few days to regain their own strength without fear of leaving their loved one home alone.

However, under current VA regulations, veterans and care givers in need of respite care are forced to travel to a VA nursing home to receive respite care. This is counter-productive because it places the care giver in the position of transporting the veteran to the nursing facility. I am willing to guess that this alone is probably a deterrent for a care giver pursuing the respite care option.

The advisory committee similarly saw the need for expanding the definition of respite care so that a veteran may receive respite care in his or her home or at a non-VA facility close to them. This is a common sense proposal and I will be introducing legislation shortly after this hearing which will codify their recommendations into law. In the meantime, I look forward to reviewing the testimony of our witnesses and thank them for their time and efforts on behalf of our nation's veterans.

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RANKING DEMOCRAT

Statement of Representative Luis Gutierrez
Subcommittee on Health
Hearing on VA Long-term Care
April 22, 1999

Thank you, Mr. Chairman. I am pleased that we are here today to discuss long-term care for our nation's veterans. I thank the witnesses for taking the time to provide their perspectives on this important issue.

As we know, long-term care is an issue that will affect a growing number of veterans as we enter the 21st century. The median age for veterans now is 57 years. According to the Department of Veterans Affairs, the number of elderly veterans will peak during the first decade of the 21st century. Although the veteran population will decline by approximately thirty percent over the next twenty years, the number of veterans who are 85 years of age or older will more than triple during that time. Next year, the number of veterans age 65 and older will reach an all-time high. Make no mistake-- our nation's aging veterans will need institutional care.

Compared to their civilian counterparts, veterans generally have lower incomes, have less health insurance coverage, are more frequently minorities and are more likely to have disabilities or be unable to work. Although VA provides quality long-term care services for many of our veterans, severe budget constraints and the transformation from a hospital-based system to an outpatient-based system prevents our veterans from receiving the adequate long-term care they are entitled to and deserve. Without the desperately needed increase in the VA budget for the next fiscal year, long-term care will continue to be inadequate. Increasingly, the VA is implementing policies that restrict length of stay for long-term care patients and reduce the number of beds that serve them. Most of the reductions in inpatient care do not appear to be complemented by increases in care delivered in outpatient settings. This situation cannot be tolerated.

Mr. Chairman, VA must meet the challenge of satisfying needs for long-term care services. Expensive programs for managing the special care needs of the aging veterans population, such as Alzheimer's Disease programs, will not be able to continue operating under the current budget. Congress should make long-term services for veterans one of its top priorities.

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STATEMENT OF THE HONORABLE MIKE DOYLE (PA-18)

Subcommittee on Health Hearing on VA Long Term Care
April 22, 1999

Thank you Chairman Stearns and Ranking Member Gutierez for convening this morning's hearing to examine the current state of VA Long Term Care and to further discuss what the future holds for the system.

We have a distinguished group of panelists with us today who represent different facets of VA Long Term Care. I want to welcome all of you and encourage you to be forthcoming about your concerns regarding VA Long Term Care as we now know it. In addition, I want to encourage you to be up-front about your recommendations for making necessary and perhaps dramatic changes to improve the quality of the system, as well as ensure its existence.

Given the current budgetary climate and the no-growth budgets that the VA has been dealt for too many years now, VA Long Term Care is not just at a crossroads - it is balancing precariously of the edge of potential collapse if the appropriate measures are not taken. The sand has run through the hourglass of discussion on this critical matter - decisive and far-reaching strategies must be employed.

I want to reiterate my firm belief that the most basic of commitments we have to our veterans is to provide them with timely, appropriate, and quality health care health care treatment and options. Without question, veterans should be guaranteed access to a full continuum of health-care services, including long-term care. Reports indicating that the VA is not providing, or adequately exploring offering a range of long-term options is troubling to say the least. Add in the fact that beds are being eliminated at significant rates and that vets are being pre-maturely discharged in some networks to control costs - and the scenario becomes unacceptable. This simply can not be allowed to continue.

As many of you know I not only represent one of the largest veterans population in the country, but one of the oldest. And I can tell you that they are deeply concerned about VA Long Term Care. In my view, the VA commitment to Long Term Care should be steadfast and heightened to meet current and future demands. In short, the VA should not pick and choose among health care services, nor should one concentration of medical care be pitted against another.

I am encouraged to hear that internal Committee discussions on improving VA Long Term Care have begun and I look forward to playing a role in this process.

STATEMENT OF
CONGRESSMAN LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
April 22, 1999

VA's Long-Term Care Programs

Good morning, Mr. Chairman. Thank you for conducting this important hearing today. I am pleased to release the findings from a survey of VA Chiefs of Staff I asked my staff to conduct last summer. I do not have the time to address all of the findings of this report today, but I would like to ask that the full report of findings completed by my staff be submitted for the record and I invite members to discuss findings with me or my staff. The survey, administered to all Chiefs of Staff between August and September 1998, focused on workload and policy changes that had occurred in VA's long-term care programs since the VA's management was decentralized in 1995.

Since 1995, VA has undergone enormous changes—many for the better. VA was quick to tout the improvements in quality and the new veterans it treated in successive years. VA has been less quick to acknowledge some of the problems. For awhile it was hard to tell what was happening in the networks, but its clear we are just beginning to see some of the effects of the revolution.

Recently, I had heard enough from my veterans and the press to indicate there was likely systemwide change taking place in VA's long-term care program. At this point, I realized the critical need to determine systematically, the changes taking place around the country. I requested my staff to administer the survey, which was completed, by almost 90% of the chiefs staff around the system. The survey confirmed some emerging concerns. Key findings included:

- Many facilities have changed the mission of nursing home beds. Many of VA's nursing homes now offer post-acute restorative, rehabilitative and palliative care, rather than ongoing care, for age-associated problems.
- The number of nursing home beds VA funds or operates and other VA beds devoted to long-term care dropped. The system has for some time been increasing these beds anticipating the peak in demand that aging veterans will have).

- VA medical centers are restricting, beyond legal parameters, the amount of care they will reimburse in private sector nursing home beds.
- VA is investing less of its budget in long-term care programs than Medicare and Medicaid invest in similar programs.
- While there has been some growth in the use of home and community services, VA has not yet made significant new investments in these programs.
- There is a great deal of variability in the types and amounts of long-term care in which the system's 22 networks choose to invest.

The reasons for the changes are numerous. Twenty-two network directors nationwide now make decisions about policy and funding that were once made at VA Headquarters. Service Chiefs at Headquarters who once made decisions about various programs, including VA's geriatric services, have now become "consultants". In their new roles, consultants offer advice about program management, but no longer directly manages them.

Along with tighter budgets for the agency, a myriad of challenges confronted health care and VA in this sea of change. Nursing home care, which VA offers to veterans at the discretion of the Secretary of the VA, became a vulnerable program and Headquarters, by design, had little ability to affect network decisions. VA's funding allocation model changed making less money available for nursing home care. Veterans' demand for services was reaching a peak as the population, particularly veterans of World War II, aged. Managed care providers were influencing a general shift from inpatient care to home and community based settings, and nursing home care was affected by these trends.

The frail and elderly are often not able to advocate for themselves so this issue may have taken longer to grab our attention than changes that effect more vocal populations. Still, it is astonishing that so much change occurred without any public dialogue. I hope that this report will at least help us understand what we are dealing with and informs our debate over this critical issue.

I look forward to hearing from our witnesses today, particularly from the distinguished Chairman of the VA's Federal Advisory Committee on Future of Long-Term Care who has made a number of recommendations I believe VA should seriously consider. Jack Rowe has made many contributions to VA's policy and practice over the years, first as a VA employee, and since he has left the VA, as a well regarded advisor on many Commissions, including the effort to address the "The Future Structure of VA Health Care" of several years ago. We

are grateful for your continued service to the nation's veterans. Thank you again for holding this hearing today, Mr. Chairman.

THE DEPARTMENT OF VETERANS' AFFAIRS LONG-TERM CARE RESOURCES

Findings from 1998 Survey of VA Chiefs of Staff

-A Committee on Veterans' Affairs
Democratic House Staff Report
to Congressman Lane Evans
April 21, 1999

Submitted by
Susan Edgerton
Democratic Staff Director
Subcommittee on Health

OVERVIEW

Serving a universe of aging veterans with static resources, VA must meet the challenge of satisfying veterans' needs for long-term care services 10 to 15 years before the rest of the nation will face the peak of long term care needs for a graying America. The median age for veterans is now more than 57 years old. Veterans who rely on the VA health care system are even older on average, more likely to be poor, represent minority groups, have less education, and have less reliable social support systems. They are less likely to be insured and more likely to view their health as fair or poor—in fact they are more likely to have comorbidities that complicate treatment than their peers. All of these factors make many veterans expensive and difficult to treat.

It has long been assumed that because its population is older, its services integrated, and its research and teaching capacity available to investigate questions about innovation and cost-effectiveness of care delivery models, VA could serve as a model for long-term care delivery. However, some factors complicate VA's ability to become this model. Within the last five years, VA has become more decentralized, hampering the effectiveness of centralized policy making, planning and monitoring efforts. It has also committed itself to living within a "frozen" appropriation; this allows no growth for inflation, pay raises, or uncontrollable cost increases. Any growth in funding is expected to come from outside funding streams.

VA's delivery system is becoming more community-based and less dependent on its physical plant. In fact, the Under Secretary for Health frequently refers to VA facilities as "hospitals without walls". For the first time, VA is implementing enrollment. Once enrolled veterans may receive a basic health care benefits package for as long as VA has space and resources available. This year VA is enrolling every veteran who applies—including those in higher income groups without service-connected disabilities who have generally not been served by VA facilities in recent years. This policy is an effort by VA to increase the number of veterans it treats and thus bring down its per veteran overhead costs. In order to accomplish these goals, VA is opening community-based clinics all over the country, while simultaneously closing beds, wards, and even hospitals at a rate no one imagined possible as recently as five years ago.

VA's basic benefits package does not include long-term care. In a fiscally strapped health care system seeking to serve more veterans with fewer "real" dollars, assigning a "discretionary" label to these benefits does not bode well for their consistent and reliable delivery system-wide. Indeed, expensive long-term care and rehabilitative services—traditionally viewed as VA's "specialties"—seem to be the first casualty of cost-saving efforts. Recent implementation of policies restricting length of stay for long-term care patients and drastic reductions in the beds that once served these individuals demonstrate this tendency. Most of the reductions in inpatient care do not appear to be complemented by increases in care delivered in outpatient settings. Marginal increases in home care visits, adult day health care and residential care are not offsetting the decreases in average lengths of stay and the growing demand for services. Instead, in many cases, VA appears to be emulating the private sector—referring some of its hardest-to-treat patients to Medicare, Medicaid or other payers.

Changing Patterns of Health Care Use in the VA

	Outpatient Visits	Inpatient Days	Unique Users	Avg. Visits/User	Avg. Days/User
1994	25442000	30604520	2800000	9.09	10.93
1995	28939000	29599427	2858582	10.12	10.35
1996	29295000	27288860	2937000	9.97	9.29
1997	30436000	24583845	3142065	9.69	7.82
1998 (est)	32761000	23157790	3278946	9.99	7.06
1999 (est)	34703000	22031035	3413394	10.17	6.45

There is some good news. VA is working harder to treat its acute patients more consistently. It has implemented preventive care, chronic disease, and palliative care indices to ensure that these practices are delivered in a more predictable manner system-wide. It is implementing clinical practice guidelines to ensure the consistent delivery of "best practice" care for asthma, diabetes mellitus, ischemic heart disease, congestive heart failure, and major depressive disorders. End-of-life care, including pain management, has become a major focus of the organization. VA is participating in a major initiative with the Robert Wood Johnson Foundation to design effective programs for end-of-life care. Geriatric Research Education and Clinical Centers have made major contributions to the practice of care for the nation's elders.

Most of these programs, however, are centered upon the acute phase of disease or chronic disease management. But questions still remain: what role should VA play in offering supportive or custodial care for frail, elderly veterans and other vulnerable veterans who, because of physical or mental impairment, require assistance with daily living activities? If so, how should it be funded? Does VA have a responsibility to all veterans or just those for whom the priority of care has been deemed greatest?

Answering these questions served as the impetus for the Democratic Staff of the House Committee on Veterans' Affairs to administer a survey to VA Chiefs of Staff during August-September of 1998. Of the 145 integrated VA facility chiefs of staff surveyed, 126 (87%) returned surveys. Responses to the survey varied tremendously in their quality as measured by the detail and internal consistency of the information provided. Staff attempted, where possible, to validate most of the data collected from facilities. Because the fiscal year had not ended when the survey was conducted, data from fiscal year 1998, which Chief of Staffs were asked to estimate, is particularly suspect.

Nevertheless, the high response rate and consistent trends reported, lead staff to believe there are dramatic changes in the policy and practice of VA long-term care. These changes have important implications for veterans and for the nation's fraying long-term care safety net that may have to catch them.

WHO DOES VA TREAT?

The median age of veterans in July 1997 was 57.7 years with the two largest groups of veterans are in the 50-54 year-old age group and the 70-74 year old age group.[1] By 2010 in the United States the average life expectancy for men is 74.7 years of age; for women it is 80.5 years.

1.

While the number of U.S. veterans is declining, the number of veterans who are at least 85 years old will increase from 375-525% in every Veterans Integrated Service Network (VISN) until the year 2010. Numbers of veterans who are at least 65 years old will increase in about half of the VISNs.[2] These veterans will require the most intensive and complex medical care and long-term care services.

Elderly veterans assess their health status to be worse than the general population; 31.8%[3] of all veterans over 65 years of age rate their health status as fair or poor compared to 28.7% of the general elderly population.[4] Veterans with lower incomes are more likely to view their health as poor than those in higher income groups.

The Survey of Medical System Users found that significant numbers of elderly respondents required help with daily activities or independent living. Because deficits in these areas are positively associated with age, the need for some assistance has undoubtedly increased in the veteran population since this survey was conducted almost ten years ago.

Help with Daily Activities		*Activities for Independent Living*	
	65>		65>
None	56%	None	54%
Heavy Housework	28%	Getting beyond Walk Distance	33%
Bathing	27%	Shopping-Personal	32%
Dressing	25%	Getting Around Community	32%
Transferring	21%	Shopping-groceries	30%
Climbing Stairs	20%	Preparing Meals	28%
Getting Outside	18%	Doing Light Housework	24%
Walking	17%	Paying Bills	22%
Toileting	14%	Telephone	15%
Eating	9%		

As a group, veterans are well insured. In 1992, about 89.3% of all veterans had some health care insurance; 11.7% had public insurance, 48.9% had private insurance and 28.7% had both public and private; lack of insurance is associated with low family income and age (younger veterans are less likely to be insured). VA users are less likely to have insurance than the rest of the veterans' population.

[1] Department of Veterans Affairs, Office of the Assistant Secretary for Policy and Planning, National Center for Veteran Analysis and Statistics, "Estimates and Projections of the Veteran Population by VISN: 1995 to 2010", November, 1995.

[2] Department of Veterans Affairs, "Estimates and Projections of the Veteran Population by VISN: 1995 to 2010".

[3] Department of Veterans Affairs, National Center for Veteran Analysis and Statistics, Assistant Secretary for Policy and Planning Survey of Veterans: p. 34.

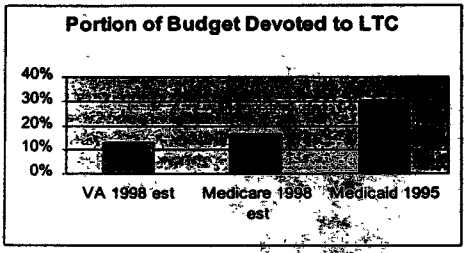
[4] Committee on Ways and Means, U.S. House of Representatives, 1998 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, May 19, 1998, p. 1045.

While changing, VA's patient population is still mostly men (96%). Members of minorities also disproportionately use VA services compared to their representation in the Armed Services.

Networks have a surprisingly equal distribution of age and need among their users. In FY 1997, only one network, VISN 2, had a statistically larger portion of its patient population that was at least 85 years old. VISN 3 had significantly more unique patients that were categorized as "special (or complex) care" patients[5] and VISN 18 had a statistically smaller portion of veterans in this category. VISN 2 also had a higher portion of "special care" users who are at least 65 years old. VISN 2 and VISN 3 have a statistically higher portion of unique users who have special needs and who are at least 85 years old. Some of these statistics may indicate suppressed demand. For example, VISN 8, which serves Florida, a well-known retirement area, may not have the capacity to serve all of the elderly veterans in the network.

BUDGETS FOR LONG TERM CARE

In 1998, VA medical centers offering a complete response to the Chief of Staff survey estimate they will allocate about 12.99% of their budgets to long term care



services[6]. This compares to 13.76% in 1997. In comparison, in 1995, Medicaid spent 68.6% of its payments for the aged, 20.6% of its payments for the disabled, and 30.2% of its total vendor payments on care delivered in skilled nursing facilities and home health services.[7] Medicare spent 14.7% in 1995 and estimates it will spend 16.5% of its Part A

[5] VA determines basic care and special care veterans for purposes of resource allocation. Veterans who are categorized as "special care" users are those who its previous resource allocation methodology identified as resource intensive care users—included in this group are those with disorders including (in order of VA's national cost in 1997) are schizophrenia and dementia, stroke, SCI old injury, rehabilitation, residents in community nursing homes, other psychosis, end stage renal disease, clinically complex patients, low activities of daily living, and Post Traumatic Stress Disorder (other care groups are also included).

[6] Included in their response were costs associated with all nursing home, domiciliary, psychiatric rehabilitative and other community residencies, home care, homemaker home health aide, and adult day care provided in VA, state or community settings.

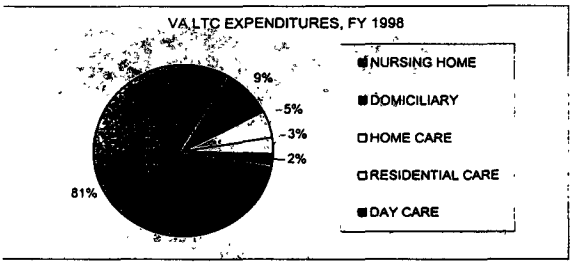
[7] House Committee on Ways and Means, 1998 Green Book, p. 984.

and Part B benefit payments in 1998 for skilled nursing facilities, home health services and hospice.[8]

VA facilities spend most (81%) of their long-term care budgets on nursing home care in VA (56%), community (14%) or state nursing homes (11%); in contrast, nationally, it is estimated 70% of all long-term care spending for the elderly is for nursing home care. Nursing homes consume 66% of all Medicaid expenditures for the population eligible by virtue of being elderly and 8% of Medicaid expenditures for the elderly are spent on home care[9]. Veterans Integrated Service Networks (VISNs) spent between 66-92% of all long-term care dollars on nursing home care.

VISNs made the second greatest investment of their long-term care dollars to domiciliary care offered in VA (8%) and state homes (1%). Domiciliaries generally offer board and care to veterans who are able to perform self-care duties, but who may require some supervision. Domiciliaries may include a limited medical component.

As VA closes its inpatient psychiatric care beds (see below), VA facilities are beginning to invest more of their long-term care dollars in Psychiatric Residential Rehabilitation programs (3% of the total LTC budget). A small share of the long-term care budget also is invested in overseeing the Community Residential Care program for veterans, a program which is primarily financed by the veteran.



VA is still making relatively small investments in home care for veterans. In 1998, VA respondents estimated they would invest 3% of their LTC budgets in Home-Based Primary Care, about 2% in Homemaker/Health Aide programs, and less than 1% in Contract Home Health Care programs.

Adult Day Health Care programs run by VA or provided by the community demanded less than 2% of the VA long-term care budget.

[8] 1998 Green Book, p 107
[9] Ways and Means, 1998 Green Book, p. 1059

CHANGES IN VA WORKLOADS FROM FY 1995 TO FY 1998

Facilities estimate they have provided less nursing home care in FY 1998 than in FY 1995; average daily census in all 3 nursing home settings dropped by almost 2%. Average daily census in VA nursing home dropped by 2% and the average daily census in contract nursing homes dropped by 25%.

Only state nursing homes realized an increase (15%) in average daily census. State homes demand the smallest commitment from VA in terms of daily operating costs. Unfortunately, State homes are not always available to VA because of geographic inaccessibility and their own restrictions on the types of patients they will admit. Increasingly many state homes are also reaching capacity levels. Forty-six-percent of VA respondents do not place veterans in state homes.

Facilities estimate that they have slightly increased average daily census workloads (by 2.25%) in VA and State Home domiciliaries between FY 1995 and FY 1998; some VA domiciliaries have designated domiciliary beds for homeless veterans.

Workloads of home health care increased between FY 1995 and FY 1998. VA Home-Based Primary Care average daily census decreased by 31% across the system, but more than doubled in VISN 14 (120%); contract home care visits increased by 30% with the largest program growth occurring in VISN 18. Homemaker/Home Health Aide visits more than doubled during this period increasing exponentially in VISN 3.

Community residential care average daily census more than doubled between FY 1995 and FY 1998 with the most program growth reported by VISN 12; VA has also instituted Psychiatric Residential Rehabilitation programs in many networks mostly on the east coast that have significant average daily census; VISN 9 has experienced tremendous growth in this program.

VA has increased both the adult day health care visits it provides (28.9%) and that which it sponsors (36.2%) between FY 1995 and FY 1998. Altogether it has increased visits by 35% over this period. VISN 15 demonstrated the greatest increase (250%) in visits.

Patterns of expenditures in networks vary tremendously. Curiously, VISN 2, which invested a statistically higher share of its overall budget to LTC services than any other network, devoted less to VA, community, and state nursing home care (66%) than other VISNs. It had a higher share of its budget invested in homemaker/home health aide programs than other networks. VISN 14 has statistically lower investment of LTC dollars in VA nursing home programs and a statistically higher portion allotted to state home nursing homes. VISN 1 and VISN 22 allocated significantly greater portions of their budgets (28% and 31% respectively) to community nursing home programs. VISN 17 commits more than a fifth of its LTC budget to the VA domiciliary program. In VISN 16, 10% of the LTC budget is committed to VA Adult Day Health Care. VISN 19 has allocated 10% of its LTC funds to Psychiatric Residential Rehabilitation.

VA has closed beds in almost every setting. VA has decreased its nursing home beds by 9% from 13,600 to 12,387; VISN 15 experienced the greatest loss in beds (60%) but, VISN 21 increased its VA nursing home beds by 60% during this same time. Overall in responding facilities, VA closed 55% of its psychiatric beds between FY 1995 and FY 1998 going from 15,188 beds to 6,850 beds in FY 1998. VISN 17 was exceptional in increasing its beds by 43% during the same period. VA has decreased its rehabilitation beds across the nation by 16%. In FY 1998, responding facilities had 671 rehabilitation beds as compared to 794 beds in FY 1995. It has also designated 569 subacute beds (some networks do not use this category of bed); VISN 10 has the greatest number of subacute beds (92). VA's intermediate beds have been reduced by 64% from 7,059 to 2,516 beds in FY 1998. Respondents in VISN 14 and VISN 22 significantly increased intermediate beds at the same time (by 89% and 44% respectively). VA respondents closed 29% (almost 2,000) of their domiciliary beds. VISN 21 added the greatest proportion of beds, tripling its program size.

VA POLICY RESTRICTIONS IN LONG-TERM CARE DELIVERY

Current law guiding Veterans Benefits (U.S. Code 38, Title 17) does not limit care to any eligibility group obtaining care in any VA inpatient setting, but does limit VA from paying for care received for non-service-connected conditions in Community Nursing Homes to 6 months; the Secretary has authority to extend that care by 45 days in certain circumstances.

Most VA facilities are developing or employing means of limiting, beyond parameters in statute, the availability of institutional and non-institutional long-term care. Some of the parameters are defined by tools that guide resource utilization in managed care organizations, such as Interqual, or criteria payers use to proscribe reimbursement, such as the Health Care Financing Administration's guidelines. VA also compares itself to its own like facilities and sometimes "benchmarks" to community standards for length of stay and appropriate patient placement.

VA uses criteria from InterQual, Health Care Financing Administration, and comparable facilities' length-of-stays for the same diagnoses to limit inpatient psychiatric care, substance abuse treatment, and treatment of Post-Traumatic Stress Disorder. In addition, many of these services are only offered on an ambulatory care basis in some VA facilities. For the facilities that offer acute psychiatric care, some limit length of stay to 7 days. For the 20 networks that use Interqual standards for some purposes, guidance recommends inpatient placement only for suicidal or homicidal ideation; some might argue that these criteria set too high a bar for admission. Thirty-four percent of respondents did state they were using Interqual or other utilization review practices to manage use of acute inpatient psychiatric care.

Forty-one percent of respondents did not have an hospital inpatient substance abuse treatment program; 34% did not reference restrictions in substance abuse programs;

24% used Interqual or other utilization review to manage programs. Interqual only identifies standards for detoxification and does not address substance abuse treatment.

Forty-three percent of respondents did not have an hospital inpatient PTSD treatment program; 34% did not reference restrictions; 22% used Interqual or other utilization review to manage programs. It is important to note that Interqual only identifies standards for acute psychiatric care needs and may not be applicable to PTSD treatment. Inpatient care for substance abuse or PTSD (if offered) is generally limited to 21 days, or 28 days for those with complex care needs or comorbidities.

Widespread variation in categorization of VA beds as nursing home, rehabilitation, intermediate, or subacute hinders clear distinctions between these bed types across the system. Many VA medical centers now categorize beds formerly known as nursing home beds as "highly skilled rehabilitative care" or "transitional care" beds.

Resource allocation may also play into VA's decisions about designating beds. For example, nursing home patients are now reimbursed at the "special rate" (about $32,000) rather than at a "basic care" (about $2,300). For each unique nursing home patient a medical center treats, the facility receives more than ten times the basic rate. So while many "nursing home" beds are now performing rehabilitative or restorative care functions it behooves facilities not to change the bed designation to reflect the mission change.

Such reimbursement practice also creates incentives for managers to treat more patients over shorter periods of time. While the reimbursement rate for special care is substantially more than that for basic care, it is often not nearly enough to provide nursing home care for a veteran for the full year (at a cost of between $60-80,000). Given the reimbursement, most facilities have made pragmatic decisions to maintain bed designations, shorten lengths of stay to about the 6 months for which they are reimbursed, and increase the number of unique patients treated in their nursing home beds.

Rehabilitation beds have decreased significantly. Sixty-one percent of respondents declared they had no rehabilitation beds. Two percent said they had rehabilitation beds, but only for very specialized purposes. Eleven percent said that they restricted care based on some sort of utilization review criteria. Twenty-five percent referenced no restrictions. Rehabilitative care is sometimes limited to as few as 14 days.

VA does categorize some beds as "subacute" but these beds are used for a variety of purposes, including supportive care for psychiatric or substance abuse patients, or observational care not requiring admission, not generally viewed as "subacute" by other providers. Only 25% of respondents had subacute beds; 14% of respondents referenced no restrictions in care; 11% applied utilization review techniques to subacute care.

Sixteen-percent of all respondents had no VA nursing home beds; another 5% stated they only offered care to non-service connected veterans when resources were available. Thirty-seven percent of facilities no longer offer life-time placement in VA nursing

homes to service-connected veterans—in contrast only 7% mentioned that they offer indefinite care for veterans with over 50% service-connection or indefinite care for SC condition; 44% no longer offer life-time placement to non-service-connected veterans.

Most nursing homes use beds for rehabilitative, restorative, or palliative care purposes. Patients are generally told they will be discharged when they stop making progress toward treatment goals or when the "maximum benefit of hospital care" is achieved (usually in about 6 months).

Fifty-nine percent of respondents limited contract nursing home care for service-connected veterans by limiting time (19%) or to care for the service-connected condition only (35%), and 5% only offered such care when funds were available. Seventy-three percent limited, beyond law, contract nursing home care for non-service connected (55% put additional restrictions on time and 18% only offered contracts when funds were available).

VA medical center respondents pay for 0-120 days of care for veterans with non-service connected conditions. Often VA will first try to identify alternative payers. Some note they will pay community providers longer in extraordinary circumstances. One network (VISN 20) has a standard policy of limiting all community NH contracts to 45 days; however, a facility within the VISN 20 noted that it has even shortened this payment time period for non-service-connected veterans.

Thirty-six percent of respondents stated they had no intermediate beds; 19% claimed they managed care in beds according to utilization review criteria, by limiting time or by using them only for a specific purpose. Intermediate beds in VA often serve rehabilitative and subacute purposes as do nursing home beds.

IDENTIFYING THE NEED FOR LONG-TERM CARE IN THE VA PATIENT POPULATION

VA medical centers are employing a number of practices to identify the need for nursing home or long-term care among its patients. Besides a veteran's eligibility and priority for care, his or her needs are assessed for a match with available services (for example, many VA medical centers no longer admit veterans for custodial care purposes). Many facilities note that VA's resource availability (funding, personnel and beds) is considered in determining whether to admit or reimburse care for patients.

A third of all respondents stated they used a screening committee to select candidates for long-term care services and to identify appropriate placements for them. Another quarter identified such patients through routine admission screens, as part of the discharge planning process or through utilization review processes. Fifteen percent only offer care for specific medical needs; another 14% identify specific risk factors in patients who are placed.

Some facilities have automated data systems that identify patients with these needs. Still others use social workers and referrals to identify patients who need services. Most facilities are looking for veterans who may benefit from short-term rehabilitative care or evaluative services. These panels also consider such factors as veterans' insurance, caregiver support, and assets. They also consider the medical needs of the patient (deficits in activities of daily living (self-care) or independent activities of daily living and cognitive skills). Some facilities with special programs for veterans with Alzheimer's, other dementia or geri-psychiatric disorders identify veterans for this type of treatment that fill voids for care they cannot acquire by contract.

PAIN MANAGEMENT

Many facilities (71% of respondents) have some type of pain management programs; some take the form of palliative or end-of-life care programs. These programs differ significantly in diagnoses referred (from chronic low back pain to cancer), services offered (medications, physical therapy, cognitive behavioral or psychological/educational/spiritual programs to comprehensive and state-of-the-art multi-disciplinary care), and how they are operated (inpatient, outpatient, or by primary care providers with consultation).

Conditions Treated and Services Offered
By Various VA Medical Centers

Conditions Treated	Services Offered
• Low back pain	• Outpatient management
• Headache	• Inpatient patient controlled analgesia, detoxification
• Chronic post laminectomy pain	• Nerve and root blocks
• Acute Head and Neck Pain with radicular pain,	• Epidural injections/blocks
• Complex regional pain syndromes	• Acupuncture
• Neuropathic pain syndromes	• Massage, manipulation and touch therapy
• Myofascial/fibromyalgia pain	• Mental health
• Vascular and atypical headache pain	• Spiritual counseling
• Cancer pain	• Transcutaneous electrical nerve stimulation (TENS)
• Acute post-op pain	• Physical and occupational therapy
• Chronic joint pain	• Pool and hydrotherapy
• Patients with behavioral disorders, including drug seeking	• Prosthetics
• Chronic cervical pain	• Trigger point injections
• Sciatica	• Medications
• Arthralgias	• Neuralysis
• Spinal stenosis	• Cryoanalgesia
• Connective tissue disorders	• Stellate ganglian injections
• Thalamic pain syndromes	• Spinal stimulation
• AIDS neuropathies	• Infusion pump
• Chronic neurologic conditions	• Radiofrequency ablation
• Myelopathy	

• Phantom pain	• Stellage blocks
• Degenerative disk, spine, facets disease	• Lumbar sympathic blocks
• Lumbar arthritis	• Cardal block
• Herpes Zoster	• Steroids
• Stump, amputee pain	• Axillary blocks
• Spinal Cord Injury pain	• Cervical epidurals
• Migraine	• Facet blocks
• Phlebitis	• Intercostal nerve blocks
• Reflex sympathetic pain	• Management of side effects
• Musculoskeletal pain	• Strontium treatment
• Renal failure	• Intrapleural catheter infusion
• Causalgia	• Invasive procedures
• Ischemic limb pain	• ice/heat therapy
• Post-herpetic neuralgia	• tissue mobilization
• Spastic disorder	• spinal cord stimulation
• Nociceptive pain	• neuroprobe
• Lumbar disc displacement	• Cognitive Behavior Therapy
• Lumbosacral syndrome	• Hypnosis
• Osteoarthritis	• Traction
• End-stage pulmonary disease	• Biofeedback
• Heart failure	• Myotherapy
• Nodulus	• Percutaneous electrical nerve stimulation
• Tenosynovitis	• Intrathecal analgesia
• Bursitis	• Neurosurgery
	• Sympathetic blocks
	• Membrane stabilizer therapy
	• Chronic narcotic use
	• Steroids
	• Biopsies
	• Brachial plexus
	• Ilioinquinal
	• Psychotropic drugs for depression
	• BA toxin injections

Twenty-nine percent of respondents offered no pain management programs to patients. One-third of programs offer care for chronic or terminal conditions. A quarter more treat multiple syndromes and conditions; 12% treat specific diagnoses only.

Of those who offer pain services, more than half deal with conditions in holistic ways that consider veterans' physical, psychological and spiritual needs. VA medical centers offer a surprising number of alternative care therapies to address patients' needs (see above). About 20% offer medication and anesthesia management for pain symptoms. Ten percent of programs are managed on a consultative or referral basis. A few programs use either psychosocial counseling and behavioral therapy or physical therapy for pain treatment.

Most pain services involve personnel from a variety of disciplines working together to develop a comprehensive pain management program. Over three quarters of the responding facilities with programs identified many disciplines involved in them. Most of the remaining programs (about 20%) were operated as consultative services which responded to a treatment team or physician and advised about appropriate medication or therapies. The best of these programs are holistic in their orientation. Some facilities offer patient education and psychological coping techniques such as cognitive behavioral therapy, biofeedback, relaxation techniques and support groups. A few facilities even subscribe to alternative therapies such as acupuncture, hypnosis, and massage therapy. Some work as consultative teams or through telemedicine, working with primary care practitioners to resolve pain issues and some offer distinct clinics or inpatient programs. Other facilities are primarily diagnostic programs offering neurological evaluation. Some provide physical and occupational therapy. Some offer narcotics contracts and medication management. These services obviously require multispecialty expertise—nurses, psychologists, social workers, rehabilitation medicine, nuclear medicine and pharmacists.

Recently, VA has developed an initiative to make pain "the fifth vital sign". Guidance has instructed all VA directors that clinicians will begin to screen for pain as part of a standard evaluation protocol by documenting patients' self-assessment of pain on a ten-point scale. Patients with pain that rates above a certain level will be referred, further assessed and treated.

HOSPICE OR PALLIATIVE CARE

In the early 1990s, VA circulated a directive to each facility requiring development of a hospice capacity. VA has had spotty success in implementing the guidance. According to the survey, many facilities (8%) state they still have no formal programs. Some facilities claim they use consultation teams, although the contribution of such teams may be negligible because so few clinicians are aware of them. Some VA medical centers sponsor hospice programs by contract. A few facilities have formal, structured inpatient programs that allow families to remain at veterans' bedsides until death, offering advance directives in which veterans' identify their preferences for care and interventions near death, comfort care, bereavement counseling, and spiritual and emotional support. Some offer home-based hospice through their own primary care teams. Hines VA Medical Center has the only designated outpatient hospice treatment program—it is accredited by the Joint Accreditation of Health Care Organizations and treated about 25 patients at a time, mostly in their own homes.

Others provide respite for caregivers and inpatient care (usually in nursing home or intermediate care beds) at VA when necessary. Staff involved in all of these programs are nurses, social workers, chaplains, psychologists, and physicians.

Hospice is a program that meets a need for terminally ill individuals with a life expectancy of about 6 months where death will come after a clear decline period. Individuals with AIDS and cancer are often treated by hospice. Medicare also reimburses

hospice providers, and VA often refers veterans with this coverage to community programs that will accept their Medicare.

VA is also part of a consortium that will assess the effectiveness of applying traditional palliative care techniques to individuals who are terminally ill with diseases that have generally not been subject to them. VA will conduct the clinical care at 6 sites within VA. While hospice often responds to illnesses that have certain decline paths, such as cancer or AIDS, this demonstration project, called Medicaring will target veterans with Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, stroke, and dementia. Through early intervention with these individuals, participants hope to allow veterans more planning time to address medical management, advance directives, pain management and wishes for emotional support.

Those VA medical centers that have hospice make the service available to veterans in a wide variety of ways. Half of the facilities with programs have a hospice team available on a consultative basis. Another 16% stated they had hospice beds on the part of a unit (usually nursing home or intermediate bed sections). Drawing the distinction between those who offered some care in another unit's beds and the additional 7% of facilities that claimed to offer "palliative care" only was somewhat difficult given the information submitted. Another 9% offered inpatient hospice care in undesignated beds. Seven percent more said they offered hospice as part of their "continuum of care" (often making referrals to programs in the community for home-based services and allowing veterans to come back to VA for inpatient care or respite for care givers). Only fourteen facilities (about 10% of respondents with programs) offered a special VA hospice unit or program for patients. It is difficult to assess how many VA medical centers offer hospice as opposed to pain management based on the responses given.

Like pain management programs, most facilities use staff from a variety of disciplines to treat hospice patients. Most often staff are assigned to hospice in addition to other duties (46%). Only about 10% of responding facilities stated they had a designated staff for hospice. Another 10% assigned a coordinator to manage hospice services or provided hospice by contract. More than a quarter of all responding facilities assigned no staff to hospice.

Given the wide disparities in ways VA makes hospice services available to veterans, it was difficult to get an accurate accounting of hospice census. Only about half of the facilities responded to the question. Those with specific hospice inpatient units were most capable of tracking this number and treated between 5 and 15 patients at a time. Almost 70% of facilities reported an average daily census of between 1 and 10 patients. The largest program estimated it offered hospice services (through a variety of means) to up to 50 patients daily.

Some facilities assign a team to assist veterans and their families with identifying community resources and sometimes, to track and coordinate with community care providers. Many VA nursing homes have palliative care beds. Some follow end-of-life

treatment protocols. Some provide hospice services through contract care providers. These programs tend to rely extensively on nursing services.

CARE MANAGEMENT

Care management strategies vary widely in use and effectiveness across the VA system. Yet experts agree that continuity of care is imperative for older patients because of their tendency to have chronic and multiple diseases. Effective case management is the best way to ensure care continuity.[10]

Many facilities have Geriatric Evaluation Management (GEM) clinics and some also have GEM inpatient services available. About half of all respondents specifically addressed these GEM programs as tools they used to help managed geriatric care. Inpatients being evaluated by a GEM are often housed in the nursing home or in intermediate care beds.

Some veterans are assigned to geriatric primary care teams—these teams may or may not follow the veteran across care settings; some at-risk geriatric veterans are assigned to geriatric case managers (one facility has a memory clinic—case workers are assigned to its veteran patients); some other primary care teams rely on expertise in geriatric care from a consultative body; a few facilities are using "continuity of care teams" that offer case management and follow patients across settings; several more offer geriatric patients a single "point of contact" within the facility; some facilities use an internal liaison (usually social workers or nurses) to refer care from VA to appropriate community providers and to monitor care received there. About two-thirds of responding VA facilities used one or more of these strategies for managing geriatric patient care.

VA now has authorized 18 Geriatric Research Evaluation Clinical Centers (GRECCs), but only 16 were operating when this survey was administered. Eight responding facilities mentioned GRECCs were involved in coordinating plans for managing geriatric patients care.

VA has a number of screening instruments it uses to determine appropriate placements for patients including the Resident Assessment Instrument and InterQual. Other facilities referenced admission screening, discharge planning, and screening committees or interdisciplinary care teams as means by which they managed geriatric patient flow. Other facilities had a geriatric product line which asked in care management (over one-third of respondents).

Some facilities have special psychiatric programs that care for and research veterans' psychiatric disorders—Alzheimer's disease, other dementia and other behavioral disorders. Some facilities employ protocols for managing conditions to which elderly veterans are often prone (pressure ulcers, falls, urinary incontinence); some have management programs for chronic disorders such as congestive heart failure, stroke,

[10] Terrie Wetle and Rowe, John W.(eds.), Older Veterans: Linking VA and Community Resources, Harvard University Press, 1984, p. xiv

Alzheimer's or dementia and periodic interdisciplinary medication reviews. About 20% of facilities mentioned these strategies for managing care. Two VA medical centers mentioned use of educational opportunities, such as LTC symposia and weekly conferences, to ensure care for veterans is state-of-the-art.

DISCHARGE PLANNING

Most facilities (more than half of respondents) describe discharge planning as an interdisciplinary process of evaluating, planning and coordinating care for patients. Often this team is also involved in treatment. While usually spearheaded by a social worker or nurse, can involve primary and specialty physicians, other attending care givers, rehab medicine (Occupational Therapy, Physical Therapy /Kinesiotherapy), dietitians, pharmacists, and home care teams. Most facilities with case managers involve them in the process.

A quarter of respondents indicated that discharge planning begins at initial assessment or admission; if patient's stay is to be time-limited, the facility may explain this to family or the veteran at admission; generally patients are screened and their needs are analyzed and documented; treatment goals are established and progress toward those goals is reviewed at periodic intervals or, in the event of changes in patient status, during the patient's stay.

One-quarter of facilities explicitly stated that discharge planning involves patient and family members as appropriate, particularly in planning for return to community: About 4% indicated they assist patients or family members with identifying other payment sources, including applying for Medicaid or other programs if appropriate. Others discuss, identify and choose appropriate referrals with patients.

Half of the responding facilities indicated that they made appropriate referrals as necessary.

Nurse and social workers are often involved in discharge planning. More than a quarter of facilities stated that they took the lead in ensuring a discharge plan was completed. Some coordinate referrals made by treatment teams without any direct care role.

Sometimes veterans are told to identify the resources within their own communities; usually (at about 10% of responding facilities) a facility assigns a liaison (often a social worker or a nurse) or a team to coordinate and sometimes monitor care in the community; some facilities also schedule an appointment with the patient's primary care team to facilitate continuity of care.

At more than 10% of responding facilities, long-term care discharge usually occurs when treatment "goals" are met (ostensibly based on the patient's achievement of "maximum functionality" in the care setting). Other factors considered include expiration of the specified length of time for admission, the patient's medical stability

and achievement of "spend down" or identification of another available placement. Only one facility mentioned that they had an impasse board for resolution of disputes about discharges.

About 10% of respondents linked discharge planning to case management—some assigned patients to an inpatient care team for each care episode and some indicated that discharge planning was assigned to the case manager (although that manager may not have been directly involved in the episode of care).

OBSERVATIONS

1. Lack of Congressional mandate to offer or define long-term or nursing home care is leading to gradual dismantlement of the VA program as need grows and budgets dwindle.
2. Because of their demographic characteristics and health status veterans who have relied upon VA are more likely to be reliant upon it for long-term care than other veterans or those in the general population.
3. Veterans' peak demand for services begins now.
4. Proportions of budgets invested in Medicare and Medicaid-sponsored long-term care substantially outweigh VA's investments in these types of care. Long-term care for all programs—those for the frail elderly as well as those for the chronically mentally ill—are threatened. Because they are entitlement programs, Medicare and Medicaid may be better equipped to reimburse the care needs of its beneficiaries.
5. Congressional direction and historical orientation toward acute academic medicine may also be contributing factors in VA's failure to address and protect long-term care.
6. In contrast, VA is making some strides as a subacute care provider. It is managing chronic disease, terminal illness and pain more effectively—aspects of the care continuum that fall between "acute" and "long-term" care and have long been neglected.
7. Changes in workload since implementation of VISNs indicate that VA is beginning to favor investments in non-institutional care venues over nursing home and institutional care. VA is dropping census in its nursing homes and increasing home-based care, residential care, and adult day health care. Inpatient programs are traditionally the foundations of geriatric clinical and research expertise within VA's system. They must not be allowed to vanish.
8. VA is also shifting some of this care (particularly home-based care) from its own programs to contracted community programs. While it is important for VA to maintain and enhance its own expertise in geriatric programs, contracting, particularly for home and community based care must increase if VA is to adequately address the growing needs of a geographically dispersed aging population. VA will have to improve current oversight and case management capacities to effectively manage these services.
9. VA's loss of inpatient beds that have traditionally responded to veterans' long-term care needs is precipitous. Workload dropped from these beds does not appear to be accommodated by new outpatient visits or programs for which VA delivers or contracts.
10. Expensive programs for managing the special care needs of the aging veterans' population, such as Alzheimer's and geripsychiatric programs, are hard-pressed to continue operating under the current budget scenario with the system's new priorities pulling them in opposite directions.
11. Organizational policy guiding resource allocation and utilization reflects VA's diminishing commitment to long-term care. Many of the choices Headquarters and the networks have

made appear to be resource driven and much of VA's recent policy regarding long-term, sub-acute, rehabilitative, and psychiatric care appears to be based upon that of private-sector managed care providers.

12. Efforts to manage care, thus continuity, across the system are still spotty. While VA has assigned most of its regular users to primary care teams, providers for geriatric patients may need more expertise to effectively addressing their complex social and medical needs.
13. Utilization review and processes that ensure adequate placement and resource utilization are critical to the system, in terms of ensuring "value-oriented care", for both the patient and the organization. Presently, VA's systems seem to do a better job safeguarding the needs of the organization. Patients and their families still appear to need more information, more opportunities for representation or direct input into the important decision-making processes that effect care, and more effective and timely procedures for grievance.
14. Congress should make clear its intentions about long-term services with a pragmatic eye to future funding for the system. Because of fiscal restraints, VA cannot serve all of the veterans who currently rely upon it for acute care services. Instead, Congress must establish new priorities for long-term care within this population of veterans and identify the programs to which these veterans are entitled. Doing so is the only means by which Congress can assure VA's long-term care mission and expertise are not left behind.

APPENDIX A

VETERANS INTEGRATED SERVICE NETWORKS

Innovative Programs and Services for Geriatric Veterans

VISN 1
Boston, MA GRECC (Bedford)
Basic Biomedical: Neurosciences/Cognitive Disorders
Applied Clinical: Dementia
Health Services: Decision Support Technology
Boston, MA GRECC (Brockton/West Roxbury)
Basic Biomedical: Metabolism, Cardiovascular Physiology and Pharmacology
Applied Clinical: Genito-Urinary, Dehydration, Cognition
Health Services: Epidemiology, Health Policy

- Interdisciplinary Geriatric Clinic
- Alzheimer's Day Health Care
- Community Residential Care targeted at the Elderly
- Community-based (senior citizen housing) Primary Care Clinic
- Assisted Living
- Immunizations Clinic
- Nursing Home Screening Clinic
- Geropsychiatric Care Team
- Extended Respite (In one month; home one month)
- Home-based primary care for the Mentally Ill
- Nighttime contract adult day health care services for patients with "Sundowner's Syndrome"
- Additional fee for health aide services delivered in contract Adult Day Health Care Centers

VISN 2

- UPBEAT—Unified Psychogeriatric Biosocial Evaluation and Treatment program: identifies patients with alcohol abuse and affective disorders on an outpatient basis.
- Telemedicine at CBOCs to rural community nursing homes for clinical care and geriatric training of fellows
- Fair Care—Demonstration project for health care delivery for dying patients and support for their families
- Vet Center—a congregate living area for indigent veterans and families which uses telemedicine for assessment and education.
- Chronic Care Networks for Alzheimer's Disease (VISN 2 and Alzheimer's Association is involved): operational laboratory to test proposed ways for imprving care for people with Alzheimer's related dementias within the constraints and opportunities of risk financing.
- VA Web Page Referral Site for Long-Term Care Options in area
- Nursing Home Without Walls—A project that works at 75% of annual cost of HRF's and SNF's in the patient's county of residence for outpatient services.

- Labmobile
- Community Outreach Worker

VISN 3

- Palliative Care Team which follows end-of-life care across settings (at home the team provides consultation to HBHC teams)
- Follow up on discharge by Telephone Triage Team
- HBPC is equipped to deliver skilled services on a short-term basis
- Home assessments of high-risk veterans in the community
- Dementia Unit for veterans who wander or exhibit socially inappropriate behavior
- Urinary Continence Program
- Music Therapy for Bed-Bound Patients
- Fall Reduction Program
- Intensive Psychiatric Community Care
- Supportive Housing
- Social Skills Transitional Living
- Senior Support Services
- Treatment of patients who are ventilator dependent or on IV antibiotics on a subacute level

VISN 4
Pittsburgh, PA GRECC (new, 1999)
Strokes in Elderly

- End of Life Planning
- Dementia Clinic
- Psychiatric and Geriatric Capability in HBPC
- Implementing IMPACT-Activities of Daily Living: Uses team approach to improve one deficient ADL which will make a patient less dependent and may enable care in a less restrictive environment and improve quality of life

VISN 5
Baltimore, MD GRECC
Basic Biomedical: Hormonal regulation of lipoprotein lipid, glucose, adipose
Applied Clinical: Effects of interdisciplinary treatment of risk factors for cardiovascular disease in older veterans with abodominal obesity, type II diabetes, hypertension, and dyslipoproteinemia, through exercise and nutrition, and cigarette smoking cessation.
Health Services: Survey of prevalence and current treatment of risk factors for cardiovascular disease in community dwellings where veterans are using VA facilities.

- Geriatric Health Promotion: Provides patient education on medications, nutrition, and exercise
- Home IV Therapy Program
- GRECC sponsored preventive care in cardio-vascular disease

VISN 6

Durham, NC GRECC
Basic Biomedical: Neoplasms and Aging; Cardiovascular Disease and Aging
Applied Clinical: Cancer; Cardiovascular Disease; Bones, Joints and Dysmobility
Health Services: Health Promotion and Disease Prevention

- Restraint free environment; use of innovative adaptive equipment ("Mercy Walkers")
- Geropharmacy evaluation and follow-up
- Use of Wanderguard System—an electronic device which allows unrestricted movement for confused veterans in the Extended Care Unit.
- Geriatric Primary Care Program
- Primary Care Team Follow-up
- Alzheimer's Outpatient Clinic with Multidiscipline Staff

VISN 7
- The Bronze Clinic: A primary care program for frail elderly veterans
- Telephone Liaison Program

VISN 8
Gainesville, FL GRECC
Basic Biomedical: Gero-pharmacology
Applied Clinical: Gero-pharmacology
Health Services: Exercise physiology and wellness program for healthy and sick elderly
Miami, FL GRECC
Basic Biomedical: Bone and Cartilage Metabolism; Prostate Disease; Neurodegeneration
Applied Clinical: Osteoporosis and Osteoarthritis; Paget's disease; Prostate Cancer; Parkinson's
Health Services: Rehabilitation (falls and injuries); Preventive Services

- Geriatric Primary Care Program
- Gait and Balance Clinic
- Memory Disorder Clinic
- Wound Clinic
- Telecare
- Teleheart
- Vent Dependent Home Care
- Hoptel: Short-term Self-Care Unit
- Senior Companion Programs—Volunteer supervision of Alzheimer's Disease
- Incontinence protocols
- Weekly medication review meetings with pharmacist, primary nurse and physician;
- a pharmacist is located at GEM and Primary Care Geriatrics Clinics for assessment of polypharmacy, drug interactions, and medication education;
- medication usage monitoring on antidepressants, neuroleptics, insulin, and oral hypoglycemic agents
- a restraints-free environment
- reminiscence therapy sessions

- aerobics with a PT.

VISN 9
- Geriatric clinic
- Mobile health stations
- Palliative care
- Geographic case manager to assist veterans with identifying community resources
- Extended Community Outreach program
- End-of-Life Planning

VISN 10
Cleveland, OH GRECC (new, 1999)
Cardiovascular disease in the elderly

- Senior Companion Program—volunteer home visitation program
- Telecare—volunteer phone visitation program with referral to SW
- Comprehensive restorative—restorative care program combined with recreational activity to improve quality of care
- Community re-entry program

VISN 11
Ann Arbor, MI GRECC
Basic Biomedical: Neurosciences and Metabolism/Nutrition
Applied Clinical: Autonomic Function, Diabetes Mellitus, Hypertension, Oral Health
Health Services: Cost and Quality of Health Care

- Alzheimer's Program
- Lifeline
- Medical/Psychiatric Unit for Elderly with Behavioral Problems
- Senior Companion Program
- VETS program
- Veterans Independent Program
- Wanderguard
- Local high school student visitation
- Geriatric primary care
- Advance Directives Clinic—offered twice weekly
- Family Support Clinic (for terminal patients and their loved ones)

VISN 12
Madison, WI GRECC
Basic Biomedical: Cancer/Immunity/Nutrition
Applied Clinical: Swallowing, Geriatric Oncology
Health Services: Critical Junctures in the Continuum of Long term Care

- Reactivation Center (funded by AMVETS)—provides comprehensive and focused rehabilitation to the frail elderly on an inpatient and outpatient basis
- Safe Eating Program for Extended Care Center/Residential Care Facility residents
- "Pets for Vets" Program (activities and therapy program)
- Hematology/Oncology Day Treatment Center (one day palliative treatment: blood transfusions, ultrasound, CT scan, chemotherapy, lab work)
- Spinal Cord Injury Residential Care Facility—LT holistic care for SCI (mostly quadriplegics)
- Lifeline—personal response program for veterans living alone which can provide immediate care
- LTC "Specialty" Facilities which Focus on Chronicity of Disease (ie, aging, substance abuse)
- Residential housing programs for veterans and spouses
- Domiciliary lodging for veterans travelling for radiation therapy during course of treatment

VISN 13
Minneapolis, MN GRECC
Basic Biomedical: Neurochemistry, Pharmacology, Imaging, Animal Models
Applied Clinical: Alzheimer's Disease, Chemical Trials, Neuropsychological Assessment, Adapted Work Program, Caregiver Education
Health Services: Medical Ethics, New Models of Health Care Delivery, Geriatric/Gerontology Education and Training Program Evaluation

- Skin Integrity Program
- Falls Prevention Program
- End of Life Care
- Chronic ventilator dependent unit
- Environmentally modified unit for dementia patients
- Dedicated unit for patients with behavioral problems in need of NH care
- Evening/weekend coverage for end-of-life care veterans through community hospice and Public Health Nursing agency
- Standard Hospice Benefits package for veterans with no insurance or Medicare

VISN 14
- Community re-entry nurse in NH (provides aftercare to patients in other than the home setting)
- Community support groups upon referral
- Psychiatric rehabilitation focuses on community re-entry
- Pilot with telephone-video connection for home follow-up of geriatric patients
- Pulmonary rehab for lung disorders

VISN 15
St. Louis, MO GRECC
Basic Biomedical: Physiology and Metabolic Concomitants of Aging
Applied Clinical: Effects of Exercise and Nutrition on Physiological and Metabolic Parameters

Health Services: Health Care Utilization and Program Evaluation; Nursing Home Care and Health Care Delivery for African Americans

- Local community nursing home evening and weekend respite care
- Development of a community-based NH program for problem-behavior dementia patients
- Hospice provided by VA HBPC

VISN 16
Little Rock, AR GRECC
Basic Biomedical: Cellular and Molecular Biology of Aging
Applied Clinical: Cancer, Nutrition and Chronic Disease in the Elderly
Health Services: Evaluation of Geriatric and Long-Term Health Care Delivery

- Interdisciplinary Palliative Care Program
- Geropsychiatric program follows veterans discharged to the community and assists with reintegration
- Alzheimer's Unit
- In-Touch Telephone Reassurance Program (targeted at infirm patients and patient who live alone or with elderly caregivers)
- Palliative Care Consultation

VISN 17
San Antonio, TX GRECC
Basic Biomedical: Metabolism/Endocrinology, Nutrition, Oral Health/Dentistry
Applied Clinical: Metabolic Diseases, Cognitive/Sensory Impairment, Oral Health/Dentistry
Health Services: Health Care Utilization, Functional Status and Ethnicity, Quality Assessment and Cost Benefit Analysis, Long Term Care

- Geriatric Primary Care

VISN 18
- Secured dementia unit
- Geriatric clinics within Geriatrics, Extended Care, Rehabilitation Health Care Groups
- Community Respite Care for Veterans with Dementia or who are Combative and not suited to care in a restorative care unit
- End of Life Planning

VISN 19
Salt Lake City, UT GRECC
Basic Biomedical: Clarification, at the molecular, cellular and physiologic levels, of factors which account for the phenotype of aging as it pertains to microbiology, immunity and cytokine production.
Applied Clinical: Evaluation of strategies intended to reverse the phenotype of aging, such as administration of deficient cytokines and hormones, application of aerobic exercise as a means of improving cognitive function.

Health Services: Development of innovative approaches to quality assurance in a real-time mode. Particular emphasis in use of computers to support sensitive, accurate and timely diagnosis, and to reduce occurrence of adverse events.

- All patients' activities day
- Special Birthday Events
- VIP Dining Program: Gourmet meal prepared for veteran and his or her family in private dining room (linens, china, silver and crystal)
- Geriatric Multidisciplinary Steering Committee

VISN 20
Seattle/American Lake, WA GRECC
Basic Biomedical: Neurobiologic and Neuroendocrine Aspects of Aging and Alzheimer's Disease
Applied Clinical: Metabolic Diseases and Cognitive/Sensory Impairment
Health Services: Bioethical Aspects of Medical Decision Making in the Elderly

- Dementia inpatient/evaluation unit and Dementia Clinic
- Dementia Special Car Unit for ambulatory, moderate to severely demented veterans
- Collaborative rehabilitative medicine and geriatrics and extended care programs which has improved staff knowledge of physical rehabilitation
- Palliative Care team

VISN 21
Palo Alto, CA GRECC
Basic Biomedical: Endocrinological and Metabolic aspects of aging, biomechanics of mobility patterns, regulation of bone mass, acquisition of bone, ethnic contributions to skeletal health, exercise effects in the elderly.
Applied Clinical: Emphasis on endocrinological and metabolic diseases of the elderly. Effect of chronic disease on cognitive function, pharmacologic interventions to modify body composition, use of psychological interventions to treat depression and related mental health problems.
Health Services: Advanced care directives; chemical and physical restraints in LTC, predictors of adverse outcome and re-hospitalization, resource utilization for frail hospitalized patients, cost-effective programs for low-vision elders, and family caregiving issues.

- VA training for DOD personnel involved in the treatment of frail elderly

Sepulveda, CA GRECC
Basic Biomedical: Alzheimer's Disease, Molecular Biology, Endocrinology
Applied Clinical: Falls and Mobility Problems, Long-Term Care, Exercise, Pain, Sleep, Quality of Care
Health Services: Cost-Effective Health Care Delivery, Geriatric Assessment
West Los Angeles, CA GRECC
Basic Biomedical: Osteoporosis, Immunology and Osteoarthritis
Applied Clinical: Osteoporosis, Immunology and Osteoarthritis
Health Services: Health Care Utilization, Rehabilitative Medicine, Residential LTC and Access

- Palliative care outpatient clinic
- Special equipment for frail elderly (i.e., bed that lowers to floor to prevent falls and obviate the need for restraints)
- "Compassion in Action"—a community based program works in collaboration with Voluntary Service to provide support for terminally ill veterans with limited family support who are receiving VA hospice services
- Geriatric Psychiatry Clinic providing comprehensive case management to veterans with psychiatric and/or organic disabilities that aids in end of life planning for the veteran and his family.

APPENDIX B

LEGISLATIVE INITIATIVES SUGGESTED BY RESPONDENTS
(In your opinion, what types of legislative initiatives should be considered to ensure the most effective use of VA's long-term care resources?)

- Increased funding for non-institutional alternative LTC (22)
- Authority for residential/foster home care, assisted living, and community based respite (22)
- Medicare subvention (some limited to LTC only) (15)
- Increased funding for nursing home care (9)
- Establish some entitlement for NH and long-term care services/ include in VA's Basic Benefiits Package (9)
- Authority for clinically based "demonstration projects" (including assisted living and shelter level care) to manage older veterans care which can demonstrate quality, improved quality of life and cost-effectiveness (rolled out across country) (8)
- Flexibility to pool funding with Medicare and Medicaid; participate in programs such as PACE (5)
- Guaranteed/enhanced long-term care benefit for veterans with highest care priorities (others get basic care) (5)
- No fixed ceiling on percentage of community NH funds that can be used on non-institutional contract care (adult day care, homemaker/home health specifically) (4)
- Allow Medical Center Directors to determine use of resources to meet patient needs (4)
- Carve out and track budget for LTC (including for long-term psych) from other VHA programs to ensure funds are spent on intended purposes (4)
- Authority (increased funding) to provide personal care services (which Medicare does not fund) through HBHC programs (3)
- Increased funding for hospice and palliative care (3)
- Medicaid subvention (3)
- Prohibition on closure of VA LTC services (including contracting all NH) (3)
- Increased funding to reimburse/provide veterans' transportation (3)
- Authorize VA to sell LTC products at market costs/quasi-governmental function (3)
- Limit LOS for VA LTC treatment for all veterans (3)
- Create incentives for increased synergies between VA loan programs and the community residential care program (financial help meeting safety code or elimination of codes) (2)
- Develop an alternative funding stream for veterans not eligible for Medicare to obtain hospice, other alternative LTC services (2)
- Authority to place certain disruptive veterans (behavior problems) in community nursing homes indefinitiely (2)
- New appropriations for a telemedicine cost-effectiveness trial (ie, following up on home placement of geriatric veterans) (2)
- Adjust VERA to adequately accommodate cost of long-term care in VA and community (2)
- Mandate that VA use other sources of payment for LTC before drawing on VA funds unless for care for a service-connected condition (2)
- Uniform pension and aid and attendance benefits for all veterans (1)

- Authority to train patients, family members, friends, and neighbors in professionally supported self-care maintenance (1)
- Authority to uses CNH funds to convert VA acute beds to LTC beds (1)
- Provide authority for VA to provide technical assistance in developing community resources for LTC options in small and rural underserved communities. (1)
- Increased funding for mobile screening clinics for preventive medicine. (1)
- Allow VBA to award aid and attendance to veterans in Community Residential Care (1)
- Assist veterans with Part B Medicare premiums (1)
- Formally state that LTC is a mission of VHA (1)
- Include LTC services in Congressional protections provided other special emphasis programs by measuring unique individuals with identified conditions within specialized bed sections and clinics, dollars expended for care, and timeliness for service delivery. (1)
- Continue to fence funds for contract programs and the percentage to be used for alternative LTC programs. (1)
- Require new CBOC proposals to detail how they will respond to patients with LTC needs. (1)
- Allow VA to offer fee-for-service adult foster care. (1)
- Create more incentives to hire more geriatrician PCPs (1)
- Authority to use VA dollars for sheltered workshops and transitional living. (1)
- Loosen restrictions on developing CBOCs. (1)
- Increased rate for LTC patients under VERA—particularly at end of life (1)
- Expand benefits for LTC under VA and Medicare and allow veterans to move between programs with ease. (1)
- Authority for community case management programs (1)
- Include VISN Extended Care Advisory Panels in National Decision-making About Resource Allocation for LTC (1)
- Reduce amount of benefits veterans' receive when in VA NH for more than 30 days (1)
- Prohibit VA LTC treatment for NSC (1)

The Democratic staff of the House Committee on Veterans Affairs wishes to thank the following individuals who advised on aspects of this report.

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Joann Lamphere, Public Policy Institute, American Association of Retired Persons
John Mather, MD, Assistant Inspector General, Office of Healthcare Inspectors
Frank Morrone, Former Associate Executive Director of Health Policy, Paralyzed Veterans of America

STATEMENT
OF
KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
ON
LONG TERM CARE WITHIN THE VETERANS HEALTH ADMINISTRATION
BEFORE
THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
APRIL 22, 1999

Mr. Chairman and Members of the Committee, thank you for inviting me to discuss long term care provided by the Veterans Health Administration (VHA) and to apprise you of VHA's current strategy for developing potential solutions to the growing demand for long term care by veterans.

As you know, VHA has a long and distinguished history of providing high quality long term care for chronically ill, disabled and elderly veterans, and VHA is internationally recognized as a leader and innovator in the care of older persons.

While my comments today will provide detail about the report of the Federal Advisory Committee on the Future of VA Long Term Care, entitled *VA Long Term Care at the Crossroads*, I would be doing the Committee and VA a disservice if I did not put the Advisory Committee's report in the context of VA's longstanding commitment to addressing the needs of elderly veterans. To do so, I will provide you a brief historical perspective; outline the demographic imperative to examining and expanding VHA's provision of long term care; and outline VHA's current long term care programs, as well as its strategy for addressing future needs.

Historical Background

Precursor organizations to VA have provided care for older veterans since colonial times. The first domiciliary and medical facility for America's veterans was authorized in 1811. In 1865, President Lincoln signed legislation creating what later became known as the National Homes for Disabled Volunteer Soldiers. These homes provided domiciliary and hospital care for large numbers of indigent and disabled veterans, although initially only for those who served in the Union Army. Because of this restriction, a few states established state operated veterans homes. By 1888, California, Illinois, Iowa, Massachusetts, Michigan, Pennsylvania, Vermont, Minnesota,

Nebraska, Ohio, and Wisconsin had established state veterans homes. The first Federal support of these state homes was authorized in 1888 – a payment of $100 per year for each veteran domiciled in a state home.

For the first half of the 20th century, VA provided long term care for veterans primarily in its own domiciliaries and psychiatric facilities, as well as through partnerships with states having state veterans homes. Some VA patients were also referred to community residential facilities. In 1963, VA's nursing home program began. Throughout the next decade there was a steady expansion of VA and State nursing homes, as well as growing use of contracts with community nursing homes to provide long term care for veterans.

In the mid-1970's, VA made what some have characterized as the single greatest commitment in U.S. history to advancing the care of older persons. In anticipation of the large cohort of aging World War II and Korean Conflict veterans, between 1975 and 1980, VA strategically planned and implemented the Geriatric Research, Education and Clinical Center (GRECC) program; established the first Geriatric Physician Fellowship programs; funded the specialized Geriatric Clinical Nurse Specialist and Geriatric Nurse Practitioner training programs; and established benchmark Interdisciplinary Team Training (ITTP) in Geriatrics. Likewise, VA pioneered the development of comprehensive home care programs, geriatric assessment units and state-of-the-art nursing home care units. An array of other long term care services, including contract community nursing home and home care, hospice, respite care, domiciliary, and adult day health care have been added over time and have greatly augmented VHA's capacity to provide the full spectrum of needed extended care services. These investments have reaped great benefits for both veterans and all frail elderly persons in the U.S. VHA's foresight has accelerated the pace of the nation's knowledge about the aging process and the application of this knowledge to improved patient care, including long term care. Indeed, quoting from a recent letter I received from Dr. Jeffrey Halter, the President of the American Geriatrics Society –

> "The VA is by far the largest institutional supporter of geriatric medicine in the United States. In fact, without the continued and ongoing advocacy for geriatrics by the Department of Veterans Affairs during the past 25 years, geriatric medicine as we know it would not exist and the AGS would be an entirely different organization." (August 31, 1998)

Somewhat similar to VHA health care in general, VHA's approach to long term care is evolving from being a primarily institutionally-based care model to one that includes a complete menu of long term care services. Indeed, just as the VHA has redefined itself in the last four years as a "healthcare" system, instead of a "hospital" system, we believe our long-term care services must expand to accommodate the growing need and patient preferences for non-institutional care. Because of the aging veteran population and the needs associated with aging, VHA now has an urgent need to increase home- and community-based care. To be responsive to veterans' needs in

a resource-prudent manner, VHA needs to expand its current home-care programs, develop partnerships with community agencies that offer these services, and find new and better ways of organizing the continuum of long term care services.

Veteran Demographics and Population Projections

Over the next 21 years, the veteran population will decline nearly 35 percent (assuming no major armed conflicts). At the same time, the percent of veterans over the age of 65 will decline only by 12 percent while those over 85 will increase by 333 percent. To continue to provide the appropriate and needed service to veterans, this "demographic imperative" must be addressed.

At present, about 38% of the veteran population is over 65, compared to about 13% of the total U.S. population. Over 51% of veterans who have service connected disabilities and/or who are poor are over 65. (Ninety-one percent 91% of current VA enrollees have service connected disabilities and/or are poor.) The number of veterans over age 65 is expected to peak at 9.3 million in the year 2000, when 66% of all American males aged 65 and over will be veterans. A second but smaller peak is expected to occur in 2015, with the aging of the Vietnam War-era veterans. The number of elderly veterans will peak during the first decade of the 21st century, well in advance of the general U. S. population (which is expected to peak in the year 2030). This is the driving force behind VHA's current efforts to find affordable long term care solutions for veterans.

Of note, while the number of veterans age 65 and older will peak in the year 2000, the number of very old veterans – i.e., those who are age 85 and over – will continue to increase until 2013. VA expects that this age group will increase from 327,000 in 1998 to 645,000 by 2003, and then expand several fold in subsequent years, peaking at about 1.3 million in 2013. This is notable since these persons are especially likely to require institutional care and to need healthcare of all types. Also of importance is the fact that current VA patients, compared to the general population, are not only older, but they also generally have lower incomes and no health insurance, and they are much more likely to be disabled and unable to work.

Development of a VA Long Term Care Strategy

Although VA has developed a full continuum of quality long term care services over the past twenty years, there are a number of problems with what is currently available. First, the system evolved from an institutionally-based care model and the investment of funds continues predominantly in that area. For example, VA spent $2 billion on long term care services in FY 1997; 83% for nursing home care, 7% for home- and community-based care and the remainder for residential care services. Second,

while the overall VA healthcare system has been transforming from a hospital-based system to a primary care, outpatient-based system, the focus of that transformation has not been on the long term care component. Third, despite a continuum of long term care in VHA, some services are not universally available and access to some services is restricted. The Eligibility Reform Act of 1997 (P.L. 104-262) considerably enhanced VHA's capacity to provide clinically appropriate care, but eligibility for nursing home, domiciliary and adult day health care was not changed by the Act, and therefore, they have remained as limited, discretionary services.

For the reasons outlined above, as well as a lack of consensus internally about the direction for long term care and the relative lack of resources to support those services, I created the Long Term Care Federal Advisory Committee. The charge to the Committee was to advise my office on VHA's current and anticipated needs for long term care in an era of no-growth budgets in VA medical care, and on the adequacy of VHA's present and planned programs for addressing these needs.

The Advisory Committee, chaired by Dr. John Rowe, President and CEO of the Mt. Sinai Medical Center and Medical School in New York City, met several times between March 1997 and February 1998.

In its report, *VA Long Term Care at the Crossroads*, the Federal Advisory Committee made 20 recommendations and 4 related suggestions on the operation and future of VA long term care services. These recommendations serve as the foundation for VHA's national strategy to re-vitalize and re-engineer long term care services.

Importantly, the Advisory Committee concluded that long term care must remain an integral part of the veterans healthcare system, but should be invigorated to meet increased demand. Its major recommendations can be summarized in 5 points:

- VA should provide financial incentives to managers to improve access to long term care.
- VA should increase its investment in home- and community-based care.
- VA should retain its 3 nursing home programs, but require stronger justification for any construction.
- VA should enhance its policies surrounding admission and discharge from long term care programs.
- VA should seek legislative authority in the areas of assisted living, respite care and nursing home care.

The Committee's report was disseminated to VA stakeholders for review and comment. I then appointed an internal task force and charged them to review the Advisory Committee's recommendations, considering stakeholder comments, and weave them into a comprehensive VHA long term care strategy.

In principle, the Veterans Health Administration endorses the Advisory Committee's recommendations, and is developing strategies to implement them. Some of activities to do so have already begun. The President's proposed FY 2000 Budget

contains the expectation of increased spending for home and community-based care, which addresses the Advisory Committee recommendations that emphasize the need for greater use of home and community-based care. As recommended by the Committee, work is underway on improving admission and discharge policies to assure that patients receive care in the most appropriate setting for their clinical needs. The Long Term Care Planning Model is being updated as recommended by the Committee, and work is progressing on implementing the Resident Assessment Instrument/ Minimum Data Set at all VA nursing homes.

While VHA accepts each recommendation, we must recognize that we face markedly increasing demand for long term care services with an essentially no-growth budget. Within this budget context, VHA will take steps to improve both the access to and consistency of the provision of long term care services across the system and intends to continue to expand home and community-based care, as proposed by the President's Budget. Both the Advisory Committee and VHA recognize that, with the steps we can take, there will continue to be substantial gaps in service availability due to budget, community resources and legislative limitations. The legislative proposals recommended in the Advisory Committee report will be considered within the context of the FY 2001 Budget and overall Administration policy. VA continue to work with communities at the local level to develop partnerships to fill gaps.

So that the Committee has a full and conveniently available reference to current treatment, research, and educational programs related to long term care as well as future need, I will describe the former in some detail and the latter, which is evolutionary, in brief.

Current VHA Long Term Care Programs

Today, VHA provides a comprehensive array of long term care services that include direct VHA provided services, services purchased in the local community, and services supported through construction and per diem grants to states. VHA also assists veterans and families in obtaining services through other publicly funded healthcare programs such as Medicare and Medicaid, and provides assistance in obtaining services that are personally financed by the veteran. While the array of services provided by VHA is comprehensive, all services are not available in all VA locations, and access to care is, regrettably, uneven.

The major long term care programs provided by VA are described below:

State Veterans Homes. A significant part of VHA's long term care strategy is effected through one of the longest existing Federal-State partnerships, the State Home Grant program. Through this program, the Department provides grants to states for the construction and support of state veterans homes to provide long term care for frail,

elderly veterans. The construction grant program provides up to 65% federal funding to states to assist in the cost of construction of new nursing home and domiciliary facilities, or expansion or remodeling of existing facilities. VA's per diem program, part of the Medical Care account, assists states in providing domiciliary and nursing home care for veterans through partial payment of per diem costs. In FY 1998, over 22,400 veterans were provided nursing home care in state veterans homes. While this program dates back to the post-Civil War era, it has grown dramatically over the past 10 years. The state home program substantially augments VHA's capacity to provide a continuous residence for veterans in need of long term care, especially for veterans in rural areas.

The Geriatric Evaluation and Management (GEM) Program. Currently, 110 VA medical centers have GEM programs that include inpatient units and/or outpatient clinics, as well as consultation services. The GEMs provide both primary and specialized care services to a targeted group of elderly patients. On the inpatient GEM units, an interdisciplinary team of geriatric experts performs comprehensive, multidimensional evaluations of frail, elderly patients. The goals of these intensive services are to improve functional status; to stabilize the acute and chronic medical conditions and/or psychosocial problems; and to discharge the patient to home, residential care, or to the least restrictive environment feasible.

GEM clinics provide similar comprehensive care for geriatric patients on an outpatient basis in addition to providing primary care for frail, older patients to prevent unnecessary institutionalization. The geriatric staffs also are available for specialty consultation on elderly patients with complex problems being cared for by primary care and other specialty services.

Nursing Home Care Units (NHCUs). VA nursing homes provide skilled nursing and related medical services through an interdisciplinary approach to meeting the multiple physical, social, psychological and spiritual needs of patients. Many also provide sub-acute and post-acute care. In general, these units are co-located with or are an integral part of the VA medical center. In FY 1998, more than 46,000 veterans received care in VA's 132 NHCUs. Approximately 75% of VA NHCU patients have a psychiatric diagnosis.

Community Nursing Home Care. VHA contracts with more than 3,000 community nursing homes to provide nursing home care for veterans making a transition from the hospital to the community. Each community nursing home is evaluated and inspected by VHA staff prior to selection as a contract facility, and VHA staff provide regular follow-up visits to assess the progress of veterans admitted to the facility and to monitor the overall quality of care.

In order to improve access to community nursing homes and reduce the administrative cost associated with maintaining hundreds of individual contracts, VHA has recently developed contracts with multi-state nursing home providers. In 1996, six multi-state contracts and one single-state contract were awarded to corporations for quality community nursing home care in 1,053 facilities. These seven contracts together span 43 states and added nearly 600 nursing homes to VHA's existing contract community nursing home program. In 1998, more than 28,800 veterans were treated in community nursing homes at VA expense.

Adult Day Health Care (ADHC). This therapeutically oriented program provides health maintenance and rehabilitation services to veterans in a congregate, outpatient setting. VHA operates 14 ADHC programs which had an average daily attendance of 442 patients in FY 1998. VA also contracts with an estimated 480 non-VA agencies for ADHC services which provided services to an average of 615 veterans each day in FY 1998. The contract program has been established by 83 VA facilities.

Alzheimer and Other Dementia Care Programs. Approximately 56 VA medical centers have developed specialized programs for the care of veterans with dementia. These programs include inpatient and outpatient dementia diagnostic programs, behavior management programs, adapted work therapy programs for patients with early to mid stage dementia, Alzheimer's special care units within VA nursing homes and transitional care units, and a model inpatient palliative care program for patients with late stage dementia. Programs for family caregivers of dementia patients include support groups and caregiver education, as well as respite and adult day health care services for the patient that allow "free time" for the caregiver. Many of these specialized programs for patients with dementia have been developed by VHA's Geriatric Research, Education and Clinical Centers (GRECCs). Indeed, five of the current 18 GRECCs have a primary or secondary focus on Alzheimer's disease and related dementias. These GRECCs have made significant contributions to both the scientific understanding of dementia and improved models of care for dementia patients. In addition, a comprehensive Center for Alzheimer's Disease and Other Neurodegenerative Disorders has recently been established at the Oklahoma City VA Medical Center to focus specifically on development and evaluation of a rural health care model using an interdisciplinary, case management approach to dementia care.

Home-Based Primary Care. This program is operated at 71 VA facilities across the country to provide in-home primary medical care to home-bound veterans with chronic diseases, as well as to patients with a terminal illness. The patient's family provides the necessary personal care under the coordinated supervision of an interdisciplinary treatment team based at the VA facility. The team plans and provides for the needed

medical, nursing, social, rehabilitation, and dietetic regimens and trains family members and the patient in supportive care. In FY 1998, comprehensive primary care was provided in the home by VHA staff to an average of 6,348 patients on any given day.

Fee Basis Home Care. VHA also arranges with community home health agencies to provide skilled home care services for veterans. Under this program, VA pays a per-visit rate to the agency providing the service, similar to what is done under the Medicare program. Approximately 15,000 veterans are served annually in this program.

Domiciliary Care. Domiciliary care is provided in VA domiciliaries, as well as in state veterans homes. VA currently has 40 domiciliaries, which provided care to more than 23,800 veterans in FY 1998. Nearly 5,000 of those veterans were homeless and admitted for specialized care. In addition to services for the homeless, the domiciliary provides other specialized programs to facilitate the rehabilitation of patients who suffer from head trauma, stroke, mental illness, alcoholism, early dementia, and a number of other disabling conditions. Although the average age of veterans overall in VA domiciliaries is only 59 years (43 years for those in the homeless program), increased attention is being focused on older veterans who reside in VA domiciliaries. For example, elderly domiciliary patients are encouraged to become involved with programs in the community such as senior centers and Foster Grandparents. These activities have facilitated continued community involvement as well as reintegration into the community. Many of the domiciliaries in state veterans homes provide similar services, although patients in the state home domiciliaries tend to be older. In FY 1998, 46 State Veterans Home domiciliaries in 32 states served more than 6,400 veterans.

Community Residential Care/Assisted Living. This program provides room, board, personal care, and general health supervision for veterans who, because of health conditions, are not able to live independently and have no suitable family or social support system to provide needed care. A multidisciplinary team of VHA staff inspects private homes that provide residential care/assisted living services prior to including the home in VHA's program and annually thereafter. Payment for services provided in a residential care home is the responsibility of the individual veteran. In FY 1998, 8,104 veterans received residential care on a daily basis in over 2,100 homes approved and monitored by VHA. Veterans in this program are visited monthly by VHA healthcare professionals who monitor the care provided in the home.

Homemaker/Home Health Aide (H/HHA). This program enables selected patients who meet the criteria for nursing home placement to remain at home through the provision of personal care services. The H/HHA services are purchased by VHA from public and private agencies in the community. Case management is provided directly by VHA

staff. During FY 1998, 118 VA facilities purchased these services for approximately 2,400 veterans on any given day.

Respite Care. Another program that enables the chronically-ill, disabled veteran to live at home longer than would be otherwise possible is respite care. This program is available at nearly all VA facilities and is designed to reduce the caregiving burden from the spouse or other caregiver by admitting the veteran to a VA hospital or nursing home for planned, brief periods, totaling no more than 30 days per year. During the inpatient stay, patients are also provided with evaluative and treatment services needed to maintain or improve functional status, thus prolonging the veteran's capacity to remain at home. A formal evaluation of this program, concluded in 1995, found a high level of satisfaction among family caregivers and a high level of enthusiasm for the program by VHA staff delivering the care.

Hospice Care. All VA medical centers have, at a minimum, an interdisciplinary hospice consultation team that is responsible for planning, developing and arranging for the local provision of hospice care. The program offers pain management, symptom control, and other medical services to terminally ill veterans, as well as bereavement counseling and respite care to their families. Education and training also has been provided to facilitate the incorporation of hospice concepts into each VA facility's approach to the care of the terminally ill. Seventy-five VA facilities offer inpatient hospice care as well as consultative services. All VA medical centers also arrange for hospice services through community-based agencies. Hospice and palliative care initiatives have recently been intensified throughout VHA. Specific strategies to increase the availability of these services to veteran patients are under development.

VHA Research Programs in Aging

VHA is widely recognized for its research programs related to aging and senior care. VHA's intramural research program includes basic biomedical and clinical research, health services research, rehabilitation research, and cooperative studies. Because of the diverse nature of diseases associated with aging, it is difficult to define precisely the content of the aging research portfolio; however, if one takes a broad view of aging, then a substantial portion of VA research funds supports studies relevant to aging.

Aging is one of VHA's Designated Research Areas (DRAs), which are priority areas recently identified for the research program. Other DRAs address issues related to health problems of the elderly, including the cancer, stroke, degenerative bone and joint diseases, dementias, and diabetes DRAs.

In 1975, VHA established centers of excellence in geriatrics called Geriatric Research, Education and Clinical Centers (GRECCs). The mission of the GRECC program is to improve the health and care of elderly veterans through research, education and training, and the development of improved clinical models of care. There are currently 18 GRECCs throughout the VA system, each with a distinct programmatic focus (e.g., interdisciplinary approaches to treatment of prostate cancer; neurobiology, epidemiology, and management of dementia; falls and instability; geropharmacology; cost-effective delivery of health care services to the elderly; and bioethical aspects of medical decision-making in aging). VA's GRECCs are widely recognized as having provided leadership in geriatrics and gerontology throughout the nation.

VHA Education and Training Programs in Aging

The training of physicians and other healthcare professionals in geriatrics and gerontology has been a priority for the VHA since the mid-1970s, when three major initiatives were implemented. The first was the establishment of the GRECC program in 1975, mentioned already. This was followed by the development of a geriatric physician fellowship program in 1978, and the designation of 12 VHA Interdisciplinary Team Training Programs (ITTPs) in Geriatrics that same year. While comprehensive geriatric training for residents and associated health students was initially only provided at GRECC and ITTP sites, such training is now provided at more than 40 VA facilities nationwide.

Eighty percent of the nation's academic leaders in geriatrics today received training in VHA, and VHA continues to be the largest single provider of geriatric training in the U.S. Special fellowship programs in geriatrics have been designated for psychiatrists, dentists, nurses, and psychologists. Beginning in 1994, additional positions were allocated to support residency training in long term care. Also, of the approximately 112,000 health professions students who receive clinical training experiences in VA facilities annually, many gain experience in care of the elderly by rotating through one or more of VA's geriatrics and extended care clinical programs.

Education and training opportunities are also provided for VHA employees. Continuing education programs are conducted at all VA facilities, in addition to regional and national training conferences conducted by VHA faculty. GRECC staff conduct, co-sponsor or serve as faculty at over 5,000 VHA geriatric care educational programs yearly. Resources related to the care of the elderly, including videos, journals, textbooks, conference tapes, clinical practice guidelines, and other health education materials developed by VA and non-VA sources, are available for VHA staff in VAMC libraries.

Future Long Term Care Initiatives

The prevalence of chronic diseases, episodes of acute illness and functional disabilities all increase with advanced age. The need for the full continuum of care, including long term care, also increases for the older, and particularly the "very old" population of veterans. All long term care patients benefit from an interdisciplinary, primary care approach that can be implemented across care settings. The site of care (e.g., home, clinic, hospital, adult day health care center) may change over time and depends more on the individual patient's circumstances, including his or her functional ability in carrying out activities of daily living, than on a particular disease entity.

Our goal of providing comprehensive, coordinated services at the right time and right place for veterans in need of such services is vital to assisting veterans to maintain the highest possible functional level and quality of life.

As noted earlier, VA is developing a strategy to implement all of the Federal Advisory Committee's recommendations. I will provide this document to the committee when it is completed. To the extent that we can do so within the existing authorities and programmatic resources, we will:

- Achieve an integrated care management system that incorporates all of the patient's clinical care needs;
- Provide more care in home and community-based settings as opposed to inpatient settings, when appropriate;
- Achieve greater consistency in access to and quality of care provided in all settings;
- Achieve greater consistency across the system in assessing patients for long term care and in managing care, including post institutional care;
- Continue to emphasize VHA research and educational initiatives that will improve delivery of services and outcomes for VA's elderly veteran patients;
- Continue to develop new models of care for diseases and conditions that are prevalent among elderly veterans. For example, by the year 2000, we project that there will be 600,000 veterans with severe dementia. To help find better ways of caring for these veterans, VHA is participating in a multi-site demonstration project on Alzheimer's disease and care management, which is co-sponsored by the Alzheimer's Association and the National Chronic Care Consortium (NCCC). (NCCC is a national nonprofit organization representing 30 of the nation's leading healthcare networks serving the Medicare and Medicaid populations.)

As noted earlier, the Advisory Committee's recommendations will be considered within the context of the FY2001 Budget and overall Administration policy.

Conclusion

VA has a long and proud tradition of delivering quality long term care services, and we believe we can improve our approach to long term care. VHA has the opportunity to again assume a national leadership role in providing care for older persons by developing innovative solutions to long term care. I believe that the manner in which VHA tackles its "demographic imperative" will provide critical experiential information and may even define the nation's approach to long term care in the coming decades. At a minimum, the VHA experience will serve to inform the policy debate about the growing need for long term care for non-veterans.

That concludes my prepared remarks. I would be happy to try to address your questions now.

STATEMENT
OF
JOHN W. ROWE, M.D.
CHAIRMAN
FEDERAL ADVISORY COMMITTEE
ON THE FUTURE OF VA LONG-TERM CARE
ON
VA LONG TERM CARE
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
APRIL 22, 1999

Mr. Chairman, thank you for inviting me to discuss the findings and recommendations of the Federal Advisory Committee on the Future of VA Long-Term Care. I am John W. Rowe, M.D., the President and CEO of Mt. Sinai - NYU Medical Center and the Mt. Sinai School of Medicine. I served as Chairman of VA's Advisory Committee on Long-Term Care.

Background

The Committee met in April and August of 1997 under the chairmanship of the late Dennis W. Jahnigen, M.D. I chaired the Committee for its November 1997 and February 1998 meetings and its summary work in preparing its report. That report, *VA Long-Term Care at the Crossroads*, was completed in June 1998.

I wish to thank the members of the Committee for their hard work, insight and dedication. I also wish to thank Judith A. Salerno, M.D., M.S., VA's Chief Consultant for Geriatrics and Extended Care, Daniel Schoeps, Director of VA's Long-Term Care Contract Programs and the staff for their work at the meetings, for devising analyses for the Committee's review, and for assisting in the preparation of the Committee's report.

Throughout this statement, reference is made to the Committee's report, *VA Long-Term Care at the Crossroads*, with the page numbers noted.

The Committee's Findings

The Committee found VA's long-term care programs to be a major strength and a crucial component of veterans' healthcare. VA, as a healthcare system, offers a fairly broad array of long-term care services that would be difficult to match in other systems of care. As a national resource with a rich tradition of providing quality care, VA's long-term care system is too important to lose. There is much to learn from VA - for the veterans who are generally well served by the system and for the nation, as it begins to look at better models for delivering long-term care. (*Crossroads*, pages 2, 11-14)

Despite the quality of the care and a sound reputation, the Committee had serious concerns about the viability of VA's long-term care services. The Committee found VA long-term care services to be at a crossroads. The Department continues to witness a growth in demand for long-term care services, but access to that care has not kept pace with demand, and in some cases, has been sharply curtailed. VA's existing long-term care programs, developed in the 1970s and early 1980s, have not been re-engineered to meet the needs of veterans of a modern healthcare system. VA has not responded to the rapid changes in care delivery that has placed a premium on home- and community-based care. At many facilities, long-term care is not integrated into the fabric of the delivery system and is not coordinated into a unified set of services. At the network level, long-term care is not adequately integrated into the VISN management structure and strategic planning. Financially, long-term care services are perceived by many local managers to be underfunded. In a no-growth budget environment, management initiatives to lower per patient costs contribute to disincentives to provide long-term care. (*Crossroads*, pages 2, 5-10)

The Committee considered a number of models to address the future of VA long-term care. These models ranged from dismantling VA's continuum of long-term care to providing all long-term care within a VA-operated structure. After a careful and deliberate examination of programs, finances and management, the Committee unanimously recommended a re-vitalization of VA long-term care services. This approach would involve an emphasis on developing home- and community-based care, minimizing capital investment, and placing a greater reliance on contract care, and, when available the State Veterans Homes. (*Crossroads*, page 3)

The Committee's Recommendations

The Committee approached its recommendations with the full knowledge that VA was operating under a no-growth budget. The Under Secretary for Health made that clear in his Charge to the Committee. As a CEO of a major healthcare organization, I appreciate the difficulty Dr. Kizer confronts in addressing this budget for all aspects of the VA healthcare system, including long-term care. (*Crossroads*, page 4)

The Committee made 20 recommendations and presented 4 ideas to improve accountability and provide incentives to re-invigorate long-term care in VA. Five recommendations address design and planning issues, 12 recommendations apply to current services and associated issues and there are 3 recommendations for legislative proposals. (*Crossroads*, pages 26-28)

The core recommendations, dealing with VA operations and policies, can be summarized in four points.

Provide Strong Incentives to Managers to Provide Long-Term Care. Incentives have proven remarkably successful in VA's re-structuring of its healthcare delivery. Objective performance measures exist that will improve veterans' access to long-term care services.

Proceed with Nursing Home Construction Only When Absolutely Necessary. VA needs to minimize its funding for new buildings. The case for new beds requires more rigorous analysis in the areas of patient need for care and the availability of alternative resources to meet that need.

Invest in Home- and Community-Based Care. The Committee called for tripling the investment in home- and community-based services over a 5-year period. The Committee strongly believed that VA should be at the cutting edge in delivering services in noninstitutional settings. At the same time, the Committee believed VA's nursing home programs should be maintained and re-engineered, and that the current level of investment in nursing home care was appropriate.

Improve Fairness in Long-Term Care Policies. The Committee was concerned by the divergence in local policies governing admission to and discharge from VA's long-term care programs. There is a clear need for national direction to insure a level of commonality in local policies, so that veterans can see an equal opportunity of access to long-term care, within the eligibility rules established by Congress. (*Crossroads*, pages 6-8, 15-18, 26-29)

The Committee's recommendations called for VA to consider three legislative proposals.

1. Respite Care. VA already provides respite care in its own nursing homes. The Committee recommended the authority be expanded to other settings.

2. Assisted Living. This emerging locus of long-term care was not contained in the Committee's Charge. The Committee sought expansion in this area, as an offset to growth in nursing home expenditures.

3. A Limited Nursing Home Benefit. The Committee sought a middle course in recommending a 100-day, post-hospital benefit, independent of existing nursing home authority. The Committee was unwilling to recommend full "eligibility reform" because of cost concerns. (*Crossroads*, pages 19-20, 26-27)

Conclusion

The VA has an outstanding opportunity to move its long-term care continuum forward to the great benefit of veterans and the nation. As a society, we have yet to struggle in a comprehensive way with the direction we want to take for elderly, chronically ill and disabled Americans. The country can learn from VA's experience.

I close this statement, mindful of the words of the late Dr. Paul Haber, the father of long-term care in VA. There is a quote from him, highlighted on the back of the title page of the Committee's report.

"As the number of aging veterans increases over the next decades, the Department will need to expend more resources for their care. Expanding services for old, chronically ill patients will cause disquietude among some in the Department".

VA was faced with competing interests in 1975 as it is today. As a result of the decisions made almost 25 years ago, VA became a national leader in long-term care. That leadership is now threatened. At this new crossroads, VA must re-dedicate itself to excellence in long-term care.

I thank the Committee for this opportunity to present the views of the Federal Advisory Committee on the Future of VA Long-Term Care.

WRITTEN TESTIMONY
OF
ROBERT SHAW, PRESIDENT OF N.A.S.V. H.

PREPARED FOR HOUSE VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH HEARING
TO EXAMINE THE
ISSUE OF LONG-TERM CARE FOR OUR VETERANS

9:30 A.M.

ROOM 334 OF THE CANNON HOUSE OFFICE BUILDING

APRIL 22, 1999

NATIONAL ASSOCIATION OF STATE VETERANS HOMES ISSUE OF LONG-TERM CARE FOR OUR NATION'S VETERANS

The National Association of State Veterans Homes appreciates the opportunity to appear before this distinguished Committee to express our views pertinent to the Issue of Long-Term Care for Our Nation's Veterans. Your understanding of our program and generosity you have provided over the years to carry out our mission of "caring for America's Heroes" is greatly appreciated.

We feel our involvement to be extremely important with the increasing demands being made upon our Federal Government for funding and taking care of our veterans, particularly those increasing numbers of elderly veterans who have reached that time in life when such care is needed

The Department of Veterans Affairs in conjunction with its nursing home and domiciliary in-house long-term care programs and the community contract Nursing Home program promotes "the care and treatment of veterans in State Veterans Homes as one means to attain the goal of developing and maintaining the highest possible quality of patient care with an appropriate scope of services to meet the eligible veteran's health care needs. Two programs are established as follows:"

GRANTS FOR CONSTRUCTION OF STATE HOME FACILITIES

This program is authorized by Title 38 U.S.C. 8131-8137, formerly 5031-5037. The objective is to assist the several states to construct or acquire State Home facilities for furnishing domiciliary, and nursing home care for veterans in State Homes. Funds can be utilized to renovate existing hospital facilities in State Homes; however, the construction or acquisition of new hospital facilities or beds cannot be financed through the program. Project grants are made by VA, which may not exceed 65 percent of the estimated cost of construction including the provision of initial equipment for any such building.

PAYMENT TO STATE HOMES

This program is authorized by Title 38 U.S.C, 1741-1743, formerly 641-643. The objective is to assist the states in providing for the care and treatment of eligible veterans in recognized State Veterans Homes, which meet such standards, as the VA Secretary shall prescribe. Per Diem payments are made by VA for domiciliary, nursing home, and hospital care provided to eligible veterans at rates established annually but not to exceed one-half of the cost of veterans' care in such State Homes.[1]

A partnership has existed between the various states and the Federal Government for over a century to provide care to veterans. If we review debates on the original Act of August 27, 1888, we find this initial statute for monetary allowances to State Veterans Homes was in effect, an invitation to the states to share the burden of domiciliary care for veterans with the Federal Government. As was stated in the Senate Committee on Military Affairs Report, S. 2115, at the time; "We propose simply to admit into State Homes for Disabled Soldiers upon the same terms in which they are admitted to National Homes." An exhaustive review of this whole relationship is contained in Report #1377 of the House of Representatives, 90th Congress, Second Session.

We respectfully submit that this impartial, detailed study clearly establishes a partnership between the State, Federal Government and State Veterans Homes operations. As a

matter of fact, the report states, "i.e., it seems quite plain to your Committee that a portion of this burden, yea, the greater part of it should be born by the Federal Government," The Federal Government in 1888 established the first grant program in American history, thus, appropriating funds to State Homes ($100 per year, per veteran) to assist them in their cost of providing care and treatment. Subsequent legislation increased the per annum rates and expanded the program in 1949 to include State Home hospital care.

In 1960, the method of Federal aid payments to State Homes was changed from a per annum rate to a per diem rate by the passage of Public Law 86-625. In 1964, Public Law 88-450 authorized the nursing home care program within the Veterans Administration, expanding the per diem program in State Homes to include a rate of $3.50 for nursing care. Again, throughout the years legislation has increased the per diem rates. During FY98, the last year for which we have figures for comparison with the community contract program and the VA in-house long-term care program, per diem rates for nursing home and hospital care being $40.00 and $17.78 for domiciliary care. VA continues to make progress toward increasing its per diem payments to State Veterans Homes until it is defraying 33 1/3 percent of the average national cost of providing long-term care in a State Veterans Home. The National Association of State Veterans Homes applauds the VA for its willingness to assume a more equitable share.

Fiscal Year	Total Days Care	SVH Average Per Diem Cost	SVH VA Per Diem Paid	VA Per Diem as a % of Cost	VA Per Diem Needed to Meet 33 1/3% Goal	Avg. VA Contract Nursing Care Per Diem Cost	Avg. VA Nursing Facility Per Diem Cost
Nursing Care							
FY98	5,302,014	$137.04	$40.00	29.19%	$45.63	$148.84	$255.25
Domiciliary							
FY98	1,323,051	$78.97	$17.78	22.51%	$26.30		

[2]

The State Veterans Home program has grown from 11 Homes in 11 states in 1888 to presently 95 Homes in 43 states. Nursing home care is provided in 88 Homes, domiciliary in 47 Homes and hospital-type care in 5 Homes. These Homes presently have over 24,000 beds and in FY98 provided more than 6.7 million days of care (nursing home care 5,302,013, domiciliary care 1,323,051 and hospital-type care 85,030).[3]

The program of assistance to states for construction, remodeling or renovation of State Home facilities began on August 19, 1964, with the enactment of Public Law 88-450, which authorized annual appropriations of $5 million for making grants to State Homes by the Veterans Administration. These grants were limited to no more than 50 percent of the cost of constructing new nursing care facilities, expanding or remodeling buildings for use as nursing care facilities, and initially equipping such facilities. Not more than 10 percent of the funds appropriated for any fiscal year could be used to assist in construction of nursing home care facilities in any one state.

Since the inception of the Construction Grant Program, subsequent legislation has made many changes and extended the program to one of permanency. The department of Veterans Affairs FY2000 Budget Submission through FY99 indicates there has been a total of 141 new bed projects with 20,139 new beds added to the State Home program and 180 projects pertinent to remodeling, renovation, fire safety, etc. Planned VA participation for all the projects reflect 62 percent of the total construction cost being underwritten by the Federal Government.[4]

The methodology for awarding construction grants has been effective over the years as noted by the number of new homes and beds in the system. With more and more states

filing projects for assistance with renovation/remodeling, to keep abreast of programmatic regulatory issues, life safety A.D.A., etc., and the concern over building of new beds at the present rate is of concern to the National Association of State Veterans Homes membership.

Why? Under the current methodology for awarding State Home construction grants, bed-producing construction projects move to the top of the priority-funding list. This process forces renovation projects down the list and out of funding range.

While under our proposal, State Home construction grant requests would be prioritized, in the year they are received, utilizing current Department of Veterans Affairs needs criteria. Grant requests received in future years would be prioritized in the same manner with the understanding that they will not receive funding until projects submitted in previous years are funded. However, a state without a State Veterans Home automatically becomes eligible for funding for its first Home regardless of the year its request is received. (Many states are having difficulty convincing their elected officials to leave state matching funds intact for remodeling/renovation projects, in some cases for years, as they wait for federal matching funds to become available. Adopting this strategy would enable states to better plan and anticipate funding time frames.)

Presently, there are only three states in the Union that does not have a Veterans Home (Alaska, Hawaii and Delaware). Some new states with Homes are waiting for VA approval; other new states have their first Home under construction, while established states in the program are adding to the number of Homes within their state.

In this era of diminishing resources and concern for increased demands for long-term care, particularly when the Department of Veterans Affairs has changed drastically from an in-patient to an out-patient care mode, reduced its long-term capability (in-house and contract) and with community hospitals being bound by the concept of the Diagnosis Related Groups (DRG), the State Veterans Home becomes more important as a long-term care provider. Why? Because care furnished by State Veterans facilities is typically for severely disabled, infirm veterans requiring complex care and for impaired veterans with poly-substance abuse and mental health problems who demonstrate a need for requiring nursing care and other professional health care services over a protracted period of time, thus, placing State Homes in the unique position of caring for the severely debilitated patients requiring extensive amounts of care over a long period of time.

And what better way to provide the quality of care that they deserve than being cared for in a State Veterans Home? The Homes have to adhere to standards of care as established by the Department of Veterans Affairs, several are approved by the Joint Commission of Accreditation of Health Care Organizations, and all must meet individual State regulatory compliance, etc The services provided by the State Veterans Homes reflect sensitivity and an acknowledgment of the contribution made by its patients. The care provided is cost-effective as noted in page three of this document and of high quality. Where else in FY98 could you purchase nursing home care for forty dollars ($40.00) per day or domiciliary care for $17.78 per day?

Currently, our nation is faced with the largest aging veteran population in its history. (VA estimates that the number of veteran's aged 75 and older will increase from about 2.6 million in 1995 to about 4.0 million in 2000). We believe the State Home program will continue, and even expand, its role as an extremely vital asset to the Department of Veterans Affairs in meeting this great challenge. State Veterans Homes, where feasible and on their own initiative, have already taken innovative steps in providing services to meet a broad range of veterans' needs. What we need is recognition of those efforts through a greater commitment of resources and support by those who share responsibility

meet a broad range of veterans' needs. What we need is recognition of those efforts through a greater commitment of resources and support by those who share responsibility for our veterans' care. Without the integration of all available resources, we will fail to meet our moral obligations to our Nation's veterans.

With this in mind, the National Association has gone on record and shared their thoughts pertinent to the following legislation initiatives with the Veterans Affairs Committees, Department of Veterans Affairs, Veterans Organizations, etc.[5]

1. Increase VA per diem payments to State Veterans Homes to an amount equivalent to 33 1/3 % of the national average cost of providing care in a State Veterans Home.[5]

2. Obtain sufficient federal dollars to fully fund the backlog of approved grant applications to the VA State Home Construction Grant Program.[5]

3. Modify the methodology for awarding State Home construction grant funds to a concept that incorporates elements of both "first come, first served" and VA's current "needs formula".[5]

4. Establish State-Home-Based Personal-Care Services through the State Home Program utilizing a funding formula with VA assuming 33 1/3 % of its average national cost of providing such care through VA hospital-based programs.[5]

We in the National Association of State Veterans Homes stand ready to meet the challenges that lie ahead feeling confident that we can continue to be a valuable resource for the Department of Veterans Affairs and the Nation in providing long-term health care services for the Nations' chronically ill, handicapped aging veterans keeping in mind service, efficiency and economy.

Thank you, Mr. Chairman and Members of the Committee.

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[1] National Association of State Veterans Homes, Membership Directory 1998-1999 D-1
[2] Caring for America's Heroes 1864-1999 FY1998
[3] VA Federal Grant Application to Nursing Home-Care, Domiciliary Care and Hospital Care, Geratrics and Grants Management Service, Department of Veterans Affairs, Washington, D.C.
[4] FY2000 Budget Submission, Department of Veterans Affairs, Summary, Volume 5 of 6. Office of the Assistant Secretary for Management February 1999
[5] Ibid., Note 2
[5] Ibid., Note 2
[5] Ibid., Note 2
[5] Ibid., Note 2
[5] Ibid., Note 2

TESTIMONY BEFORE THE HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS AFFAIRS REGARDING ALTERNATIVES FOR REDESIGNING VA STRATEGY FOR STATE VETERANS HOME CAPITAL INVESTMENT DECISIONS

Submitted by:
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Birch & Davis Associates, Inc.

April 22, 1999

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TESTIMONY BEFORE THE HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS AFFAIRS REGARDING ALTERNATIVES FOR REDESIGNING VA STRATEGY FOR STATE VETERANS HOME CAPITAL INVESTMENT DECISIONS

Birch & Davis Associates, Inc. (B&D) was engaged in August, 1998 by the Department of Veterans Affairs (VA) to examine the State Veterans Home (SVH) Construction Grant program. This study effort was conducted over a period of approximately 8 months. Specifically, B&D was contracted to:

- Identify current SVH utilization patterns and residents demographic characteristics
- Determine the levels of care and types of services offered to the residents
- Review the role of SVHs within the VA long-term care continuum
- Analyze the method the VA uses to assign priorities to construction grant requests
- Develop options to restructure the prioritization process for the SVH Construction Grant Program

To conduct its examination, B&D reviewed statistical and programmatic information furnished by the VA; interviewed various stakeholders, representatives of Congressional committees, and other concerned parties; visited nine SVHs to discuss care delivery systems, resident needs, and facility maintenance; gathered information from several State health planning agencies concerning the issuance of certificates of need to SVHs; and analyzed data collected from a questionnaire distributed by the National Association of State Veterans Homes to all 95 SVHs.

The questionnaire distributed by the National Association of State Veterans Homes was designed to obtain information regarding the level and type of services provided to SVH residents, their demographic characteristics, and utilization related data. Seventy-six of 95 SVHs (80 percent) representing 86 percent of all authorized beds completed and returned the questionnaire. The responses, coupled with information from other sources reveal that:

- About one-half of the SVHs provided nursing home care only in 1998, 4 SVHs provided domiciliary care only, and the remaining SVHs provided multiple levels of care, including hospital care in 5 SVHs.
- The number of authorized nursing home beds in SVHs increased 65 percent between 1987 and 1998 (from 10,686 to 17,644) as the number of SVHs with such beds leaped from 48 to 88.
- During the same time period (1987 to 1998), the number of authorized domiciliary beds decreased 15.4 percent (from 7,056 to 5,969), although the number of SVHs with such beds increased from 43 to 48.
- The responding SVHs offered a wide range of nursing, rehabilitation, nutrition, personal, social, and transportation services to their residents.
- Approximately 7,100 persons were admitted to the responding SVHs in 1997 from a variety of locations, including 19 percent from VA facilities. About 6,100 residents were discharged during the year.

- The weighted average occupancy rate for authorized nursing home beds in SVHs was 89 percent in 1998 and 67 percent for authorized domiciliary beds in SVHs.

- The average length of stay in the vast majority of responding SVHs exceeded one year. In more than a few SVHs, the reported average stay exceeded three years.

- Over nine-tenths of the residents of 33 SVHs with nursing home beds only and 42 percent of four SVHs with domiciliary beds only were 65 years and older.

- About 7 percent of SVH residents in 1998 were not veterans. Federal regulations allow SVHs to admit 25 percent nonveterans (e.g., veterans' spouses and other immediate family members) and still qualify for SVH construction grants.

2. CURRENT METHOD FOR ASSIGNING PRIORITY TO CONSTRUCTION GRANT REQUESTS

Since 1977, the States have requested grants for a combined amount that has consistently exceeded the amount the Congress has appropriated for the SVH Construction Grant program. As a result, since 1988, the VA has assigned a priority to each request based on a method specified in Federal legislation and regulations. The annual amount appropriated for the program has fluctuated widely over the last decade, from $41.3 million in FY 1990 to $90 million in FY 1999.

Prior to 1988, SVH construction grants were awarded on an essentially first-come, first-served basis. Since then, a bed needs method that relies on six priority groups has been used to determine the order in which grant requests are funded. This method is applied within a hierarchical framework. Grant requests are assigned priorities based on specific variables arranged in a predetermined order. The sequencing of the variables is, therefore, nearly as important as the variables themselves in deciding whether and when a project is funded. In other words, a grant request that scores poorly on a variable early in the sequence is unlikely to be funded because low initial scores cannot be overcome even by extraordinarily high scores for variables later in the sequence.

The current priority method favors certain types of projects over others. Higher priority is given to grant requests (1) from States that obligate sufficient funds for a project, (2) from States with unmet bed needs above 91 percent, (3) for nursing home projects over domiciliary projects, (4) for bed-producing projects over renovation projects, (5) for life safety projects over other renovation projects, and (6) for projects with the earliest preapplication and application dates. These preferences help to explain why:

- Seventeen of the first 20 grant requests on the priority list for 1999 (a total of 89 projects) are bed-producing projects. The first renovation project is 20th on the list; it requests funds for a life safety project.

- Bed-producing projects account for 80 percent of the dollar value of the grant requests on the 1999 priority list but only 30 percent of the number of grants requested.

- Over 90 percent of the dollar value of the bed-producing projects on the priority list for FY 1999 are for nursing home beds; the remaining 10 percent are for domiciliary beds.

- Bed-producing projects accounted for 97 percent of the dollar value of the grants awarded in 1998.

The chief advantage of the current priority method is its simplicity. Grant requests can be ranked manually, without any complex calculations. Assignment of priorities is based upon answers to the following questions:

- Has the State obligated sufficient funds for the project?
- Does that State have an unmet bed need at or above 91 percent?
- Will the project add nursing home, domiciliary, or hospital beds?
- Will the project renovate a nursing home, domiciliary, or hospital unit?
- Is the grant requested for a life safety project?
- What are the preapplication and application dates?

However, while simplicity is the main advantage of the current priority method, it is also the primary source of its limitations and shortcomings.

3. LIMITATIONS OF THE CURRENT PRIORITY METHOD

Sixteen methodological issues have been identified. Nine of them emanate from the fact that bed need is measured in terms of the maximum bed capacity or bed supply the VA would help finance if Congress appropriated the money. Veterans are assumed to need these beds, and their need is assumed to be uniform nationally. Unmet need is said to exist whenever a State does not have the maximum bed capacity that the VA would fund, regardless of the availability of suitable beds in VA facilities, community nursing and domiciliary homes, or existing State homes. The maximum bed capacity that the VA will fund is 4 nursing home beds per 1,000 veterans and 2 domiciliary beds per 1,000 veterans. We found no empirical justification for these bed standards.

Second, bed need is measured in terms of the entire veteran population rather than veterans who are likely to utilize beds in State homes. This distinction is very important because the total veteran population is expected to plummet 20 percent between 1998 and 2010 and an additional 19.7 percent between 2010 and 2020. In contrast, the number of aged veterans• or those over 64 years of age and most likely to need long-term care• is forecast to decrease "only" 7.6 percent between 1998 and 2010 and "only" 5.5 percent between 2010 and 2020. Additionally, the number of veterans 85 years and over is projected to nearly quadruple between 1998 and 2010, and then decrease slightly between 2010 and 2020.

Third, unmet bed need is predicated on the number of veterans residing in a State at the time a grant request is submitted rather than the number of veterans who are likely to seek care during a home• s useful life. This difference is important in light of the dramatic decline expected during the next two decades in the veteran population.

Fourth, unmet bed need plays a role in the assignment of priorities to grant requests submitted by States with an unmet bed need at or above 91 percent of the maximum allowable or "fundable" capacity. Unmet bed need has no bearing on the priority assigned to other grant requests, however. In other words, the current priority method does not differentiate between an unmet bed need of minus 10 (i.e., maximum bed capacity exceeded), 20, 45, 60, or 90 percent, except whenever a State must justify, to the VA• s satisfaction, that more than 2.5 nursing home beds per 1,000 veterans are needed.

In addition, the current method does not factor the quality of care furnished in existing State homes into the priorities assigned to grant requests for renovation projects. Although subpar performance can be penalized in the awarding of grants, exemplary care cannot be rewarded in assigning priorities to grant requests. Finally, use of application and preapplication dates to determine priority is not need based. States with the earliest grant requests may not be the States with the greatest unmet bed needs.

4. OPTIONS FOR CHANGE

Several stakeholders and other concerned parties have concluded that the current priority method should be revised. In fact, the National Association of State Veterans Homes and the American Health Care Association have issued position papers recommending specific changes. The National Association of State Directors of Veterans Affairs has issued a proclamation supporting NASVH• s position. A bill entitled *The Veterans• Nursing Care Availability Act of 1996* also recommended ways to modify the current method.

There are a variety of ways the VA could revise the priority method. There is no single best method, independent of specific policy goals. A number of methods are possible which depend upon the criteria or variables used and how they are sequenced and weighted in the prioritization process.

The following five objectives guided B&D's review of the current priority method and subsequent analysis of the ways in which it could be modified:

- **Fairness**—Any changes should ensure that the method is equitable to all States and enables veterans in similar circumstances to have the same opportunity to obtain the long-term care services they need.

- **Objectivity**—Quantitative rather than qualitative information should be used to assign priorities to competing grant requests. An objective method would help to minimize the challenges, disputes, and inconsistencies that may accompany subjective ranking methods.

- **Data Availability**—Public data published by credible organizations should be used to establish priorities. The data should be published at regular intervals and preferably, be available in computerized files to facilitate analysis.

- **Administrative Ease**—The method should be relatively ease to apply and describe to interested parties. It should not be unduly complex or require a costly infrastructure or investment in time to maintain and monitor.

- **Predictability**—Interested parties should be able to predict whether and when grant requests would likely be funded.

The preceding objectives are not entirely consistent with each other. Consequently, in revising the priority method, it is quite likely that some tradeoffs among the objectives will be necessary.

It is important to note that Federal statutes or regulations will need to be revised to make certain changes in the methodology, and consensus will be easier to build for certain changes than for others. In all cases, the VA and States will need time to make conforming administrative changes.

A changeover from a maximum bed capacity or supply-driven concept of need to a veteran or demand-driven concept would represent a fundamental change in the priority method. Grant awards would be based largely on veterans• functional and health status coupled with bed availability in all settings rather than a predefined number of beds in a specific setting. This change would affect both the aggregate numbers of beds in State homes that could be funded as well as the interstate distribution of those beds. Some States would lose beds, while other States would gain them. Certain gains or losses might be significant.

This critical supply-to-demand changeover could be accompanied by several other changes of varying degrees of importance. Among the possibilities are:

- The priority method could be applied within a nonhierarchical framework rather than a hierarchical framework. A nonhierarchical approach would assign priorities to projects but without the variables being arranged in any preset order. Each variable would be assigned a weight, and grants would be awarded based on overall weighted scores. A grant request

that scores poorly on any one variable would therefore not necessarily be precluded from receiving a grant award.

- The current methods preference for bed-producing projects over renovation projects could be erased by splitting the total amount Congress appropriates for the SVH Construction Grant program into two distinct funds, one each for bed-producing and renovation projects. Different priority methods could be applied to bed-producing and renovation projects.

- The current methods preference for nursing home beds over domiciliary beds could be changed by leveling the numerical values assigned to all bed-producing grant requests.

- To promote cost efficiency, the definition of acquisition and construction of beds could be expanded to accommodate long-term lease arrangements.

- Unmet bed need could be used to assign priorities to all grant requests, not just those from States with an unmet bed need above the 91 percent threshold.

- The current practice of using the same unmet bed need percentage to establish priorities for multiple grant requests submitted by a State on the same priority list could be terminated. Alternatively, a limit could be imposed on the number of grants a State could be awarded during a single year or consecutive years.

- Unmet bed need could be based on the projected number of veterans likely to seek care from State veterans homes rather than the total number of veterans residing in the State at the time a grant request is submitted.

- Bed availability in VA facilities, community nursing homes, and existing State veterans homes could be considered when assigning priorities to grant requests.

- The current priority method could incorporate the quality of care in existing State veterans homes when assigning priories to grant requests for renovation projects. The quality of care could be based on information from diverse sources, such as resident assessments, satisfaction surveys, and medical record reviews that compare treatments with practice guidelines or clinical pathways.

Initiatives to revise the current priority method will spark questions about when the new method will be implemented and how the changeover will affect grant requests on the current priority list. A critical issue will be whether some or all of these grant projects are grandfathered into the new program. If all such projects are grandfathered, the new priority method will have no impact on the grants awarded for several years to come.

5. POLICY RELATED ISSUES TO BE CONSIDERED IN METHODOLOGY REVISION

As indicated above, there are a number of ways in which the current grant construction methodology could be modified. In changing the methodology, the VA will have an opportunity to incorporate variables in the decision making process that will result in the funding of projects that meet veterans' needs and reflect the strategic direction of the Agency.

We recommend that the VA and its stakeholders address answers to the following questions as part of the revision effort:

Issue	Questions for Policy Makers
Framework	Will the priority method be hierarchical or non-hierarchical? What variables will be used to assign priorities to grant requests? In what order will the variables be sequenced or what weights will be assigned to them?
Two Distinct Funds	Will two distinct funds be used for bed-producing and renovation projects? What percentages will be used to split the budget appropriation into two funds?
Information Requirements	What information must States submit with each grant application? What penalty be imposed for noncompliance or late submissions? How will new information be collected, maintained, or processed?
Obligated State Funds	Will States be required to obligate funds? Will the State match vary according to request type?
Unmet Bed Need	Will the definition and measurement of need be changed? Will need be based on all veterans or veterans likely to use State homes? Will need be based on current estimates or projections of the veteran population? Will need be supply or demand driven?
Alternative Sources of Care	Will alternative sources of care be factored into the grant award formula? Which alternatives? Beds in existing State homes? Beds in community nursing homes and/or domiciliary homes? Beds in VA facilities? Substitutable services offered by noninstitutional providers? How will the alternatives be measured?

STATEMENT OF DISCLOSURE

Birch & Davis Associates, Inc. conducted the "Alternatives for Redesigning VA Strategy for State Veterans Home Capital Investment Decisions" under the VA Management Studies and Analysis Contract, Contract Number V101(93)P-1442, Task Order 19. The total value of this contract was $313,727.

PAMELA FISH ZINGESER
Principal

BIRCH & DAVIS ASSOCIATES, INC.

PROFESSIONAL EXPERIENCE

Since joining Birch & Davis Associates, Inc. (B&D), in 1979, Ms. Zingeser has engaged in the full spectrum of traditional management consulting efforts. She has provided short-term technical assistance; conducted nationwide training events; directed large-scale survey research activities; and conducted a host of program/project evaluations. Her expertise in health care financing is derived from her work with numerous Federal and State agencies and a variety of private-sector clients, including health maintenance organizations (HMOs), community health centers, and third-party payors.

During her more than 17 years with the firm, Ms. Zingeser has directed a number of large-scale task order/technical assistance contracts and has demonstrated a keen ability to manage multiple assignments that cross a number of technical areas. She received her master's degree in health care administration with a concentration in health care planning from The Johns Hopkins University.

At present, Ms. Zingeser directs the management studies related task order contract for the Department of Veterans Affairs. As Project Director, she is overseen the following engagements:

- **Re-Designing VA's Strategy for State Veterans Home (SVH) Capital Investment Decisions**—B&D conducted a review of the VA's State Home Construction Grant Program and developed alternative methodologies for prioritizing State grant applications. B&D researched alternative models and methodologies for needs assessment; designed a survey instrument and collected data of SVH patient and facility characteristics; and conducted site visits of select facilities to assess the range of services provided and the characteristics of the veteran population being served.

- **Evaluation of Primary Care Delivery at the Veterans Affairs Medical Center, Altoona**—B&D conducted an efficiency review of the James E. Van Zandt Medical Center's primary care delivery system and provided alternative methods for staff utilization and coverage of primary care clinics, inpatient and emergency duties.

- **Conduct the Veterans Health Administration (VHA) Under Secretary's National Survey of VA HIV/AIDS Treatment and Prevention Programs**—B&D conducted the VA's national survey of all VAMCs as well as 1,000 HIV/AIDS hands-on providers to obtain current information about the status of prevention and treatment services for HIV disease in the veterans health care system; and identified factors that facilitate or impede the provision of comprehensive care for HIV disease in the VA health care system.

- **Apply Private Sector Best Practices to VHA Strategic Planning**—B&D assisted the VA in evaluating VHA's strategic planning process. As part of this effort, B&D identified private sector best practices to improve the organization and content of VHA's strategic plan as well as VISN business plans; reviewed 22 VISN business plans against private industry best practices; and providedassistance to the VA in the development of *Journey of Change, Volume II.*

- **Review and Assess the VHA's Surgical Programs and Processes**—B&D assisted the VHA in assessing the productivity, efficiency, and effectiveness of the surgical care program nationwide. As part of this effort, B&D conducted site visits to 20 VAMCs to identify opportunities to improve the pre-operative, intra-operative, and post-operative processes and collected benchmark data to compare the VA to private sector organizations. This effort will result in a series of recommendations to the VA to improve the efficiency of their surgical program.

- **Veterans-Focused Business and Information Technology Integration Program**—B&D and its subcontractor, CACI, Inc. are providing technical advice to the Office of Information Resources Management on the use of present and future information technologies (IT) to ensure that VA uses such technology to provide better service to veterans and other customers. This will include development of an IT vision; provide advice on how VA's business plans, processes, and objectives fit into the IT vision; and recommend how they should interface. B&D will also assist in the development and implementation of a veteran-centered IT architecture.

- **Provide Requirements Analysis, Technical Design, Software Development, and Implementation Assistance for DHCP Diagnostic Radiology Imaging System**—The DHCP Imaging System allows for clinical images to be inserted into the VA electronic patient medical record. B&D has been engaged to recommend DHCP software enhancements to provide better quality imaging capability for VAMC radiologists performing diagnostic interpretations.

- **Evaluate VA/DoD Data Sharing Requirements And Recommend An Approach To Permit Electronic Transfer Of Medical Data And Information**—B&D has been engaged to identify data sharing requirements for both DoD and VA facilities and to provide recommendations for implementing a standardized technical solution permitting electronic transfer of patient laboratory related data.

- **Develop Computer-Based Orientation and Training for Compensation and Pension (C& P) Examiners**—B&D and its subcontractor, Learning Sciences Corporation, has been engaged to develop a computer-based orientation and training package, which will provide C&P examiners with the opportunity to master appropriate skills and learn the information required for conducting C&P exams.

- **Development Of A Specialized Multimedia Database To Instruct VA Medical Center Staff In The Development Of Clinical Pathways**—B&D and the Learning Sciences Corporation are developing a multimedia training package regarding the process used to develop clinical pathways.

- **Develop a Training Program to Enhance Clinical and Administrative Abilities of VA Executives**—B&D and its subcontractor, Roger Schank and Associates, has been engaged in an effort to create a VA chief of staff training course using goal-based scenarios. Goal-based scenarios will be used to train newly appointed VA chiefs of staff

in redesigning their organizations to accommodate new approaches to health care delivery.

- **Determine Costs and Benefits of Introducing and Operating Filmless Radiology Technology**—B&D is the prime contractor for this effort to provide an economic and operational analysis of the Baltimore VAMC filmless radiology system.

- **Tennessee Veterans Administration Medical Centers(VAMCs)**—Ms. Zingeser directed a strategic planning effort for the Memphis, Nashville, Murfreesboro, and Mountain Home VAMCs to develop a consolidated business plan to respond to the rise of managed care and health care reform initiatives at the national and local levels.

- **Atlanta Veterans Administration Medical Center (VAMC)**—Ms. Zingeser facilitated a multidisciplinary task force responsible for restructuring health care delivery at the VAMC. Issues focused on emphasizing patient centered care, primary care team development, organizational streamlining and flattening to achieve high quality and efficient health care.

- **Philadelphia Veterans Administration Medical Center(VAMC)**—Ms. Zingeser worked with the Philadelphia VAMC to explore the potential for expansion of their women's health care program. This effort involved conduct of focus groups, market research, data analysis, and strategic planning.

Prior to her work with the Department of Veterans Affairs, Ms. Zingeser has conducted a wide variety of engagements for the U.S. Department of Health and Human Services, State agencies, and private sector organizations. They include:

- **National Child Health Leadership Conference**—Since 1990, Ms. Zingeser has been one of the key architects and coordinators of this annual national conference. The conference has focused largely on health care reform initiatives at the federal and state levels and how they will impact child health and general health care delivery. The conference includes more than 400 attendees and a speaker panel of more than 70 prominent experts in child health and health care reform.

- **National Association of Community Health Centers**—Ms. Zingeser developed and conducted a series of national training seminars for community health centers on changes needed in management information systems to support managed care initiatives.

- **Virginia Department of Medical Assistance Services**—For the Virginia Department of Medical Assistance Services, Ms. Zingeser assisted in the development of alternative patient-focused models for the inclusion of the mentally disabled population in a mandatory managed care plan in Northern Virginia. To conduct this effort, she supported the activities of a 40-member task force which included: mental health providers, consumers, community service boards, family members, health maintenance

organizations, and representatives of state and local governments. Results of this effort were presented to the Virginia legislature.

- **Office of the Assistant Secretary of Defense, Health Affairs (OASD/HA)**—Ms. Zingeser directed a major project to provide policy analysis and statistical support to the Department of Defense regarding the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). As part of this effort, B&D provided support to CHAMPUS in the areas of claims processing systems and enhancements, redesign of the military health benefit, and analysis of selected health care projects. While under Ms. Zingeser's direction, B&D prepared a cost analysis of the National Military Family Association proposal for a military health benefits program; performed an evaluation of the costs associated with implementing an occupational therapy benefit; and prepared briefings on health reform initiatives.

- **National Institute on Drug Abuse (NIDA)**—Ms. Zingeser was the Project Director for the 1990 and 1991 National Drug Abuse and Alcoholism Treatment Unit Survey (NDATUS). NDATUS is a facility-based survey of virtually all drug abuse and alcoholism treatment and prevention programs in the United States (approximately 13,000 facilities). Data collected are used by public and private researchers, Congress, Federal agencies, State and local governments, and others to assess the nature and extent of these resources, identify gaps in service, and provide a database for treatment referrals.

- **Health Care Financing Administration (HCFA)**—Ms. Zingeser recently completed a contract funded under the Small Business Innovative Research (SBIR) program to design a guidance manual to assist States in implementing Medicaid prepayment programs. This contract resulted in the development of a detailed outline of the manual that was reviewed by selected States participating in prepaid Medicaid efforts.

- **Pennsylvania Department of Public Welfare**—Ms. Zingeser conducted the first-year evaluation of the HealthPASS program—a Medicaid Health Insuring Organization (HIO) demonstration program in Philadelphia County. The evaluation was conducted in an extremely short time and examined quality of care, access to health services, and cost of the HealthPASS program as compared to the traditional fee-for-service Medicaid program. Contract activities included personal interviews with HealthPASS staff, clinical providers, and community members as well as data collection from the State of Pennsylvania and the HealthPASS program.

- **Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance (BHCDA)**—Ms. Zingeser directed several major contracts for the Bureau of Primary Health Care (formerly BHCDA) to help community health centers (CHCs) remain financially viable through third-party revenue maximization. Under these contracts, Ms. Zingeser surveyed virtually all CHCs engaged in Medicaid prepaid risk contracts to determine the array of revenue enhancement activities under way. She has also conducted in-depth site visits to selected CHCs to further explore their financing schemes and managed the delivery of technical assistance to nearly 25 such centers. As

part of these efforts, Ms. Zingeser co-authored and managed the production of several monographs and training seminars in the area of prepaid risk contracting for CHCs nationwide. Topic areas included: "Preparing for Prepaid Health Services—A Challenge for Community Health Centers," "Managing Referral Service Costs Under Prepaid Risk Contracts," and "Community and Migrant Health Centers Critical Performance Measures for Prepayment."

- **Health Resources and Services Administration, Office of Health Maintenance Organizations (OHMO)**—For several years, Ms. Zingeser directed this national HMO technical assistance (TA) contract. Through this contract over 200 HMOs nationwide have received TA in the areas of finance, marketing, health services delivery, management, and management information systems. In addition to TA, over 150 consultants conducted technical assessments in the same specialty areas to determine the HMOs' ability to receive Federal Qualification. Ms. Zingeser assisted OHMO in managing the network of consultants and supervised the financial administration of the contract.

- **Veterans Administration (VA)**—Ms. Zingeser developed and directed an executive development seminar series for VA Medical Center Directors throughout the country. These week-long seminars focused on emerging trends in the health care industry and examined such areas as trends in health care financing; HMOs; health information systems development; medical ethics; health care technology; issues in long-term care; and a variety of other topics.

Prior to these efforts, Ms. Zingeser worked with representatives of the Department of Health and Human Services, Office of Emergency Medical Services (EMS), and representatives of the Egyptian Ministry of Health to develop an evaluation design for A.I.D.-funded EMS services in Egypt.

Other assignments illustrative of Ms. Zingeser's management skills include:

- **National Institute of Mental Health (NIMH)**—Ms. Zingeser directed a study of the impact of mental health services utilization on general health care utilization and costs. Claims and eligibility related data were analyzed for Medicare beneficiaries and Medicaid enrollees from several States.

- **Health Care Financing Administration (HCFA)**—Ms. Zingeser conducted a nationwide survey of long-term care and related institutions. The purpose of the survey was to identify the extent to which Medicare beneficiaries are institutionalized in selected county areas. Data collected through this survey was used by HCFA to calculate prospective reimbursement rates for health maintenance organizations participating in the Medicare Competition Demonstration Program.

- **National Institute on Drug Abuse (NIDA)**—Ms. Zingeser provided technical assistance (TA) services on a national basis to Single State Agencies and drug abuse treatment centers in the areas of general management, client record-keeping systems, program

development, operations, and evaluation. Under the national technical assistance contract Ms. Zingeser completed the following assignments:

— **California Department of Alcohol and Drug Programs**—Ms. Zingeser designed a technical assistance system for the State of California to respond to the needs of substance abuse programs in the areas of financial management, program administration, clinical management, and prevention. Under this assignment, she developed a detailed operations manual describing the system and conducted a series of TA training seminars for senior management staff and TA providers throughout the State. The TA training concentrated on (1) the purpose, methods, key principles, optimal conditions, and limitations of technical assistance; (2) the role of the TA provider; (3) the technical assistance process, i.e., problem identification, TA mode and provider selection, needs and resource assessment, task plan development, monitoring, and evaluation activities; and (4) a system for managing, providing, and coordinating technical assistance efforts among State, county, and program/clinic levels.

— **New York State Department of Substance Abuse Services**—Ms. Zingeser conducted several training seminars for representatives of substance abuse programs in New York State. The first seminar series, "Effective Outreach Practices," was designed to identify the range of successful outreach practices employed by substance abuse programs in the State. These seminars resulted in the production of a summary report, which was made available to programs statewide. A second seminar series, "Development and Implementation of Client Fee Systems," was presented to substance abuse program Executive Directors and Financial Managers in the State. These seminars presented unit cost methodology, development of sliding fee scales, implementation of patient billing systems, and procedures for collecting accounts receivable and following up on delinquent accounts. In addition, the training explored methods used to: (1) monitor and evaluate a patient fee system; (2) prepare program staff for system implementation; (3) conduct clinical staff sensitivity training; and (4) inform patients of their financial obligations.

- **Health Care Financing Administration**—Ms. Zingeser completed a major evaluation of seven statewide demonstration projects designed to collect and disseminate integrated, uniform hospital discharge, billing, and cost data. As a State Manager, Ms. Zingeser was responsible for the evaluation in two of the seven States. In this capacity, she examined such issues as:

— Data quality

— Timeliness of the data
— Cost-effectiveness of the data systems

— Usefulness of the data to the user community

— Structural and political factors influencing the development and outcome of the system

— Replicability of such a system nationwide

To carry out the evaluation, Ms. Zingeser worked directly with several hospitals in each State, health planning and regulatory agencies, major third-party payors, prominent members of the research community, and others. She identified the impact of these Integrated Data Demonstration (IDD) systems in each State through pre- and post-IDD implementation studies involving:

— The conduct of a major user survey
— Documentation of the organizational and political factors impacting the IDD
— Descriptions of data flow patterns in the test sites
— Identification of personnel costs associated with activities under study
— Description of computer-related support involved in the IDD system

- **Health Care Financing Administration**—Ms. Zingeser assisted in the development of a Medicaid expenditure database for care provided to the chronically mentally ill. Data collected from a sample of States will be used to develop projections of the total cost of care for the chronically mentally ill in the United States.

- **Agency for International Development**—Ms. Zingeser provided consulting services to the Agency for International Development (A.I.D.). In this regard, she participated in the development of an information documentation management system for the Office of Development Information and Utilization (DS/DIU). The project involved:

  — Documentation of the sources and flow of information within A.I.D.

  — Identification of information that must be acquired and retained by DS/DIU to satisfy the information needs of A.I.D.

  — Documentation of the methods used by A.I.D. to acquire development information

Prior to joining B&D, Ms. Zingeser was an Administrative Resident at the Boston Hospital for Women, a division of the Affiliated Hospitals, Inc. In this capacity, she worked closely with senior management and members of the hospital staff to develop and implement various stages of the Boston Hospital for Women's merger with two major teaching hospitals in the Boston area. In this regard, Ms. Zingeser served as a member of selected interhospital committees charged with the responsibility for:

- Consolidation of departmental personnel and equipment
- Development of uniform departmental policies and practices

In addition to her role in the merger process, Ms. Zingeser engaged in a variety of other hospital activities including:

- Maintaining primary responsibility for the financial management of a tuberculosis screening program conducted by the hospital

- Preparing an analysis of the hospital's outpatient registration/billing system; working with the finance department and administration to upgrade the system and to ensure its compatibility with those of the hospital's other divisions

- Managing the first multidisciplinary audit of the quality of care provided in the hospital's Teen Pregnancy clinic, involving the participation of the Medical, Nursing, Social Service, and Dietary departments

- Designing a Diagnostic Service Manual that served as the primary resource guide to the laboratory areas for members of the medical, nursing, and support staffs throughout the hospital

- Participating in the development and implementation of a marketing program for the hospital

- Developing patient health education material related to prenatal genetic diagnosis

In addition to her experience in the hospital sector, Ms. Zingeser has worked in a variety of other health care settings:

- **Philadelphia Health Management Corporation**—As an instructor of cardiopulmonary resuscitation and emergency care, Ms. Zingeser conducted a series of training and certification programs throughout Philadelphia.

- **Philadelphia Department of Public Health**—Ms. Zingeser documented the distribution of physicians in Philadelphia by health district and medical specialty. She also assisted the Department in the control of infectious disease outbreaks in Philadelphia.

- **Rabinowitz Center for Disease Detection and Prevention, University of Pennsylvania**—Ms. Zingeser participated in a Disease Screening and Health Education Program at the Center.

CHRONOLOGICAL SUMMARY OF EMPLOYMENT

Agency	Date	Title
Birch & Davis Associates, Inc.	1979 to Present	Principal
Boston Hospital for Women	1978 to 1979	Administrative Resident
Philadelphia Health Management Corporation	1976	Instructor/Coordinator
Rabinowitz Center for Disease Detection and Prevention	1975 to 1976	Disease Screener/Health Educator

Philadelphia Department of Public Health	1974 to 1975	Intern

EDUCATION

The Johns Hopkins University, School of Hygiene and Public Health, 1979, MHS, Health Care Planning/Administration
University of Pennsylvania, 1977, BA, Health Care Administration, Sociology
University of Pennsylvania, 1973-1975, BS Candidate, Nursing

PROFESSIONAL AFFILIATIONS

Member, American Public Health Association
Member, Executive Committee, The Johns Hopkins University, School of Hygiene and Public Health, Society of Alumni
Chairperson, Society of Alumni, Activities Committee, The Johns Hopkins University, School of Hygiene and Public Health
Member, Society of Alumni, Annual Program Committee, The Johns Hopkins University, School of Hygiene
and Public Health

LANGUAGE CAPABILITY

Spanish

Testimony of Steve Watson
Administrator, Ocala Haborside Healthcare Nursing Home
On behalf of the
American Health Care Association
Before the
House Committee on Veterans Affairs
Health Subcommittee

Good morning, Chairman Stearns and members of the subcommittee, my name is Steve Watson and I am the administrator of Harborside Healthcare, a 180 bed nursing home in Ocala, Florida. I am here today representing the American Health Care Association and as a nursing home operator with 15 years experience in the field. AHCA's member nursing homes have long been a partner with the VA in the provision of long-term care for veterans. AHCA is eager to continue working with the VA and to be a part of the solution to serving the long-term health care needs of veterans. We appreciate the invitation from you to testify on the Federal Advisory Commission's study on the future of VA long-term care. [full name of the study-- *VA at the Crossroads: The Federal Advisory Commission on the Future of VA Long-term Care.*]

I come before you today both as a nursing home administrator with nearly 15 years experience and as a veteran, having served 18 years in the U.S. Navy. This combined experience gives me a double set of concerns and allows me to see these issues from both sides of the fence. I believe when a veteran needs long-term care and needs to go into a nursing facility, he or she should have access to facility care as near as possible to home to facilitate visits from family, relative and friends.

As our society ages, we have been hearing more and more about long-term health care. As a nursing home administrator, I am well aware of the large population that will require long term care in the coming years and fully realize how important it is that solutions be put in place now to resolve the challenge of providing and paying for long term care. I commend the work of this Committee in recognizing that solutions must be found to the problem of providing and paying for care. We were invited to take part and we were an active participant on the Federal Advisory Commission that prepared this study. Generally, we support the report's findings and I would like to point out some of the specific recommendations that AHCA supports.

AHCA supports the recommendation that the VA should retain its core of VA operated long-term care services and improve the efficiency of operations. We especially agree with the recommendation that most new demand for care should be met through contracts and existing State Veterans Homes. The use of contracting such as through the Multi-state Contract program allows the VA to meet need when and where it arises without heavy investment in more infrastructure. The VA has a long established infrastructure and may not need new construction to fulfill its obligations to our veterans. We feel it is important that the VA have the flexibility to dedicate their dollars to services and not necessarily to expensive construction projects.

The VA provides services along the entire continuum of care—adult day health care, home based primary care, respite, and nursing home care; but its no surprise nursing home care receives the largest allocation of the long-term care budget. The VA provides nursing home care three ways: Nursing homes connected with VA Medical Centers, State Veterans Nursing Homes, and the Community Contract Nursing Home Program. AHCA member nursing homes partner with the VA in the Community Contract Nursing Home Program. The VA initiated this multi-state contract program in 1996 to secure agreements with nursing home companies that would offer beds nationwide with substantial benefits to the VA, thus allowing the veteran to access nursing home care in their communities and near their families. Through a "best value" competition, the VA awarded contracts to seven companies and will expand the program this year by allowing local and regional long-term care providers to participate in addition to the multi-state providers. We are proud of our participation in this program and confidently endorse its continuation, offering convenient long-term care services to veterans in an efficient manner. We understand that the VA is truly at a crossroads in trying to meet demand for services while having to meeting a reduction in staffing. Through the Community Contracting program, we can help the VA meet those goals without sacrificing quality, services and even achieving cost savings where needed.

Another way the VA provides nursing home care to veterans is a program that offers grants to states for facility construction and renovation through the State Veteran Nursing Home program, paying up to 65% of construction costs. Also, the VA subsidizes a portion of the daily care at these state facilities through a per diem payment. AHCA agrees with the Commission's recommendation that the VA should not seek funding for any new facilities except those justified by objective standards and by a lack of existing community need or capacity. We also agree that renovation projects that affect life and safety should receive higher priority.

Currently, the VA must use a priority system that is written into the U.S. Code for funding grant requests to build new State Veteran Nursing Homes. This funding methodology gives a high priority to states that do not currently have a State Veteran Nursing Home and also to those whose grant requests already guarantee all needed state dollars. We are concerned that this methodology is silent on the community's capacity to serve veterans in existing community nursing homes. Let me give you a few examples to illustrate why we believe this practice should be reassessed.

In Louisiana, the state government is contemplating the approval of three additional veterans homes. This state already has veteran homes in three other communities. Right now, Louisiana's private nursing home industry is operating at an average annual occupancy rate of only 81%-- which is very low. While I am supportive of veterans, in areas where the community's existing capacity can serve the vets, I believe the funding priority system should take into consideration the availability of capacity in its priority-setting process.

Let me briefly cite another example. In Minnesota, the state legislature instituted a moratorium on new nursing home bed construction in 1983. Moratoria are put in place by state governments when too many beds already exist; this helps to contain Medicaid costs. Despite this moratorium the Minnesota legislature authorized three new State Veteran Nursing Homes to be built. Each time one of these three State Veteran Homes opened, there was a corresponding decrease in community nursing home occupancy rates in the state. This can jeopardize viability of community nursing homes and put existing residents at risk.

In California, with an 86% occupancy rate in non-governmental nursing homes, we have more than enough capacity to serve veterans in those facilities. California continues to send grant requests to the VA to build more homes. I believe veterans want a choice of where to live if they are going to access the VA's long-term care system and accepting veterans in existing community facilities would provide that choice without incurring expensive new construction.

Lastly, I want to tell you about a private nursing home in Louisiana that provides special programs for veterans. Col. Bryan Batulis, a retired Marine, opened a wing of a private nursing home in Napoleonville, Louisiana, specifically to serve local veterans, called Veteran Memorial Hall. The last Thursday of each month offers a Veteran Social and members of VFW chapters around New Orleans come to the nursing home for the event with the residents. Additionally, the nursing home provides special programs for vets such as a daily ceremony where the P.O.W. flag with the U.S. flag are raised and lowered in military tradition. Right now preparations are underway for a Memorial Day program, which traditionally involves the governor. I tell you about this example because I want you to know that community nursing homes can offer specialized support for vets.

We agree that the VA should not abandon its three nursing home programs, but attempt to operate them in the most efficient and effective manner possible. We are supportive of VA's efforts to offer veterans long term care services along the continuum of care. Not all patients needing long-term care must enter nursing homes, and veterans should have choices that include home and community-based care when they are an appropriate setting for the patient. Also, we know the VA is prohibited from financing assisted living care for veterans, and we commend the Commission for recognizing that many state VA programs are moving in the direction of including assisted living in the services they offer. We would support the VA seeking legislative authority to allow for the payment of assisted living through contracting with private assisted living facilities. What is important is the appropriate care environment for the veterans and we support efforts by the VA to determine the best environment and provide access.

I want to commend the Commission on their development a long-term care quality index that would standardize and measure the quality of care delivered to VA health care beneficiaries. The process would include an assessment for patients over age 70 who are potentially at risk for needing long-term care services. The veteran would undergo a comprehensive assessment that would screen him on functional status. The model also

includes care coordination with an interdisciplinary treatment plan. We are pleased to see that outcomes will be monitored and studied. AHCA strongly supports the use of outcome measures, quality indicators, and resident satisfaction measurement to continuously monitor and improve quality in long-term care. We are proud to see the VA at the forefront on long-term care quality as well.

Thank you for inviting me to testify. We look forward to policy options the Committee and the VA will recommend as solutions to providing long term care for vets. We want to continue to be actively engaged in developing those solutions and we offer our full assistance. Thank you, Mr. Chairman.

The American Health Care Association does not receive federal grants or contracts relevant to Medicare, Medicaid or long-term care services for U.S. veterans.

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RESUME OF QUALIFICATIONS

EDUCATION:	FLORIDA TECHNICAL UNIVERSITY B.S. NATURAL SCIENCE
	CONTINUED EDUCATION (University of Central Florida) One year Post Graduate Studies in Public Health Service 1983
LICENSES:	NURSING HOME ADMINISTRATOR State of Florida Department of Health and Rehabilitation Services 1985 – Present

EMPLOYMENT HISTORY:

May 1987 – Present:	Administrator, Harborside Healthcare, Ocala Florida
June 1986 – 1987:	Administrator, Chateau Vivon Nursing Home, Daytona, Beach, Florida
May 1986:	Administrator during Receivership, Glades Healthcare, Pahokee, Florida
1984 – 1985:	Assistant to Administrator, Ocala Geriatric Center, Ocala, Florida
1974 – 1984:	General manager, Durham Young Outpatient Clinic, Leesburg, Florida
1972 – 1974:	Medical Records Administrator, Lake Community Hospital, Leesburg, Florida
1972:	Medical Records Consultants, Okaloosa County, Florida
1951 – 1969:	Retired after 18 years of service in the United States Navy

Statement By

Managed Care Solutions, Inc.

Mr. Richard Jelinek
Senior Vice President

on

Veterans' Long Term Care

Before the
Health Subcommittee of the
House Veterans' Affairs Committee

April 22, 1999

Chairman Stearns, Congressman Gutierrez, and Members of the Health Subcommittee. Thank you for inviting our company, Managed Care Solutions (MCS), to testify this morning. We have been asked to describe our experience assisting government agencies, such as state Medicaid programs, in improving access to long-term care and other medical care services for frail, elderly and disabled individuals. In addition to increasing access for chronically ill individuals, the state programs we are involved with also focus on quality improvement initiatives and stabilizing the growth in expenditures. We hope this information will be helpful as the Committee considers how best to provide long-term-care services to veterans.

Managed Care Solutions is a national health care company, specializing in the administration of long-term care services. Currently, MCS is providing care management and other services to over 170,000 people in seven states--most of whom are Medicare- or Medicaid-eligible, and some of whom are veterans. MCS is not a traditional Medicare or Medicaid HMO, but rather a full service care management company serving the chronically ill.

MCS' contract with the State of Arizona is now in its 10th year, and was the first risk-based Medicaid long-term-care program in the country. One of our more recent contracts is the STAR+PLUS demonstration in Houston, where we have teamed with Blue Cross Blue Shield of Texas to provide care management services to 19,000 high risk, Medicaid-Medicare-eligible individuals.

There are several reasons why we believe our experience as a Medicaid contractor is relevant to the work of this Subcommittee and the mission of the Department of Veterans Affairs.

- First, states are grappling with a demographic challenge similar to that facing the VHA: namely, a population at risk for long-term-care services that is expected to increase five fold in the next four years;

- Second, the key elements in our tested care management approach mirror almost exactly the recommendations of the Federal Advisory Committee on the Future of VA Long-Term Care; and

- Third, putting this approach into practice in Arizona has demonstrated success by:
  - Increasing access to long-term care and other medical and social services;
  - Improving the quality and continuity of care for individuals receiving the services;
  - Controlling costs by increasing the members receiving home and community based services from 7% in 1989 to 46% in 1998;
  - Achieving an average total program and administrative cost savings of 17% per year for the past 10 years; and
  - Spending approximately 22% less than traditional fee-for-service Medicaid programs in other states.

In addition to these benefits, the Arizona program has also given the State the ability to project more accurately and manage the growth in both the demand for services and the cost of services to this population.

It's worth noting that fewer than one percent of this country's long-term care recipients are currently in managed care programs. However, the states are intensifying their search for alternatives to fee-for-service programs, because they do not have sufficient resources to meet the dramatic escalation of service needs and projected costs. Arizona, Texas and Minnesota have already implemented managed long-term care programs. New York is planning a managed long-term care plan implementation in the near future, and at least eight more states are likely to implement or dramatically expand Medicaid managed long-term care programs within the next one to three years.

The critical success factors in our care management approach match the Federal Advisory Committee's recommendations to the VA.

The first element contributing to our success is a comprehensive, integrated and coordinated continuum of services, which includes:

- Medical care
- Prescription drugs
- Behavioral health services that address depression, other mental health issues and substance abuse services
- Institutional care (assisted living, nursing home services, etc.), and
- Social issues such as access to appropriate care givers and supports

It cannot be overstated that unless all the services in the continuum are available and coordinated, it is impossible to optimally manage each individual's care--because we will have to provide someone with more or less care than they actually need or put a patient in a setting which may actually reduce his or her quality of life.

The second success element is a highly trained care manager, usually an experienced nurse or social worker, who works directly with patients, their families or care givers, and their personal physicians to:

- Assess each individual's medical, social, behavioral, long-term care and home and community services needs;
- Consult the patient, the patient's family, the patient's physician, about their concerns and preferences, and include the patient in many decisions about his/her plan of care;
- Identify the best service plan and the least restrictive setting in which to meet the patient's needs; and

- Arrange for the services to be delivered, and then re-assess the patient on a regular basis to assure that the patient's plan of care is followed, and that the patient and family are satisfied with the provision of services.

The third element is a state-of-the-art information system that incorporates our cumulative history of patient care. At MCS, each care manager carries a laptop computer with software designed to perform care assessments in real time. The software contains:

- Each patient's medical assessment, including all medications being used by the patient, and all physicians and service providers who are treating the patient;
- A socioeconomic profile;
- A psychological assessment;
- A functional assessment; and
- Alternative options for services, providers, home and community placements, institutional placements, and durable medical equipment.

The care manager enters the patient's assessment into the system, and the system analyzes the data, highlighting issues pertaining to the level of care the patient may need, and identifying optional ways to meet the patient's needs. The care manager then reviews the options, consults with the patient and the patient's family, and then authorizes a plan of care.

There are several aspects of this assessment and care plan that I want to draw to your attention:

- Our care managers are trained as advocates for patients and their families, so they are trying to achieve three objectives simultaneously:
  - Improving the patient's quality of life;
  - Serving the patient in the least restrictive, least disruptive setting --while also addressing his or her full range of needs; and
  - Using the most appropriate resources.

- Because they are balancing these factors, care managers do not necessarily select the lowest cost alternative for every patient.

- Care managers serve some patients in rural areas where there are not geographically accessible nursing home or home- and community-based services. In order to get those individuals the care they need without relocating them hundreds of miles from their families, we have had to hire and train local residents to provide the non-medical supports that make it possible for patients to remain in their homes.
  These support services include housekeeping, meal deliveries, transportation to physicians and treatment facilities, respite care for family members, home modification services such as wheelchair ramps and safety bars, etc.

- Care managers may find it necessary to locate health care providers willing to travel a significant distance to deliver the long-term care services our patients need.

These examples highlight **the fourth critical success factor, which is the necessity of identifying or creating alternatives to nursing home services wherever appropriate.** Over the last ten years, state Medicaid officials have realized that if all the individuals at risk of institutionalization are placed in nursing homes, the states will not only have major budget deficits in future years, but they will also be unable to serve all the people eligible for and in need of long-term-care services. To drive home this fiscal reality, states have required service providers and care managers to be at financial risk for providing services within a fixed fee per member per month. The state also monitors those providers and care managers for the quality of care that patients receive.

As care managers, we still place many of our patients in nursing homes, because even though that is the most expensive level of care, it is often the most appropriate placement to meet their needs. But we try to place patients in less costly and less restrictive alternative settings--such as assisted living, other congregate care or even their own homes--and then assure that they receive the kind and quality of long-term care services they need to address their illness or disability, and also improve their quality of life.

The final critical element in our success is quality assurance. We continuously monitor clinical outcomes, utilization and costs of the services our patients receive, and assure that we are meeting the stringent oversight requirements of the states.

Our highly trained staff monitor key clinical indicators such as:

- Influenza
- Pressure ulcers
- Hospitalization and emergency room use
- Activities of daily living
- Fractures related to falls
- Psychotropic medications
- Emergency room utilization during physician office hours
- Pneumonia immunizations
- Depression in nursing home residents
- Avoidable hospital readmissions
- Diabetic foot care to prevent amputations of lower extremities.

We are always engaged in clinical quality outcomes studies to improve our practice in the prevention and management of illnesses such as depression, asthma, diabetes and cancer.

I want to **re-emphasize the fourth element--developing alternatives to nursing home care--because that is undoubtedly the most important component of implementing a sound and affordable long-term care policy. Our experience is that unless the full range of long-term care services and settings is available, it will not be possible to stretch resources to serve substantially more veterans.**

We therefore agree with the Federal Advisory Committee's recommendation to amend VA legislation to:

- Broaden the provision of respite care in all settings;
- Allow for the payment of assisted living/residential care; and
- Expand the VA benefit package to include nursing home care when that is the appropriate service and setting.

We also support the Committee's equally important recommendations to:

- Expand options and services for home- and community-based care, making these services the preferred placement site, where clinically appropriate, for veterans needing long-term-care services; and
- Establish system-wide care coordination processes.

With regard to system-wide care coordination, we recommend that the Department **undertake several long-term care demonstration programs in order to test the impact of care coordination on the VA's ability to deliver long-term-care services to more veterans.** These demonstrations could be offered as incentives for VISNs to develop and manage long-term-care services in a manner that is responsive to local needs. Without some kind of incentive, and without an opportunity to test and learn, it will be difficult to successfully implement this kind of approach in a short period of time. We suggest that:

- Demonstration sites should include a sufficient number of veterans to be statistically significant.
- Demonstrations should be strategically placed in settings that reflect the variety of challenges facing VISNs and VA medical centers. For example, the mix should include both urban and rural regions, high density and scattered populations, areas with and without numerous existing community providers; and
- Demonstration sites should collect extensive data, and have an independent evaluation that includes an analysis of clinical and cost outcomes, veteran and family satisfaction, and effective management of the continuum of services.

We believe that broad distribution of information about these demonstrations and broad discussion of the experience of veterans and their families, as well as VA medical and administrative staff, will promote learning and excitement about the benefits of this approach.

Thank you for allowing us to share our experience with the Subcommittee. We will be happy to answer any questions, or to provide you with additional information.

Follow-up Questions
Concerning the April 22, 1999, Hearing

for
The Department of Veterans Affairs

from
The Honorable Cliff Stearns
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives

Note: These responses were prepared by Dr. Kenneth W. Kizer, prior to his departure as the Department's Under Secretary for Health and are representative of the Department's views.

1. Dr. Kizer, in your opening remarks, you testified that during the development of what became the Veterans Health Care Eligibility Reform Act of 1996, "we encouraged [Congress] to get long-term care and acute care on the same footing...[A]nd today under the law, long-term care is considered a discretionary program." You further stated, in response to a question about the marked variability in access to long-term care from VISN to VISN, that "'[y]ou have provided in law, on the one hand, a package of mandatory services that we have to provide. On the other hand, you have some discretionary things that you can provide if funding is available. In an era when our budgets are severely strained, we are providing the mandatory things that you expect and have said, have to be provided." In light of this testimony, please answer the following questions:

(a) At the request of the Committee's Chairman, you submitted a report dated May 7, 1996 on H. R. 3118, the Committee's health care eligibility reform legislation, the bill which provided the framework for the eligibility reform provisions of P. L. 104-262. In reporting on that bill, you observed that "[a] principal objective of the legislation is to make the delivery of health care to eligible veterans more rational by eliminating the current 'pre-, post-, and obviate' restrictions on outpatient care." You further stated, "In that respect, H. R. 3118 is consistent with VA's Reinventing Government II initiative and with the following [six cited] objectives which we consider essential to beneficial reform." Your letter was devoid of any reference to long-term care, of any implication that Congress should make any change to eligibility for long-term care, or of any hint that you anticipated that a two-tier system of care would arise as a result of the proposed changes. Please either provide for the record documentation of the recommendation you testified having made prior to enactment of P. L. 104-262 that acute and long-term care should be placed on the same footing, or correct for the record the April 22, 1999 statement to that effect.

Answer: You are correct in pointing out that at the time that the Congress was actively considering eligibility reform legislation I made no formal recommendation to the committee concerning long-term care eligibility. During the two years that I was directly involved in this issue there were myriad other communications about the matter than those which you reference; most of these were verbal. To the best of my recollection, my discussions about long term care were with Senate Veterans' Affairs Committee staff, and I do not know the extent that long-term care was considered as Congress completed its consideration of eligibility reform legislation. I have edited the hearing transcript to more specifically reflect what I recall having occurred.

(b) Insofar as your testimony purports to instruct the Committee as to the import of current law regarding a distinction between a "mandate" to provide acute care and the "discretionary" nature of long-term care services, please provide for the record whatever legal opinion you are relying on that expresses such a distinction.

Answer: I was not relying on any specific written legal opinion, but my understanding that there is a distinction in the law between so-called mandatory care, that the law says we "shall" furnish, and discretionary care, that the law says we "may" furnish. More specifically, it is my understanding that the law states that we shall furnish hospital and outpatient care to certain veterans, but that we may furnish various kinds of long-term care, including nursing home care, domiciliary care, and respite care. I have been advised that the distinction between the word "shall and the word "may" is one of priority. Thus we generally must try and give a priority to the care that Congress has said we "shall" provide. It is that notion of priority that I was trying to convey in my comments at the hearing. When there are competing demands for resources, VA officials try to give priority to furnishing acute hospital and outpatient care, which is considered mandatory, rather than discretionary long-term care.

(c) How, if at all, does current law preclude you from deciding – in the interest of optimal patient care – to enroll less than all category A and C veterans (or less than all category A veterans) and thereby (through such deployment of discretionary medical care dollars) enable you both to meet more effectively the long-term care needs of those enrolled and to minimize the variability in access to long-term care services from VISN to VISN?

Answer: It is my understanding that by distinguishing in the law between care that we "shall" furnish and care that we "may" furnish, Congress intended that we give a priority to the former over the latter. I am advised that this distinction first appeared in the law in 1986, with passage of Public Law 99-272, and that the legislative history of that Public Law clearly indicated that Congress intended that VA give a priority to the care that we "shall" furnish. Accordingly, I believe we could curtail care to category C veterans (those to whom we "may" furnish care) and reallocate those funds for long-term care. On the other hand, I believe it would be inconsistent with congressional intent for us to curtail care to category A veterans (those to whom we "shall" furnish care) and reallocate those funds for long-term care.

(d) Is it your testimony that you lack any tools or decision-making authority to reduce the disparity in veterans access to long-term care from VISN to VISN, as described in the advisory committee's report?

Answer: We intend to issue policy guidance aimed at increasing the consistency of decision-making regarding long term care across all VISNs. However, day-to-day operational decision-making authority is decentralized to the VISN level, and given the discretionary authority for long-term care services and the limitations on resources, some variability is inevitable.

2. Dr. Kizer, you have called for establishing parity between acute and long-term care. Isn't that a policy goal you can implement, through one of two approaches: either restricting enrollment to a number of veterans whose acute and long-term care needs can be met, or requesting substantially increased appropriations to meet both acute and long-term care needs of the expansive list of priority groups VA has heretofore invited to enroll?

Answer: We view current law as the expression of congressional intent regarding the priority to be given to long-term care services. We possibly could attempt to mandate a discretionary program through policy issuance, but I feel the best approach is for Congress to address the priority question and the attendant funding requirements.

3. In responding to post-hearing questions following a November 23rd, 1998 field hearing you indicated that you expected to make "more innovative use" of VA's hospital-based nursing home resources. Please clarify and expand on what you meant by that phrase; please provide examples.

Answer: It is anticipated that interdisciplinary clinical care teams will continue to assess the clinical care needs of individual patients and will be empowered and encouraged to develop comprehensive treatment strategies and plans that ensure that the patient is provided the right care in the right place at the right time. Significant emphasis will be placed on meeting, to the extent practicable, the needs of the patient in non-institutional settings. In appropriately reducing the amount of time that patients stay in the nursing home, it is expected that program resources will be made available for use in the development of innovative rehabilitative strategies that address a broader range of patients than have been traditionally served in the nursing home setting.

4. Dr. Kizer, you submitted for the record a draft version of a proposed strategic plan for VA long-term care. That paper's "Strategic Action XIV" calls for establishing "system-wide care coordination processes" based on a standardized comprehensive assessment tool. The paper proposes that VA "should reassign and train existing staff to implement such processes." In this regard, we would ask you to review the testimony provided at our hearing by Mr. Richard Jelinek of Managed Care Solutions (MCS). His testimony indicates that MCS provides long term care management services to chronically ill patients, and, by way of example, cites its long experience in furnishing such services contractually under a risk-based Medicaid long term care program.

(a) Given the recommendations of the advisory committee on long-term care to make greater use of contracting to meet non-institutional care needs, would the services of such an entity offer potential benefit to VA?
(b) Is that an approach worth testing vs. reassigning and training staff in a system which is already under severe staffing pressure in many areas?

Answer: VA's general approach to care management is to integrate the full spectrum of care needs, including long term care. We frequently use contractual services, if they are the best value approach, to meet part of the patient's care needs. VA needs to adopt more effective care management strategies that are integrated with all other VA care. I believe it is worth evaluating the effectiveness of services MCS offers, however, not as an alternative to making the improvements in VA care management that the strategic plan addresses.

5. The draft version of your proposed strategic plan for VA long-term care addresses the advisory committee's recommendation regarding assisted living services. It states that you staff would "initiate a request for new legislative authority for payment or co-payment of facilitated residential living (assisted living) for eligible veterans."

(a) Given the variety of so-called "assisted living" arrangements being marketed, what do "assisted living" services mean for purposes of providing a new benefit?
(b) How would you best describe the level of functional impairment, disability or medical need which would establish "eligibility" for this benefit?
(c) Could a veteran "apply" for this benefit, or would the individual have to be referred by a clinician or team?
(d) Would the determination that the individual did not meet the requisite level of functional impairment, for example, --and thus was not eligible for a monetary payment (to the veteran or to the "provider" on the veteran's behalf) -- be subject to appeal?
(e) Would payments or partial payments be made to the veteran or to the facility; what would you envision to be the rights and obligations of the parties?

(f) The fact that this proposed action plan is framed in terms of authority for "payment or co-payment" would suggest that such a proposal is at best in an early stage of development. Would it be fair to say that considerably more work needs to be done on this issue before the Department would be prepared to advance a legislative proposal?
(g) Assisted living services are often targeted at families with incomes well above the current VA means test levels; some of these facilities may offer relatively costly amenities. Accordingly, what would be the rationale and circumstances warranting payment in full?

Answer: As noted in the text of the question, VA action plans regarding legislative authority to provide "assisted living" services are in the earliest stages of analysis. The provision of such care would not likely be viewed as a new healthcare benefit but as a measured, clinically appropriate, cost-effective response to patient needs that, in the past, may have resulted in the clinically unwarranted utilization of hospital or nursing home care services.

It is anticipated that veterans most likely to seek and to benefit from assisted living arrangements would be those with impairments in individual ability to perform activities of daily living that effectively inhibit their ability to provide adequately for themselves in an independent living situation. A review of literature regarding the concept of assisted living appears to suggest that decisions regarding entry into private sector assisted living arrangements are based upon ease of access, personal choice and ability to pay, as well as clinical need.

VA has recently undertaken a studied analysis of potential payment or co-payment options that might be employed in the provision of assisted living services. Veteran eligibility, financial status, clinical need and personal choice must all be addressed in the development of payment or co-payment models.

It is believed that assisted living services could be provided through a number of service delivery models that might involve direct care by VA as well as partnering and/or contracting with private sector providers. VA fully supports the creative use of its Enhanced Use Lease Authority in the structuring of public/private partnerships intended to improve veteran access to high quality assisted living services.

6. Dr. Kizer, your chief consultant for geriatrics and extended care, Dr. Salerno, in responding to a question for the record following a November 23, 1998 hearing, stated that "the challenge in caring for older veterans (as well as for all older Americans) is to change the culture of health care to emphasize long term strategies that improve or maintain a person's functional capacity." Do you agree with that assessment? What oversight mechanisms would measure the extent to which such cultural change is taking place in VA?

Answer: Dr. Salerno's assessment is completely consistent with my own. We must monitor and measure our progress in meeting the challenge aptly described by Dr. Salerno through the development and system-wide application of uniquely designed clinical outcome measures, program performance indicators and stakeholder satisfaction assessment mechanisms.

7. The advisory committee on long-term care stated in its report (p. 16) that "VA's nursing home programs need restructuring...[Serious consideration of the size and nature of the programs, especially VANH, is indicated...[Any changes in program structure should be carefully managed."

(a) What is your understanding of what the advisory committee meant in concluding that "VA's nursing home programs need restructuring"?
(b) What are your views regarding the conclusion as well as the advisory committee's guidance that "serious consideration" should be given to the size and nature of the VA nursing home program?

Answer: Based on the Federal Advisory Committee's discussions on this issue, it is clear that they were concerned that planning for nursing home care was too program-specific and was not firmly linked to the need for care. The Committee envisioned the VA, community and state nursing home programs as connected to one another as well as to other long-term care services. The Committee wanted to see more evidence of joint efforts in strategic planning and budget formulation.

The Committee attempted to balance a number of factors affecting the delivery of nursing home care services. First, the Committee recognized that VA Nursing Homes (VANHs), as hospital-based facilities, are uniquely positioned to provide post-acute, rehabilitation and specialized care. Second, the Committee recognized that VANHs have a solid reputation for providing high quality care. Third, the Committee recognized that VANHs serve selected groups of patients who are extremely difficult to place in community nursing homes. Fourth, the Committee also realized that in certain parts of the country, VANH costs cannot be explained by higher levels of patient care needs, by higher levels of nursing staffing, or by other factors. VHA has concluded that VANHs must exploit their strengths as a hospital-based system, while providing continuing care to those patients who cannot be placed elsewhere or who have become long-term residents. Further, VHA has concluded that certain VANHs in the system have specialized missions and populations that are not readily available in the private sector.

8. Under current law, VA's adult day health care authority is limited to being provided as a follow-up to a period of hospitalization. (a) What are the programmatic implications of this limitation? (b) Would lifting this limitation offer veterans an option that would help defer or avoid institutionalization?

Answer: VA has provided Adult Day Health Care (ADHC) under Community Nursing Home (CNH) authority, which allows for the direct placement of non-service-connected veterans without prior hospitalization. This change to CNH authority was established in P. L. 105-114. From 1991 until the passage of P. L. 104-262, VA utilized the outpatient authority for ADHC. Expanded access to ADHC is unrelated to the exceptionally modest growth the program experienced through most of the 1990s. VA believes that the determination of whether or not a veteran should receive adult day health care should rely on a careful assessment of the veteran's individual needs, regardless of whether or not they have been hospitalized. Adult day health care is an important component of a comprehensive home and community-based care strategy and, when used appropriately, can help defer or avoid institutionalization.

9. Under current law, VA's adult day health care authority is also limited in duration to a period of six months. (a) What are the programmatic implications of this limitation? (b) What would be the likely effect(s) of lifting this limitation?

Answer: The six-month limitation on most patient placements in non-VA ADHC facilities is required by law. In the contract nursing home care program, veterans with non-service-connected conditions, who need services beyond six months can often be transferred to State Medical Assistance (Medicaid) Programs. That option does not exist in most states for patients receiving ADHC, since ADHC is not a federally mandated service under Medicaid. From a clinical/programmatic perspective, the limitation hinders VHA in using its resources most effectively to meet the long-term care needs of veterans with chronic illnesses.

Between 1991 and October 1996, when the six-month limit did not apply to the VA ADHC program, VHA experienced no unusual program growth or increased demand for ADHC services. Some veterans will need less than six months of adult day health care, and others will need more. The practical effect of lifting the six-month limit would be to offer greater continuity of care to certain ADHC sub-populations, notably veterans with dementia.

Follow-up Questions
Concerning the April 22, 1999, Hearing

for
The Department of Veterans Affairs

from
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives

Note: Dr. Kenneth W. Kizer, former Under Secretary for Health, is no longer with the Department. These answers represent the views of the Department of Veterans Affairs.

1. Dr. Kizer, does the $106 million request to come from management efficiencies VHA made for expanding home and community in FY 2000 adequately address the "urgent need" for this care you describe in your statement? Does it put VHA on target to meet the Advisory Committee's recommendation of tripling the portion of the budget invested in these programs in the near future? If VA continues to invest at the same rate as the FY 2000 request, will you be able to ensure these services comprise 7.5% of the VHA budget in five years?

Answer: The $106 million increase in home- and community-based care (H&CBC) for FY 2000 signals the Administration's commitment to expanding these services. "Same rate" increases in H&CBC alone would not reach the Committee's recommendation of 7.5% of VHA's budget invested in non-institutional long-term care.

2. In your opinion, is 6 months of care sufficient to provide patients who have conditions, such as Alzheimer's or other dementias, which will deteriorate over time? If you had more adequate resources what types of Long-Term Care services would you provide to veterans with these conditions?

Answer: Chronic, progressive disorders, such as Alzheimer's disease and other dementias, require a wide range of inpatient and outpatient health care services over a period of years. There may be considerable individual variation in what services are needed or preferred, at what time, and in what setting. Six months is not likely to be adequate for persons with Alzheimer's Dementia. In general, a comprehensive system would provide an integrated continuum of care throughout the course of the disorder, addressing both patient and caregiver needs over time; in home, community, and institutional settings and integrating VA-provided services with those provided under public and private insurance plans. Services would include early recognition and diagnosis, treatment of the target condition and co-occurring disorders from early to late stages, and planning and implementation of end of life care, as well as condition-specific education and training for professional and non-professional staff and families. As with other disorders, there would be multiple ways to provide these services, both directly in VA settings and indirectly through contracts or sharing agreements with community providers. Although VA provides many components of such a comprehensive system of care for veterans with Alzheimer's disease or other chronic conditions, additional resources would facilitate the development and integration of these components in every Veterans Integrated Service Network (VISN) in the VA system.

Time limitations on long-term care services are historically based, originating in the Community Nursing Home Program, as authorized in P.L. 88-450. The limitations address budget concerns, rather than patient need. They establish an

assumption that other payors will continue to finance the needed care. This assumption may not be correct in all cases.

3. What types of LTC are considered part of VA's basic benefit package, which any enrolled veteran should reasonably expect to receive if needed?

Answer: Home Health Care (HHC) services, including skilled care and homemaker/home health aide services and hospice care are included in the basic benefits package. VHA does not intend to preclude a veteran's choice of using other eligibilities, e.g. Medicare Home Care, to meet their care needs.

4. Does the VERA allocation model reimburse nursing home patients at the "special care" rate? How much nursing home care would this reimbursement cover in one year?

Answer: A patient classified as a nursing home patient is included in the Complex Care Group (previously called "Special Care") if he or she stays in the nursing home for more than 30 days. In FY 1999, the amount VERA allocates to networks for each Complex Care patient is $36,955. VERA does not limit the amount of nursing home care funded within a year. VERA is a capitation-based, prospective payment system rather than a reimbursement system; therefore, networks and facilities have the flexibility to treat Complex Care patients in the most appropriate manner and to balance the risk of Complex Care patients who will need more resources with those who need fewer resources.

In FY 1998, there were 32,753 Nursing Home patients (including care both within the VA as well as under contract) with total costs of $1.5 billion, this averages to approximately $45,000 per patient. The number of nursing home patients treated in FY 1998 increased by 5.8 percent from the FY 1997 level. This demonstrates that VERA provides the networks and facilities the flexibility to support the relatively higher costs of the nursing home care patients, because they have other populations of Complex Care patients that are relatively less costly.

5. Are you aware of how many facilities have changed the missions of their nursing home beds? How many still offer lifetime placement for new admissions? For patients that have resided in VA facilities for 1,000 days or more?

Answer: We do not maintain this data nationally. Most of our nursing homes that have changed their mission have set a target date for implementing the change. Those patients in the nursing home over the 1,000 days, but prior to the target date, generally remain in the nursing home unless it is clear that the nursing home cannot provide the care they require. New admissions after that date are informed that their stay will be limited and planning for continuing care is begun early in the stay. The patient and family/significant others are included in setting long- and short-term goals and discharge goals fairly soon after admission.

6. Does HQ monitor, in any way, how often VA refers its patients to Medicare or Medicaid or where in the system this is most likely to occur?

Answer: VHA has no reliable information at present on Medicare/Medicaid referrals for long-term care. Information will be captured on home health referrals, beginning in FY 2000.

7. In what situations will VA provide or reimburse home care services? What is the typical duration of VA's provision or reimbursement of this care?

Answer: VA provides direct home health care services through its Home Based Primary Care (HBPC) program. This is a comprehensive, interdisciplinary healthcare team approach to home care services. HBPC targets the chronically ill with multiple medical problems and physical impairments. There are also a growing number of patients who need short-term, post-acute home care. HBPC

patients must live in the designated service area, generally within 30 miles of the VA facility. The average length of stay in the HBPC Program is 5 months. VA also provides home health care through contracts and under the "fee" authority. These patients tend to be short-term and post-acute. The average length of stay is 2 months. VA purchases homemaker/home health aide services for the physically impaired, often in conjunction with the professional services, outlined above. Currently, length of stay information is not available for this program.

8. How does VA select the vendors to win contracts for providing non-institutional LTC to veterans?

Answer: Contracts for home health care are relatively new for VA. Contracts were authorized in P.L. 104-262. A recent survey indicated that less than a dozen VA Facilities had competitively bid contracts for standard HHC services. The vast majority of care is purchased through a fee arrangement. VA is developing a national template, with standards and criteria, for bidding and awarding contracts. Contract Adult Day Health Care (CADHC) services are purchased via sole source contracts, using the Community Nursing Home authority.

9. Dr. Kizer, Congressman Evans recently received a report based on findings from a survey of your Chiefs of Staff. Ten percent of the respondents to the survey indicated they had no hospice program, including a consultative team. Do you differ with this finding, and, if so, on what basis?

Answer: I am not familiar with the survey and have no basis to either differ or agree with it. The Veterans Hospice Care Study indicated that 98% of VA medical centers reported having active hospice programs in FY 1996. From the 1998 Geriatrics and Long Term Care Survey, 103 VA medical centers reported that they provide inpatient hospice care, 80 VA medical centers reported that they have a hospice consultation team, and 115 VA medical centers reported that they use community-based hospice services for veterans. All of the available data on hospice care in VA at this time is obtained through surveys or self-reporting by VA medical centers. The difficulty in obtaining accurate data is complicated by the diversity among hospice and palliative care programs across the system. Hospice is traditionally a program that is limited to patients who have a clear prognosis of six months or less (primarily cancer patients.) While hospice is important, it does not meet the needs of many dying veterans. VA is taking a more comprehensive approach to improving care at the end of life, believing that hospice is just one program in an array of services that should be available to terminally ill veterans.

10. The Evans report found wide disparities among facilities, even those within networks, in the referral to, use of, and payment for contract long-term care for veterans. You indicate that VHA understands there are problems in uniformity of access to various LTC programs. Will your new proposal offer recourse?

Answer: VHA is aware of access problems in the Community Nursing Home and CADHC Programs and is committed to enunciating new policy that will ease these concerns within current budget constraints. The goal is to make placement decisions based on patient care needs, not fiscal needs. We expect to establish these policies this summer.

11. In 1984, "Caring for the Older Veteran" identified a GAO report critical of VA's oversight of state homes. This winter, 15 years later, the Office of Health Inspections has issued a report that is critical of VA's oversight of state homes. I would like to learn how VHA ensures that its contract and state home programs are inspected, how often they are due for inspections, and how quality is ascertained during these inspections and how often VHA completes these inspections for each of its long-term programs. Finally, I would like to know if HQ monitors these processes. Can you provide me with this information?

Answer: In long-term care, VA reviews the quality of care and the quality of life in two programs: Community Nursing Homes (CNH) and State Veterans homes.

In the CNH Program, VA uses the State Survey Agency (SSA) inspections. VA monitors the care of veterans in CNHs with monthly visits by a VA nurse or social worker. VA staff reviews the reasons for re-hospitalization of veteran patients to determine if poor care was involved. VA assesses the quality of nursing facilities by reviewing SSA reports. Recently, VA has added to its quality review the detailed CNH information from HCFA's On-line Survey, Certification and Report (OSCAR). VA is committed to its oversight approach as a purchaser of care.

The State Home Program is a grant-in-aid program to States for providing authorized long-term care to eligible veterans and non-veterans (defined as spouses of veterans or parents of all whose children died while serving in the armed forces of the United States). The law requires the Secretary to establish standards related to each grant program. No per diem payment may be made to any home unless the home is determined to meet the VA-determined standards. The VA has sole oversight responsibility for the State Home Program. The Chiefs of the State Home Per Diem Program and the State Home Construction Program monitor the grant process and are located in the Geriatrics and Extended Care Strategic Health Care Group in VA Headquarters. VA surveyors (from VA medical centers of jurisdictions), by regulation, are required to review and audit all records of the State home facility that have a bearing on compliance with any of the VA grant-in-aid requirements. The directors of the VA medical centers of jurisdiction are required, at least annually, to make judgments, based on VA surveys and other relevant information related to the standards, about compliance with VA standards and recommend the continuation or withholding of per diem grant payments. Training for VA survey teams is available.

The former Under Secretary for Health pointed out in the recent Inspector General Report #9HI-A06-014, dated January 25, 1999, that inconsistencies of annual inspections over the past three years have had a negative impact on the quality of care in some of the State Veterans Homes. VHA will make every effort to reverse the perception that VA Medical Centers no longer have direct responsibility to oversee the quality of care in the State Veterans Homes.

Chairman Stearns to Richard Jelinek

Questions for the Record for Managed Care Solutions, Inc
Mr Richard Jelinek, Senior Vice President
Hearing on VA Long Term Care

1. **Mr. Jelinek, your testimony suggests that providing case management services could reduce VA costs. What is your current per patient charge under your Medicaid contract in Arizona?**

Managed Care Solutions (MCS) manages a well organized, coordinated and focused case management system which provides a more comprehensive, cost effective and integrated continuum of health care delivery to the frail elderly and chronically ill. To appreciate how costs can be reduced for our veterans, while enhancing quality and satisfaction, it is important to understand the methodology of our case management system. We believe most organizations utilize case management practices without addressing the fragmentation present and fail to incorporate all levels and types of care. This fragmentation can result in inappropriate placement settings for clients, lack of follow-up for clinical issues, and treatment delays. At MCS we have developed our case management program into a comprehensive and complete *care coordination* strategy we call CareOne Service. Through this we are able to provide the frail, elderly and chronically ill populations an integrated program that focuses on managing an individual's care before intensive services or assistance is needed, rather than after an acute episode of treatment occurs. CareOne Service embodies full medical, social, and behavioral medicine. CareOne Service Care Coordinators, who are registered nurses or social workers, work with individual clients, family members and their physician to ensure comprehensive services can be maintained through the most cost effective approach.

The care manager completes thorough assessments with the client and family present, and then a comprehensive individual care plan is created to meet the unique medical and social needs of the person. Clients with minimal functional or cognitive impairments may be eligible for assisted living arrangements, in-home attendant care, or on-call nurse assistance. Care managers utilize the results of the assessment, individual and family ability and desires, and cost effectiveness criteria in making placement decisions. Periodic re-assessments are conducted in order to maintain the most appropriate placement setting.

By expanding the benefits available to clients to include various home and community-based services, MCS has found that overall spending can be decreased, while the quality of care and quality of life is maintained or even increased. MCS' goal is to stabilize a client's condition through a combination of less resource-intensive services delivered on an on-going basis. The scope of services utilized in the CareOne Service model includes institutional placement (when appropriate), adult home care, adult foster care, alternative residential sites, personal/attendant/respite and hospice care, and environmental modifications.

To illustrate the savings potential, we are providing a cost data example from our Arizona LTC health plan. Our health plan has operated in seven Arizona Counties since 1989 and is the largest private contractor in the Arizona Health Care Cost Containment System's Long Term Care System (ALTCS). ALTCS is the only state program that has required all LTC Medicaid members to enroll in managed care programs for all long term care, behavioral health, home and community-based services (HCBS) and acute care services. The foundation of MCS' success lies in its care management approach.

For a non-ventilator dependent individual in a nursing facility--the most restrictive setting--annual costs can range from $36,000 to $40,000. The least restrictive setting, at home with or without assisted living and residential care, costs can range from $6,000 to $13,200 per year.

CASE STUDY

Ryan is a 49-year-old quadriplegic male, who is ventilator dependent as a result of a gunshot wound to the cervical spine The average monthly cost for a Nursing Facility placement, including therapies, durable medical equipment and acute care services is $21,276. The average monthly cost for Home-Community Based Services, including respite, durable medical equipment and acute care services is $7,467, yielding average monthly savings of $13,809. If Ryan were already in a nursing facility, there would be a one-time cost to relocate him to a home. The average cost for a home modification is $7,500 and transportation home is around $1,270 for a total one time cost of $8,770.

2. **You recommend in your testimony that VA undertake several long-term care demonstration programs in order to test the impact of care coordination on the VA's ability to deliver long-term care services to more veterans. If you were awarded a VA contract to provide services under one or more of such demonstrations, would you be willing to bear any of the cost of their evaluation (since MCS could derive benefit from that evaluation, too)?**

We are willing to participate in research activities and initiatives that will measure outcomes and results of our integrated, coordinated approach. Part of our model produces data for comparative analysis purposes, therefore, MCS is willing to create reports and provide data to the Veterans Administration and other interested parties.

Managed Care Solutions, Inc.
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May 24, 1999

Sandra McClellan
Room 333
Cannon House Office Building
Washington, DC 20515

Dear Ms. McClellan:

Enclosed are the questions and answers for Mr. Richard Jelinek as requested by Rep. Lane Evans regarding the Health Subcommittee's hearing on VA Long Term Care on April 22, 1999. If you have any questions, please do not hesitate to contact me at 602-331-5100.

Sincerely,

Arlene Davidson

Arlene Davidson
Director, Corporate Development & Strategic Planning

Follow-up Questions for Mr. Richard Jelinek
Senior Vice President
Managed Care Solutions, Inc.
7600 North 16th Street, Suite 150
Phoenix, Arizona 85020

1. **At one time nursing home admission criteria suggested admission was indicated if patients have 3 or more activity of daily requirements or significant cognitive impairment (this was at least true if Medicaid was paying). Has this changed?**

Under what circumstances would your organization place an individual in an institutional setting as opposed to providing care in the community or home?

No, nursing home admission criteria has not changed in terms of Medicaid payment. The decision to place an individual into a nursing home or arrange for home-based services, however, depends on a variety of circumstances. At Managed Care Solutions (MCS), all individuals undergo a thorough assessment with the client and family present. After this assessment, a service plan is created which guides the care manager, the client and family into the most appropriate and least restrictive placement setting based on their clinical and social needs. An individual would be placed in a nursing home if:

- significant cognitive or physical impairment were present with no ability to care for oneself in the home setting (that is, there is also a lack of adequate family support);
- the individual needs assistance and care greater than eight hours per day, seven days per week;
- the impairment is of a long-term nature;
- state contract mandates institutionalization if it is more cost effective and the individual and family are in agreement, or
- it is the individual and family's desire.

2. **Can you tell the Committee in your expert opinion how you now differentiate between patients who would benefit from placement in enriched housing or assisted living and those that would benefit from skilled nursing home placement? What are the factors case managers consider in making these placement decisions?**

At MCS, we assess clients utilizing a diverse set of criteria in order to make appropriate placement decisions. This process involves the individual as well as their family in a thorough assessment of their ability to function independently or in need of assistance. The diverse set of criteria include:

- functional status
- Activities of Daily Living (ADLs)
- whether or not they are in need of 24-hour care, seven days per week
- whether or not they are able to care for themselves
- any issues of abuse, neglect or safety
- cognitive ability
- family ability to assist
- any misuse of the client's personal funds, and
- cost effectiveness.

In addition, the Minimum Data Set (MDS) is used along with our own developed and state approved assessment criteria. The care manager completes thorough assessments with the client and family present, and then a comprehensive service plan is created to meet the unique needs of the individual. The individual and family indicate agreement with the recommended plan of care with their signatures. The assessment and service plan, in cooperation with the individual and family, outline the most appropriate setting. Clients with minimal functional or cognitive impairments may be eligible for assisted living arrangements, in-home attendant care, or on-call nurse assistance. In some cases, there is no cognitive impairment, but an individual with significant physical inability may receive more cost effective care in a nursing home. Some states, such as Arizona, require cost effectiveness analysis and mandate institutionalization, if warranted by the assessment. So, care managers utilize the results of the assessment, individual and family ability and desires, and cost effectiveness criteria in making placement decisions. Periodic re-assessments are conducted in order to maintain the most appropriate placement setting.

3. **What are the benefits a case management system can provide for the frail elderly?**

A well organized, coordinated and focused case management system can provide a more comprehensive, cost effective, and integrated continuum of health care services to the frail elderly. We believe most organizations utilize case management practices without addressing the fragmentation present and fail to incorporate all levels and types of care. At Managed Care Solutions, therefore, we have developed our case management program into a comprehensive and complete *care coordination* strategy we call CareOne Service. Through this we are able to provide the frail elderly and chronically ill populations an integrated program that focuses on managing an individual's care before intensive services or assistance is needed, rather than after an acute episode of treatment occurs. CareOne Service embodies full medical, social, and behavioral medicine. CareOne Service Care Coordinators, who are registered nurses or social workers, work with individual clients, family members and their physician to ensure comprehensive services can be maintained through the most cost effective approach. CareOne Service Care Coordinators:

- Serve as the client advocate
- Conduct comprehensive initial and ongoing assessments

Follow-up Questions for Mr. Richard Jelinek
Senior Vice President
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- React immediately to changes in client conditions
- Provide cost comparisons of placement alternatives
- Formulate comprehensive treatment plans
- Coordinate all placement and service needs
- Continuously monitor the quality and level of care delivered
- Perform appropriate discharge planning
- Identify preventive health care goals and measures
- Provide educational and supportive services
- Establish strong relationships with family members and providers.

By expanding the benefits available to clients to include various home and community-based services, MCS has found that overall spending can be decreased, while the quality of care and quality of life is maintained or even increased. MCS' goal is to stabilize a client's condition through a combination of less resource-intensive services delivered on an on-going basis. The scope of services utilized in the CareOne Service model includes: institutional placement (when appropriate), adult home care, adult foster care, alternative residential sites, personal/attendant/respite and hospice care, and environmental modifications.

In summary, the benefits a care management program can offer the frail elderly are:

- An integrated approach to long-term care across the full continuum of services
- More cost effective treatment plans
- Increased client and family satisfaction.

RESPONSES TO QUESTIONS SUBMITTED TO BIRCH & DAVIS BY CONGRESSMAN LANE EVANS, RANKING DEMOCRAT HOUSE OF REPRESENTATIVES, COMMITTEE ON VETERANS AFFAIRS

1. **How would VA accommodate capacity in private sector community homes in its model given that many of these homes are "unavailable" to VA in terms of cost or conditions they are willing to treat?**

The perception that many private sector community nursing homes are "unavailable" to the VA in terms of the conditions they are willing to treat may not be a "given" for a large number of veterans. In our report, Birch & Davis discusses a number of issues that appear to support this contention. First, we found a high degree of similarity in the most frequently reported medical conditions for residents in State Veterans Homes (SVHs) and in the most frequent admitting diagnoses for Medicaid and Medicare residents in community nursing homes (CNHs). For example, four of the five most frequent diagnoses or conditions found in SVH residents are also the most frequent admitting diagnoses found in Medicaid and Medicare residents in CNHs (i.e., diabetes, dementia or organic psychotic conditions, hypertension, and cerebrovascular disease). The similarity in medical conditions found among SVH residents and the Medicaid/Medicare population in CNHs suggest that many veterans, although perhaps not all of them, can be accommodated in private sector facilities.

Second, our report notes that, on any given day, there were an estimated 257,600 unoccupied beds nationally in private sector CNHs in 1997. This is ten times the total number of existing beds in the entire SVH system. Admittedly, the types of unoccupied beds may not always be appropriate for veterans who need care. For nursing home care, however, the number of such instances may be relatively small, partly because there were at least 112,600 special care beds in the nation's nursing homes in 1997. About two-thirds of these special care beds were dedicated to residents with Alzheimer's disease and another 18 percent for residents needing special rehabilitation care.

Third, the quality of care in some community nursing homes may not compare favorably with the quality of care in SVHs. In instances where this is the case, community homes would not be substitutable for State homes, regardless of the number of unoccupied beds. However, all else being equal, veterans could be admitted to such homes after the deficiencies were remedied. Unannounced inspections could then be made by either the VA or the State to ensure that the quality of care continues to meet VA standards. The VA currently ensures that State homes as well as contract nursing homes meet VA standards by conducting periodic inspections of these facilities.

Finally, although only 28 percent of residents in CNHs in 1997 were male compared with approximately 91 percent in SVHs, it is more than likely that many of the male residents in CNHs are in fact veterans.

For the reasons discussed above we feel that capacity in community nursing homes can be incorporated into a methodology for prioritizing SVH construction grant requests. This is not to say that all veterans can be accommodated in CNHs but many, if not most, can be. Difficult cases may require special arrangements (perhaps at VA hospitals), contracts would need to ensure that these homes meet VA standards, and capacity would vary by state, however, the relatively small number of veterans that could not be accommodated in community nursing homes should not drive the methodology.

The Birch & Davis report did not examine the costs associated with caring for veterans in private sector community nursing homes and the extent to which this factor may make these homes "unavailable" to the VA. One argument that is frequently cited in the debate on costs of caring for veterans in SVHs versus community or contract nursing homes is that the per diem cost to the VA for veterans in SVHs (i.e., $40 per day) is significantly lower than that for veterans in contract nursing homes. This argument, however, does not factor in the costs to the VA for providing construction grants.

The fact that community nursing homes can and do provide the specialized and/or rehabilitation care frequently required by veterans, coupled with the similarity in medical conditions among both SVH and CNH resident populations suggest that, if rates are adequate, community homes would be appropriate for veterans and that the capacity of these homes may be an appropriate consideration in prioritizing SVH construction grant requests.

2. Does B&D recommend a way to divide grants into separate funds available for renovations and bed-producing projects?

B&D did not recommend a specific method for dividing available resources into separate funds available for renovations and bed-producing projects; however, we did discuss a number of possible methods for accomplishing this objective. These included:

- Amending existing legislation and/or VA regulations governing the program to designate a certain percent of the total grant dollars available for both bed-producing and renovation projects. This percent can be expressed as a flat percentage of the total funds available or can be presented as a minimum or maximum amount of the total.

- These percentages may be derived from the *dollar value* of past grant requests (not grant awards). The percentage for renovation projects could be calculated by dividing the estimated cost of all grant requests for renovation projects by the total combined estimated cost of all grant requests for bed-producing and renovation projects submitted during a defined time period (e.g., the last 1, 3, 5, or 10 years). The time period could have a material effect on the resultant split, depending on the annual variability in the types of requests submitted. The remaining portion would be for bed-producing projects. Because the current method favors bed-producing projects over renovation projects, past percentages for renovation projects might be artificially depressed initially. As States learn about the new approach, however, requests for renovation grants might increase faster than requests for bed-producing grants, resulting in a higher percentage of grant requests for renovation projects.

- The percentage for renovation projects could equal the higher of the percentage established by Congress or the percentage derived from past grant requests. The remainder would be used to fund bed-producing projects. This approach would mean that at least a minimum percentage of the budget appropriation for the SVH Construction Grant Program would be available for renovation projects. At least initially, the minimum percentage could be set above the percentage derived from past experience, if the latter is deemed too low. A limit also could be imposed on the maximum percentage that could be used to fund renovation projects.

- Percentages could also be derived from the *number* of grant requests on the priority list for one or more years. The percentage for renovation projects would be obtained by dividing the number of grant requests for renovation projects by the total number of requests; the percentage for bed-producing projects would be the difference between 100 percent and the percent for renovation projects. This "numbers" approach would weight all grant requests equally, whereas the "dollar" calculation would weight grant requests by cost.

- Percentages could be based on national expenditure averages for new nursing home construction and nursing home renovations. One possible source for this information are statistics published from the Annual Capital Expenditures Survey which is conducted as part of the U.S. Census. Another possibility are statistics maintained by F. W. Dodge; they are available annually for a fee, presently $1,500. Concerned parties may question whether national experience for the private sector reflects or should reflect the experience of State homes. In addition, there are no comparable data for domiciliary homes.

If the appropriation were split into two funds, action would be needed in the unlikely event that the combined dollar value of the grants requested for beds or renovations were less than the corresponding fund. On a preset date, any residual in one fund could be transferred automatically to the other fund.

The preceding methods predicate the use of different priority methods for bed-producing and renovation projects on the existence of two construction grant funds. This assumption is not absolutely necessary. Different priority methods could be used for bed-producing and renovation

projects under the current one-fund approach. If different priority methods were used with one fund, however, a method would be needed to determine the order in which bed-producing and renovation projects are funded. Would, for example, first priority go to the first renovation project or to the first bed-producing project? Similarly, which project would be funded second? Or eighth?

Priorities could be sequenced in a checkerboard fashion. Funded first, would be the top-rated bed-producing or renovation project. Funded second ,would be the top-rated project that was not funded first. Funded third would be the second-rated bed-producing or renovation project, and so on until the VA's appropriation is exhausted.

Alternatively, multiple projects on one priority list could be funded before any project on the other priority list were funded. For example, the first four projects on the renovation list could be funded before the top project on the bed-producing list if each renovation project met the criteria before the top bed-producing project met the criteria.

The projects on two priority lists could be funded based on cost, preapplication or application date, a quality of care measure, the number of months since the State last received a grant award or conditional approval, or other bases. Higher priority could go to the project with the lower cost, more timely grant request, higher quality of care, or longer time period without a grant award or conditional approval.

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May 27, 1999

The Honorable Lane Evans
Ranking Democratic Member
House Committee on Veterans' Affairs
Room 333 Cannon House Office Building
Washington, DC 20515

Dear Congressman Evans:

The American Health Care Association is pleased to provide information and answer your questions in response to the Health Subcommittee hearing on the future of long-term care for veterans.

Questions

1. You cite 81% and 86% occupancy as too low. Birch and Davis suggest that the average state home is at 89% capacity. What is the appropriate occupancy rate for a nursing home?

- Occupancy rate measures the demand for nursing facility services. The appropriate occupancy rate for a nursing home should be as close to 100% that means supply is meeting demand. The occupancy rate considered low by industry standards is currently 85%. The Birch and Davis report states an average occupancy rate of 87% in FY 1997 and 89% in FY 1998 fiscal year for State Veteran Nursing Homes. This shows the State Veteran Nursing Homes are operating just above what the industry considers low occupancy. According to the VA's contracted study on *Alternatives for Redesigning VA's Strategy for State Veteran Home Capital Investment Decisions*, there are 18 states where State Homes' occupancy rates have averaged 85% or lower. These include Alabama, California, Colorado, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Mississippi, Missouri, Montana, Nebraska, New Mexico, Ohio, Pennsylvania, South Carolina, and Washington. The effect of this low occupancy is that 3,600 beds go empty in these State Homes.

- The national occupancy rate in community nursing homes is 86% for 1997. This shows nursing homes around the country are not operating with a high occupancy rate on average. Thus, the demand for nursing home beds is not high and in some areas of the country, there is an oversupply of beds. States have taken action to combat this oversupply. Approximately 35 states currently have laws that prohibit construction of nursing home beds without state approval.

- The State Veteran Nursing Home funding methodology gives the highest priority for approval of projects to build new nursing home beds to a state that has fully funded the state share of construction costs-- *it is not based on the need for new beds in the community*. Under the methodology, unmet need is defined by a state not having a percentage of the maximum bed capacity that the VA would fund which is 4 beds per 1000 veterans. This is regardless of the demographics of the veteran population in that state or locality or the number of empty beds in community nursing homes or existing State Veteran Nursing Homes.

Recommendation:
The American Health Care Association (AHCA) recommends the VA require states to have a demonstrated need for nursing home beds prior to the VA issuing grants for construction of new State Veteran Nursing Homes. Currently the VA has no statutory power to require such an analysis to demonstrate need for new beds.

2. VA has often stated it would be more willing to place veterans in community nursing homes if these nursing homes were more willing to treat patients with more complex conditions. Will you respond to community nursing homes' capability and willingness to take on more of these complex patients?

- Currently, community nursing homes serve veterans all over the country. Nursing home providers also serve veterans when other VA long-term care programs are unable. For example, an Idaho community nursing home was asked to accept and treat a veteran who is ventilator dependent, a medically complex condition. The community nursing home is the only provider in Idaho who has the capability to provide ventilator treatment and willingly accepted this veteran into the nursing home. The VA funded Birch and Davis study compared the most frequently reported medical conditions for residents in State Veteran Nursing Homes with residents in community nursing homes. The comparison shows that four of the five most frequent diagnoses are similar for both populations. These diagnoses include diabetes, dementia (or organic psychotic conditions), cerebrovascular disease, and hypertension. Thus, community nursing homes are treating people for the same conditions as State Veteran Nursing Homes.

- Nursing homes have increasingly accepted and treated patients with higher acuity over the last 15 years. This is due to the growth of assisted living and faster discharges of patients from hospitals. This trend is referred to as "quicker and sicker." In fact, as of 1997, data collected from Health Care Financing Administration (HCFA) shows that residents of nursing homes need assistance with 3.67 of the 5 activities of daily living (ADLs). The 5 ADLs are bathing, transferring, dressing, eating and toilet use. This means the average nursing home resident needs help with more than 3 of these activities. A full 63 percent of the nation's nursing facility population are disoriented or memory impaired. Approximately 42% of nursing home patients have some type of dementia and require special care for this mental status. Patients with documented psychiatric diagnosis account for over 10% of the nursing home residents we treat. In response to patients being sicker when they enter nursing homes, nursing facilities have changed to meet the needs of the patients. Of the 112,555 total special care beds in the country, the following shows the complex patients that nursing home providers treat:

Type of Bed	# of Beds	Percent of Total
Alzheimer's disease	74,625	66.3
Special Rehabilitation	19,926	17.7
Ventilator beds	6,084	5.4
hospice beds;	3,731	3.3
AIDS beds	2,695f	2.4
other special care beds	5,494	4.9
Total	112,555	100%

Recommendation:

- **Community nursing homes will continue to proudly serve veterans in their communities while keeping them close to their support system of family and friends. AHCA member nursing home companies partner with the VA through Community Contracting which provides quality long-term care to over 6,000 veterans in their communities, an investment of $325 million by the VA. The VA is planning to increase veterans' access to nursing home beds in the community by broadening their Contracting to include regional providers. AHCA supports efforts to increase the Community Contracts thus providing more opportunities for veterans to access long term care near their families.**

3. Have you had the opportunity to review Birch and Davis' testimony? Will you share your thoughts about the methodology revisions they suggest with the committee?

AHCA commends the VA for undertaking a study of the methodology that prioritizes funding for State Veteran Homes. We agree with the VA that the methodology needs reassessment and change. First, we will explain our thoughts on the shortcomings of the current methodology and then give our recommendations.

The Birch and Davis study found 16 problems with the current priority method. We agree with the findings of the study and we would like to highlight a few of these problems:

- **Alternative Sources of Care Not Considered-** The veteran population's unmet need for beds in State Homes is currently determined independently of bed availability in other facilities. (p. III – 11)

- **Bed Capacity Is Measured, Not Veteran Need** – Unmet need is defined in terms of a maximum bed capacity or bed supply that the VA will help finance. Despite using the term "unmet need" it is not based on need for beds. Veterans are presumed to need these beds in State Homes and the need is assumed to be uniform across the states regardless of a small or large veteran population or the availability of appropriate services from other providers. There is no empirical justification for the current bed need standard and the capacity standard of 4 nursing home beds per 1,000 veterans is arbitrary. (p. III-9-10)

- **Current Estimates Are Used, Not Projections-** Unmet bed need is based on estimates of the number of veterans who reside in a state at the time the application is filed. Yet the number of veterans in a state may change dramatically during a nursing home's useful life. Large population decreases could result in beds and State Homes that are needed today being largely unoccupied for much of tomorrow. (p. III-10)

- **State Not Market Area for Determining Unmet Bed Need** – Unmet bed need is measured for a state as a whole rather than for the catchment or market area where a nursing home will be located. (p. III-13)

- **All Veterans Are Counted, Not Older Veterans** – Unmet bed need is currently measured in terms of the total veteran population rather than the subset of veterans most likely to need nursing home care. Yet, aged veterans are more likely to need such care than are younger veterans. (p. III-10)

- **Life safety projects** – The current method does not differentiate among types of life safety projects that qualify for special preference. An argument can be made that projects to remedy life safety problems that pose an immediate danger to veterans should have a higher priority than other types of life safety projects. (p. III-14)

Recommendations:

AHCA supports the recommendations in the Birch and Davis study that bed availability in VA facilities, community nursing homes, and existing State Veteran Homes should be considered when assigning priorities to grant requests. We believe the current methodology should be modified to include a review of occupancy rates in community nursing homes. The VA should require states to demonstrate a need for beds prior to the VA issuing grants for construction of new State Veteran Nursing Homes. Currently the VA has no statutory power to require such a review. The State Veteran Nursing Home funding methodology gives the highest priority to projects not based on need for beds in the community, but whether the requesting state has fully funded the project. The current methodology measures need as a percentage of the maximum number of beds the VA would fund, regardless of the availability of beds in VA facilities, community nursing homes or existing State Homes. The maximum number of beds the VA will fund is 4 beds per 1000 veterans, regardless of the demographics of the veteran population in the state.

The Honorable Lane Evans
May 27, 1999
Page 4

We support the following recommendations in the Birch and Davis study:

- **Unmet bed need could be based on the projected number of veterans likely to seek care from State Veteran Homes rather than the total number of veterans residing the state at the time a grant request is submitted. (p. xiii)**

- **Bed availability in VA facilities, community nursing homes, and existing State Veteran Homes could be considered when assigning priorities to grant requests. (p. xiii)**

- **The definition of a life safety project could be clarified in regulation to apply only to deficiencies that pose an immediate or imminent threat to the lives or safety of a home's residents and should be assigned a higher priority. (p. IV-10)**

- **The current priority method could be amended to consider the prevalence of unoccupied beds in existing State Veteran Homes when priorities are assigned to new grant requests. Likewise, unoccupied beds in community and VA nursing homes could also be considered when assigning priorities. Indeed, to portray bed availability accurately, unoccupied beds in all settings would have to be considered when assigning priorities. (p. IV-11)**

We appreciate the opportunity to express our position and recommendations regarding the Birch and Davis study to change the methodology for funding the construction of State Veteran Nursing Homes. We look forward to working with you and the committee to put these changes into action.

Sincerely,

Bruce Yarwood
Legislative Counsel

Cc Susan Edgerton
Democratic Staff Director, Subcommittee
On Health, House Veterans Affairs Committee

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