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OVERSIGHT HEARING ON LONG-TERM CARE PROGRAMS IN VA

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

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OVERSIGHT HEARING ON LONG-TERM CARE PROGRAMS IN VA

THURSDAY, MAY 22, 2003

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

The subcommittee met, pursuant to call, at 1:45 p.m., in room 334, Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Beauprez, Renzi, Stearns, Rodriguez, Filner, Snyder, Berkley and Evans (ex-officio).

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The subcommittee will come to order. I want to thank everybody for coming this afternoon, and I want to welcome our witnesses.

The purpose of today's hearing is to review the current status and future of long-term care programs for veterans in the Veterans Health Administration. In particular, we will examine existing VA long-term care programs and expenditures, and appraise VA strategy for addressing future long-term care needs of aging and disabled veterans.

Under Public Law 106–117, VA is required to operate and maintain certain long-term care programs in nursing home care and enhance other programs such as geriatric evaluation, domiciliary care, adult day health care, respite, palliative and hospice programs, both institutionally and in some noninstitutional basis.

Although VA's long-term health care services have undergone some positive changes in recent years, VA's commitment to long-term care has not kept pace with veterans' needs, in our opinion. I believe GAO will be speaking to this issue in their testimony today.

I would argue that VA's biggest single challenge in health care today, and for the next decade, is how to best address the steadily increasing numbers of elderly veterans who need care.

We all know and appreciate the problems that VA has. Six or seven years ago, VA began shifting its care base to primary care and opened what some people refer to as the "flood gates."

VA is full to overflowing with enrolled veterans, and many of these aging veterans have health care problems that can't really be resolved by an outpatient approach, regardless of its intensity.

While we support these advances in home care and other alternatives to institutional solutions, such as VA nursing home care,

it still holds true that aging veterans are going to need nursing home beds in a much larger proportion than veterans use them today.

I will insert the rest of my opening statement into the record to conserve time and to allow maximum opportunity for members to address our panels.

[The prepared statement of Chairman Simmons appears on p. 35.]

Mr. SIMMONS. I would ask at this point if my ranking member has a statement that he would like to make.

I recognize Mr. Filner.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you.

I appreciate your remarks, Mr. Chairman, and we know, of course, that the veteran population that is in need of nursing home care is rising rapidly. As the figures that I have show there are 640,000 veterans over the age of 85, and that number is expected to be 1.3 million over the next decade, and the VA does not seem to be ready to meet this need.

There are nursing home beds in 131 hospitals and one standalone nursing home in Colorado. There were 13,000 beds in 1998, and Congress froze the number of nursing home beds in the Millennium Care Act that we passed.

In spite of that freezing, the VA has removed 2,000 beds. Now, I understand, Mr. Chairman, that the Secretary of VA has sent a letter to you that those beds will be replaced. We will have to ask Dr. Roswell if he has been told that. I am not sure that everybody is on the same page here.

The administration's budget proposed removing another 5,000 beds, and I oppose that. I don't know where the chairman is on that, but as you said, Mr. Simmons, we support the primary care in outpatient clinics, but we cannot do that at the expense of the old, chronically ill veterans. They have no place else to go. So I am looking forward to this hearing. We have to make sure that we can take care of both populations. That should be our aim, and I look forward to working with you to achieve it.

Mr. SIMMONS. I thank the gentleman for his remarks, and I agree that this is an issue that we need to look at. That is the purpose of this hearing here today, and at this point I would ask our panelists to come forward.

STATEMENT OF CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE, VETERANS' HEALTH AND BENEFITS ISSUES; ACCOMPANIED BY JIM MUSSELWHITE, ASSISTANT DIRECTOR, HEALTH CARE

Mr. SIMMONS. The first panel consists of Ms. Cindy Bascetta, who is the Director for Veterans Health and Benefits Issues at the U.S. General Accounting Office. I believe that she will be accompanied by James Musselwhite, Assistant Director for Health Care, and I will let them get settled and fill their glasses with water and arm themselves for this process. You see the green light. You know how it works.

I look forward to hearing your testimony.

At the conclusion of the testimony, we will go from side to side on questions.

STATEMENT OF CYNTHIA A. BASCETTA

Ms. BASCETTA. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss our work on VA's noninstitutional long-term care services. As you know, the number of veterans 85 years old and older is expected to double, reaching about 1.3 million over the next 10 years.

These older veterans are the ones most likely to need long-term care and many of them will prefer care in their own homes or in community settings where possible. Almost 5 years ago, the Federal Advisory Committee on the Future of VA Long-term Care recommended that VA meet growing demand for long-term care by greatly expanding home and community-based service capacity, while at the same time maintaining its nursing home capacity.

Although VA provides a continuum of noninstitutional and institutional services, it spends much more on institutional care. In fact, VA spends less than $300 million to serve an average daily census of about 24,000 veterans, compared to nearly $3 billion to serve an average daily census of more than 43,000 veterans in institutional settings, including nursing homes.

Against this backdrop, we surveyed facilities in 2001 and again in 2002, about six noninstitutional services. These are home-based primary care, skilled home health care, and homemaker/home health aid services, as well as three other services, adult day health care, geriatric evaluation and home-based respite care that VA provides to meet the requirements of the Millennium Act.

We are reporting today that little progress has been made since last year in improving the availability of these six services. Our new report also shows that service gaps and facility restrictions result in inequitable access to these services. As a result, access is still often limited or nonexistent and dependent on where veterans live.

I would like to focus on the reasons for these access limitations. First, many facilities do not offer the six noninstitutional services at all. We found that 126 of VA's 139 facilities did not offer all six services. The least commonly available service was noninstitutional respite care, which was not offered at 106 facilities.

In contrast, only seven facilities did not offer skilled home health care, the most widely available service. This means that similarly situated veterans may not have access to similar services if they live in areas where the services are not available.

Second, this inequity in access is worsened because many facilities that offer a service limit it to part of the geographic area that they serve. For example, 76 facilities offer adult day health care, but do so only in part of the geographic area they serve. Even skilled home health care, the most widely available service, is not offered in the entire geographic area by about 20 facilities. In some cases, this is because contract health care providers may not be available or for other reasons.

The third reason that further limits access is facilities setting their own eligibility standards or limiting either the amount of service or the number of veterans who can receive a service at any

time. We found that 57 facilities have waiting lists for one or more of the six services in our review because of restrictions placed on the number of veterans who may receive a service.

But perhaps more serious are the facility imposed eligibility standards. Nine facilities told us that they based access to services on specific service-connected disability levels, and it is possible that a systematic review would reveal that this is more widespread. These facility standards conflict with VA eligibility standards, which state that most services are to be available to all enrolled veterans, regardless of their priority group.

VA concurred with our recommendation to ensure that facilities adhere to it eligibility standards, so that similarly situated veterans have access to similar care, regardless of where they live.

Mr. Chairman, VA Headquarters has contributed to access limitations and inequities because it has neither emphasized the importance of noninstitutional services in the long-term care continuum, nor has it provided sufficient guidance on how to provide these services.

For example, VA has not established measurable performance goals to increase access to similarly situated veterans. Faced with competing priorities, field officials have chosen to use available resources for other services. VA has also provided inadequate guidance on what constitutes noninstitutional respite care and on which home-based services should be part of the benefits package. As a result, some networks and facilities have been confused about how to provide noninstitutional respite care, and, not surprisingly, facilities have varied in their interpretations of which home care services they need to provide.

To address these problems, we are recommending that VA refine its current performance measure, clarify what constitutes noninstitutional respite care, and specify which home-based services should be available to all enrolled veterans. These actions, if followed up with effective oversight to ensure that they are implemented in the field, should result in more equitable access to noninstitutional services in the future.

This concludes my remarks, and we would be happy to answer your questions and those of the subcommittee members.

[The prepared statement of Ms. Bascetta appears on p. 42.]

Mr. SIMMONS. I have a couple of questions, at which point I will then defer to my ranking member, and we will go back and forth with questions.

On the front page of your testimony, or at least on the front page of the VA Long-term Care Report that I have dated May 22, 2003, it states that VA concurred with both of your recommendations, and my first question is concurrence is great, but do you see any effort from VA to implement those recommendations?

And then my second question goes to the issue of home-based primary care. I have been briefed in my home State about some of the efforts to enhance the technological approaches to home-based health care that include a device that can be connected to the phone lines that measures temperature, blood pressure and various other vital signs that is relatively easy to use. It seems to me, and with simple supervision or maybe no supervision at all, the aging veteran or the veteran's family can assist in using that device. I

was curious if you had any knowledge on whether those types of devices are being used at all or to a moderate degree or extensively to address the issue of home health care.

Ms. BASCETTA. Let me answer your question about their concurrence first. We have taken a quick look at the attachment to Dr. Roswell's statement, and I have a few initial reactions.

First of all, if you look at the four recommendations that we made, these items don't align quite with the recommendations. There is a lot here that isn't directly addressing the recommendations that we made, but for what is here, let me offer my initial reactions.

Regarding the eligibility standards, the directives that they plan to issue, of course, are a good first attempt, but we would want to have more assurance that the enforcement that would follow up on these recommendations would be powerful enough to ensure that, in fact, the field complied with the directives.

On noninstitutional respite care, my understanding is that they have, in fact, issued guidance in a brand new handbook that has been long awaited, but, again, monitoring the field to assure that, in fact, implementation of the guidance and handbook is carried out, is what really counts.

With regard to specifying what home care services ought to be available, I can't tell from this document whether they have made any progress on that front or not.

And with regard to the performance measure, the words here, to discuss the formal performance measure and set specific program targets, look like the right words, but we are really concerned about that performance measure. As written, without revision, it allows better performers basically to cover for poorer performers. And what I mean by that is that as long as access increases in the aggregate, they can meet the standard. So they can increase access in facilities that are already offering the service, and those facilities would in effect be compensating for little or no improvement in other facilities.

The bottom line is that without individual facility performance being measured, the measure won't all hold networks and facilities accountable for more uniform access improvements.

Mr. SIMMONS. So as my staff indicates, somebody standing in a bucket of ice water with his hair on fire still has a temperature of 98.6?

Ms. BASCETTA. That is correct.

Mr. SIMMONS. Thank you. I would now like to recognize the ranking member, Mr. Rodriguez.

Ms. BASCETTA. You had your second question. I need to answer your second question.

Mr. SIMMONS. Oh, yes, please. I beg your pardon.

Ms. BASCETTA. That is okay. It is a short answer. We have heard anecdotally that these technological devices, sometimes called telemedicine, are very promising, but we don't have any work on the extent of the availability of those services within the VA.

Mr. SIMMONS. I thank you for that answer, and at some point I will probably ask VA to supply that. Home health care is the way to go for many families, to include veterans families, and I understand these devices are fairly expensive now, but if I can do things

around the world with this little Blackberry, I am sure that with a little application of technology and a little effort, we can help a lot of those families who don't have easy access to the facilities and don't really need easy access to the facilities right now.

I thank you, and I recognize the ranking member, Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you very much, and I want to personally thank GAO for their report and what you indicated. There is some very startling comments on there, as well as the findings in the disparity that exists among the facilities, and I will have an opportunity to maybe follow up a little bit more with you, but I do want to take this opportunity because I know we have our ranking member on the full committee, Mr. Lane Evans, and I want to relinquish my time to him because he has got to be leaving.

[The prepared statement of Congressman Rodriguez appears on p. 37.]

Mr. RODRIGUEZ. Congressman Lane Evans.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you for yielding, and I thank the Chairman giving me the time today.

Today, I am releasing a report prepared at my request by the GAO, demonstrating significant service gaps in the delivery of noninstitutional care services to veterans.

In 1999, Congress passed legislation which added certain home and community-based services to VA's uniform benefits package. The GAO reported on these and other services. Not all VA facilities offer the same services, and even if they did, some services are limited to certain geographical areas.

The report is particularly critical, because the VA claims it wants to increase noninstitutional options in favor of a diminished nursing home program. Veterans are aging and their needs for long-term health care are growing. Very few medical facilities within the VA offer all these services, but some facilities have been equally diligent in providing these services.

In addition, other VA medical centers cap the amount of some types of care that they will offer according to the availability of funding, resulting in extended waiting times and unmet needs.

These reports don't paint a very good picture of the veterans access to noninstitutional long-term health care. VA is light years away from having an adequate response to the growing needs of our elderly veterans. Long-term health care is also an important part of VA's care continuum and deserves greater attention.

Mr. Chairman, I urge you to keep vigilant about this issue, and I appreciate the opportunity to be heard.

[The prepared statement of Congressman Evans appears on p. 40.]

Mr. EVANS. I yield back to the gentleman from Texas.

Mr. RODRIGUEZ. Thank you very much, and I want to thank you also for those comments.

Let me just—I want to thank, once again, the GAO for their report, and I want to just quote Dr. Roswell's statement, when it says that—when it was indicated that access to noninstitutional care services in the VA health benefits package is unrealistic and that the VA does not agree with the GAO's conclusions that there has been a lack of emphasis by the VA on increasing access to noninstitutional long-term care services.

I would like to ask you your response to those comments that were made.

Ms. BASCETTA. Well, we were surprised to see that, because in their official comments on the report, which are published as an appendix to the report, VA concurs with both our findings and our conclusions and recommendations. So obviously, they have done some rethinking since they wrote that concurrence.

I am not sure why they said that our recommendation was unrealistic. We are not suggesting that veterans in every single location have every single service available to them. We are suggesting that what is required is that similarly situated veterans have access to similar services, and we are noting disparities such as major locations, major metropolitan areas having a total absence of a particular service. We are not talking about areas that are remote where something isn't available because there isn't a contractor or there isn't a way to provide a service to every veteran.

So we disagree with that characterization.

Mr. RODRIGUEZ. And I would agree with you too, because it really bothers me when there seems to be a move from—apparently based on the assessments, and I want to get your clarification. From an inpatient to outpatient type of effort throughout the system—and I don't know, is that part of just trying to bring down the cost, or is that only a detriment, because I know that the disparities exist in terms of actual service? I know that that is negative, and that shouldn't be the case, but is it from a more—you know, if you look at it from a logical perspective, would it be the right thing to do to try to treat everyone on an outpatient perspective?

Ms. BASCETTA. Well, that is a very important question, because cost is certainly an important factor. Our understanding of the community-based services is that they are less expensive on a per-unit basis, but depending on how many veterans are served or non-veterans, if you are talking about the general population, the cost could be very significant. And son what is important about our work is that we continue to find that both the policy and the data that VA have need to be much more clearly articulated, and the policy needs to be data-driven. We need to know how these services are being delivered now, to how many people, with what kinds of variations in either their eligibility or other kinds of restrictions, and what the basis for that is, and what the costs are. And then we can think together about what a more reasoned approach might be.

Mr. RODRIGUEZ. I know I have gone over my time, but would it be fair to say that if you—I don't want to look at it legally, but if I live in a particular area, and I am a veteran, you know, based on this report, then I might have access to certain services, but if I live in another area, then those veterans there are not getting it.

So I see that as extremely discriminatory to some veterans based on just locality of the situation.

Is there any liability there? You know, we ought to be concerned about?

Ms. BASCETTA. That I don't know, but equitable access means that similarly situated veterans, in other words, veterans in cities, veterans in suburban areas, veterans in rural areas, ought to have access to similar services in those areas. They should not be having differential access or great disparities in the services that are available to them.

Mr. RODRIGUEZ. Thank you very much.

Mr. SIMMONS. The Chair recognizes Mr. Beauprez, followed by Dr. Snyder.

OPENING STATEMENT OF HON. BOB BEAUPREZ

Mr. BEAUPREZ. Thank you, Mr. Chairman. Probably more of a comment than a question, but I would be interested in your response.

The chairman raised the issue, the question of evolving technology and how it may assist. I am most anxious, given the seriousness of the concerns that you raised in your report and in your testimony both, to hear from Dr. Roswell, but having aged parents myself that are in long-term care, I have witnessed, I guess, some of the great assistance that has come with evolving technology for both aged or long-term, depending—not everybody in long-term care, I guess, is necessarily elderly.

But I also recognize, and having sought that care out, fortunately, we found it in our community. The difficulty of finding the quality health care that everybody would like to think is available to everybody in communities that are relatively accessible to all, and I am guessing that Dr. Roswell may tell us that therein lies a lot of the challenge. But having said that, we have an obligation, if we accept the obligation, of quality health care to all of our veterans, it becomes an obligation, I think, to those in most serious need. That has to be the greatest obligation.

Did you in any of your—in any of your findings, do you have any recommendations for use of some of the new technology or evolved long-term health care that might assist the VA directly? Where is the silver bullet?

Ms. BASCETTA. We don't have any specific recommendations aimed at those kinds of services.

Do you have anything to add?

Mr. MUSSELWHITE. There may be promise in some of these technologies. We did not look specifically at that, but their application, as I suspect Dr. Roswell may speak about, works for some things but not others. For example, in the home, a very important type of care that many people need is hands-on care, for example, bathing, dressing, those sorts of things. So for some things, technology may not be as directly applicable as it may for others.

Mr. BEAUPREZ. So the answer is you—and I am not suggesting that it should be otherwise, but you basically discovered the shortcomings, and we are going to leave the solutions to others. And that is fair, if that is the case?

Ms. BASCETTA. Yes.

Mr. BEAUPREZ. That is fine. Mr. Chairman, I will anxiously await Dr. Roswell's testimony.

Mr. SIMMONS. I thank the gentleman.

Have we resolved who was in the room first?

Mr. FILNER. Whoever was here when the gavel went down is equally eligible.

Mr. SIMMONS. Okay. The Chair recognizes Mr. Filner, who was here when the gavel went down.

Mr. FILNER. I will be very brief and yield to my friend, Dr. Snyder.

Ms. Bascetta, you have not painted a very pretty picture here, and my own anecdotal evidence, I would say, supports your findings. Is this question purely of money or is there a deeper systemic problem that we are dealing with? If I said, to fix this it requires X millions or billions of dollars, could we fix it with money?

Ms. BASCETTA. Well, you can always provide more services with money, but I think the more fundamental problem here is a lack of policy and a lack of data at headquarters about what is going on now. In other words, had there been greater emphasis on the need to develop long-term care policy, not just for the noninstitutional services but for the entire continuum, we might be in a better position now to know what might be causing these service gaps, the limitations in the geographic areas, the imposition of facility-specific eligibility standards, and we might be in a better position to know how much could be solved by reallocation or redistribution of the funds as opposed to the need for additional funds.

Mr. FILNER. I find that situation that you described as sort of systemic in various areas. That is, when we have passed other legislation, we have had difficulty getting evidence that has been successfully applied across the VA.

Ms. BASCETTA. Excuse me.

Mr. FILNER. And I suspect Dr. Roswell may be very definitive about this rather than figuring out how to deal with it, but, we are left with how to oversee these policies. Even if we pass legislation, all of a sudden 2,000 beds are taken away when we said they were frozen. How do we oversee this situation which should not be occurring? This is reprehensible, and we don't seem to have the tools, to come to grips with it.

I am sure Dr. Roswell will have an explanation for that situation, but it seems to me that they are in contempt of Congress in what has occurred here. I am not sure there is a legal kind of situation, but I would even pass some sort of resolution saying that if this were the case that was the finding that we made.

It seems to me that we on this subcommittee and the full committee have to figure out how to have the oversight that we claim that we have. Do you have any comments on that, contempt of Congress?

Ms. BASCETTA. I think I will leave that up to you, but I would say that you certainly can't make informed decisions or deliberate on long-term care policy without data, good reliable data, and they need to do a much better job of providing that.

Mr. FILNER. But how did you do your study?

Ms. BASCETTA. Well——

Mr. FILNER. You have the data, so let's give it to them and say act on it. You have the data, right, that you say they don't have?

Ms. BASCETTA. Yeah. Part——

Mr. FILNER. We will buy it from you, give it to them, and then say they better do something about it within X amount of time.

Ms. BASCETTA. Part of the picture—we have part of the data, but not all of it, and not as much depth in all of the areas that you would need to really take a hard look at long-term care policy overall.

Mr. STEARNS. Would the gentleman yield?

Mr. FILNER. Yes.

Mr. STEARNS. My colleague from San Diego mentioned—asked you a question. You said it is lack of policy and lack of data. So you are saying from your standpoint, the GAO's standpoint, it is not lack of money why they are not implementing the Millennium Health Care Bill. It is lack of policy and lack of data, that I just want to firmly establish, in your opinion, is that correct?

Ms. BASCETTA. Yes. For example, there wasn't guidance issued on some——

Mr. STEARNS. I understand. You talked about service gap, geographic area and these different things you mentioned I understand. But I think for this committee to hear from you that it is not money, because that is what we hear, but it is just lack of internal policy developed by the VA and lack of internal data that you have that you could give, so when the second panel comes up, Mr. Roswell, that is the people that we should go from your statement to them and say, okay, tell us.

So I thank the gentleman.

Mr. FILNER. Mr. Chairman, again, this is just one of many areas, but somehow we have to come to grips with these problems and really provide the oversight that we should be doing. It is, of course, very difficult. All of us who have served in public life for a long time, this is the most frustrating thing we have. That is, to really come to grips with the executive branch that is implementing what we have passed. It is always a problem, I have been on the school board and the city council, and it is the exact same thing. It goes from millions to billions and hundreds of billions, but we have to figure out a way to get some accountability, and I leave it to your creative mind to figure out how we might do that.

Mr. SIMMONS. I thank the gentleman for his comments.

I will simply note that in a previous life, I served on a committee on the other side of the Hill that had oversight responsibilities for the intelligence community, and I would say that dealing with the Veterans' Administration is a welcome, open, and transparent exercise after what I was confronted with in that previous life. And that being said, I would recognize Mr. Renzi, followed by, I think, Dr. Snyder at this point.

Mr. RENZI. Thank you, Mr. Chairman, and thank you for your testimony today. I was not here at the 106th Congress, and it is interesting to look at the history of this and see how it looks as if we asked the VA to implement and establish six new noninstitutional service home-based health care services, six of them, and in all honesty, I want to ask maybe your experience in the years you have served in helping us up here on the Hill, is it fair to say that

here, in the 108th, we have given them enough time? I mean, the idea that home-based health services, while being seen as the new wave of the future and as being seen of cost-effective and certainly more healthy for the patient, they can be at home, with their families, staying at their homes and loved ones, certainly, I can see all the benefits of it, but have we honestly given them enough time to institute six—and I am not looking to create—excuse this one, because I am going to wack them in a minute, but have we given them enough time in your thoughts?

Ms. BASCETTA. Yes, we have, but let me clarify for the record that the three new services that they implemented to comply with the Millennium Act were adult day health care, geriatric evaluation and home-based respite care. The other services were already being provided.

Mr. RENZI. Thank you. I didn't realize that.

Ms. BASCETTA. The law was passed in 1999. It took almost two years to issue implementing regulations, and it has taken even longer for us to see any improvement, and we haven't seen much in the availability of the three additional services.

Mr. RENZI. So in your opinion, the three additional services, we have had enough time?

Ms. BASCETTA. Yes.

Mr. RENZI. Your report is interesting when it talks about many facilities restrict the number of veterans. You use that word restrict. Is that something that they are doing purposefully, or is it because of facilities themselves?

Mr. MUSSELWHITE. Those decisions are made at the local level and facilities have discretion, in part based on network policies and sometimes without network policies, concerning how essentially they will allocate the resources and services they have available. So they may restrict a service, for example, by the number of veterans who might receive it at any one time. So, for example, if they have resources for 50 veterans to receive it at that time, no one else could receive a service until one of those 50 no longer received it.

Mr. RENZI. So it is really a function of the brick and mortar, the idea of how many they can fit into the box. It is not so much—or am I wrong? Please.

Mr. MUSSELWHITE. It may not be brick and mortar because these services, for example, some of the home-based services are provided at home, so the number of providers of that service or the number of dollars available for that service——

Mr. RENZI. So you are saying dollars then?

Mr. MUSSELWHITE. Well, that is the way they have made a decision about how they will spend their dollars.

Mr. RENZI. Okay. Any thoughts on the idea that under the original budget proposals that did not get implemented because of this chairman and because of Chairman Smith at three o'clock in the morning prior to the vote we were able to save those accounts, the idea that we are going to cut almost 7,000 nursing home beds and that those nursing home beds, the lack of those nursing home beds, would have to have been the—the burden of not having them around would have to be picked up by the home health care with this type of noninstitutional care.

Any thoughts on how that would have been accomplished, given the fact that, you know, see all the gaps that are in it, you now see all the restrictions that you have called out, you now talk about the fact we don't have enough people in some areas? Where would those veterans have gone to? Any idea?

Mr. MUSSELWHITE. We don't know the answer to that.

Mr. RENZI. The streets. Okay. Thank you.

Mr. SIMMONS. The Chair recognizes Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

I want to pursue this discussion a little bit about money or no money, because it is obviously an important question over the long-term, and I guess I am still a bit confused on what I think the answer is.

In your report, there are several factors that seem to be at play. One of them is you refer to the aging population, talk about the number of, I guess, doubling from 640,000 to a million two or a million three or something over the next 10 years of people—veterans 85 years of age and older. You also, someplace in your report, talk about how Congress has changed the eligibility standards to make more people available. Well, if we have got an increasing number occurring, why is that not a question of—I mean, surely at least that is a question of money, if we are going to double our numbers in terms of age, or if we are going to even augment that even further by the change in eligibility standards, surely that is going to create some pressure to have a bigger portion of the pie go for services for people 85 years of age and older. Or is my math wrong? Is my math wrong?

Ms. BASCETTA. No. I think our point is that we need a needs-based analysis of long-term care, what is happening now, and what VA would project to be happening in the future before we can figure out not only what the long-term care cost components would be, but how they—how with their entire appropriation, they would be able to fund long-term care services looking at the demographics of the entire population, not just the aged portion but all other veterans.

Mr. SNYDER. I would accept that. So what you are saying is, it may actually indeed be a question of money. If you are just saying, at this time, we don't know how much and what amount——

Ms. BASCETTA. That's right. We wouldn't have any basis for making that assessment at this point.

Mr. SNYDER. Right. You talk on page—oh, I guess it is the very last page you refer to ″faced with competing priorities and little guidance from headquarters,″ I think is your statement, but competing priorities implies to me, an acknowledgment that, even today, there is money problems. Is that a fair statement or not? Competing priorities to me would—that generally around here—when we are setting priorities, we are talking about who gets money and who doesn't.

Ms. BASCETTA. It is a little hard to hear you. I can see where you would read it that way. What we were specifically talking about in that part of the report is the fact that VA sets performance measures for certain activities that the networks then understand clearly are high priorities, and we were making the point that the non-institutional measure was not in that set of performance measures

and that, as a result, the networks were going to turn their attention and their resources to those items which they knew they would be measured on.

Mr. SNYDER. That makes sense. And on Page 9 of your written statement—and this concerns me, because, you know, you always want,—you know, good people can disagree about what is best for a patient or an individual or a veteran, but it ought to be an honest disagreement. On Page 9 you make the statement, one network director told us that the pressure from VA Headquarters to maintain nursing home utilization is much greater than that to offer noninstitutional services.

That is a concerning statement to me, because it is saying you may have a veteran when you think the best place for that veteran to be is at home, but somehow pressure is coming down—now, this would obviously occur on an individual basis, but it is obviously the pressure is coming. No, don't send Master Sergeant Smith home, keep him in a nursing home. Would you explain that statement?

Ms. BASCETTA. Well, we would agree that that would not be the preferred outcome, that—again, beginning with a needs-based assessment, we would hope that there would be sufficient flexibility in the system to provide the service that the veteran needs in the least restrictive environment.

Mr. SNYDER. Well, I want you to respond to the statement there. I mean, that is quite an allegation that some—one director is feeling pressured to keep people in nursing homes even though it is the policy—I think it is the policy of Congress and the desire of most people to be at home, but you are saying someone is feeling pressured to keep people in nursing homes who may indeed want to be at their real home. What did you mean—I mean, what do you know of that, or what is going on there?

Ms. BASCETTA. Well, again, I believe that this reflects an emphasis on headquarters in measuring nursing home capacity—the continuing capacity to provide nursing home beds, rather than an emphasis on the noninstitutional.

Mr. SIMMONS. I thank the gentleman. We have got a 15-minute vote, followed by a 5-minute vote.

We have time for one more set of questions, and so the Chair recognizes Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman. I had the great honor and privilege when I served as chairman in your capacity, we actually authored the Millennium Health Care Bill, and with the help of the staff over here, we got it through, and had a conference on it, and finally got it through. We had great expectations, and obviously we are a little bit concerned that they are not being implemented. And I am glad to hear, from your standpoint, it is lack of policy and lack of data and not lack of money, because usually up here, everybody says it is rack of money.

But just for a second, as a hypothetical, let's say you are the Under Secretary for Health, you have the responsibility, and the question for you is, what would you do in terms of reforms, VA reforms? And don't give—if you can, don't give me things like develop performance data or measure accountability. I mean, specifically, what would you do in terms of programs, implementation of these

programs if you were the Under Secretary of Veterans Affairs? Do you understand what I am trying to ask?

Ms. BASCETTA. Yes.

Mr. STEARNS. Just real specific here, so we have got the Under Secretary behind you here, and I am sure he will take a couple notes, for whatever it is worth.

Ms. BASCETTA. Well, I would find it hard to make a first move without——

Mr. STEARNS. Remember, you are so lucky here. Nothing you say is going to be implemented. It has no bearing. You are just hypothetically, for a day.

Ms. BASCETTA. I would be very frustrated in making a first move and thinking about reform until I had a very good handle on exactly what was going on in the field with regard to the services that were available and what veterans needed.

Mr. STEARNS. Are you saying they don't have that now?

Ms. BASCETTA. Yes. I am.

Mr. STEARNS. You're saying, right now, they have no understanding of what is happening in the field?

Ms. BASCETTA. They have a limited understanding, certainly. So first of all, you develop procedures, so that everybody can see what the current status is?

Mr. STEARNS. Right, and then what would you do?

Ms. BASCETTA. Well, then I might look to the nonVA world to determine what benchmarks might be, although I think that everybody pretty well knows that what is required is a good mix of institutional and noninstitutional care, and on the noninstitutional side, that mix includes both services that are more medically oriented, as well as services that require less skilled provision, so that you can both avoid institutional care, which is much more costly, but so that you can also give people the care in the manner that they prefer it.

Mr. STEARNS. Well, Mr. Chairman, I don't know if we have more time. So I think I will pass.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. Mr. Chairman, I am going to have a very difficult time coming back, and this is a very important issue for me. Can I just take 2 minutes?

Mr. SIMMONS. You most certainly can, because the gentleman has yielded back his time.

So you go for it, but we don't want to miss our vote.

Ms. BERKLEY. I will be very quick. First I want to thank you. I think while it is important that we do Congressional oversight on the existing VA nursing care facilities located across the country, it is also very important to determine where the demand for long-term care services remain unmet, and I can tell you in Las Vegas, they are unmet. We have well over 150,000 veterans now in southern Nevada. We have no nursing home. There is one State-run VA nursing home that has—that the VA has expanded the number of beds in the Nevada State nursing home in Boulder City, Nevada to 180. However, the VA has acknowledged that this expansion will not meet the needs of southern Nevada because of the expected vol-

ume demand and because the State home does not provide rehabilitative services.

The VA has also recognized the ability to contract in community nursing homes in Vegas. However, we have a tremendous lack of available community resources to contract with. Contracting with community nursing homes in southern Nevada is limited due to the quality of care deficiencies, high community nursing home occupancy rates, up to 96 percent, lack of specialized services, Alzheimer, psychiatric care, ventilator care just simply doesn't exist in southern Nevada. Nevada is ranked last with the lowest number of skilled beds per thousand persons age 65 and older. I am at my wit's end with what to do with my veterans. I think it is a function of money, as well as everything else, and I need to know when I am going to get some relief. And these veterans who retire to Las Vegas, they are healthy when they get there, by the time they are 85 and, by the way, 85 is the—that is the fastest growing veterans population in Las Vegas, our 85-year-olds and above. What are we to do with these people? Are they going to die in the streets? Are they going to die alone without family? Are they going to die without any nursing home care in a country of great abundance? This is a disgrace, and we have to address this problem. And if anybody can explain to me how I can get these necessary resources to a community that has an abundance of veterans and a lack of any facility to help these people, I would be very grateful, because this is an abomination.

Thank you.

Mr. RODRIGUEZ. Just a quick point of clarification. I want to get something clear, because a couple of members said that it wasn't about money. My understanding, did you say that you didn't have enough data to report on that? What you have reported is the fact that with the money that they do have, that they still have the disparities and that they haven't moved on the specific services, and if you have a veteran in one area, it doesn't get the same services that you give veterans. So it isn't that they don't need any money. It is that you have to make the assessments. Is that correct, yes or no?

Ms. BASCETTA. That is correct.

Mr. SIMMONS. Tune in in 15 minutes and the show continues.

[Recess.]

Mr. SIMMONS. The subcommittee will reconvene. I have polled my colleagues at the dais, and it appears that we are now ready for the second panel. So I wanted to thank our panel for their fine testimony. We appreciate it very much. We will probably have some follow-up questions for the record. So prepare yourself.

Now I would like to welcome Dr. Robert Roswell, Under Secretary for Health of the Department of Veterans Affairs. If he could come forward. He is accompanied by Dr. James Burris, the Chief Consultant for Geriatric and Extended Care at the Veterans Administration.

STATEMENT OF HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JAMES F. BURRIS, M.D., CHIEF CONSULTANT FOR GERIATRIC AND EXTENDED CARE

Mr. SIMMONS. I suspect that both of you gentlemen have heard some of the interaction of the first panel. I look forward to hearing your testimony. We have a prepared statement from you, Dr. Roswell; feel free to summarize that as you see fit. Then we will get into questions.

STATEMENT OF HON. ROBERT H. ROSWELL, M.D.

Dr. ROSWELL. Thank you. Mr. Chairman. It is a pleasure to be here. I am pleased to introduce Dr. James Burris, who after a lengthy hiatus, where we have not had effective leadership in the Office of Geriatrics and Extended Care, joins us as our highly qualified new chief of that office.

As you have suggested, Mr. Chairman, I have submitted my formal testimony and won't read that, nor I will read the summary statement I had prepared and planned to read as an abbreviated version, because I would like to take this brief time and address some of the issues that have already been raised in response to the first panel.

First, let me publicly acknowledge and thank the General Accounting Office for helping us better understand the availability of noninstitutional services to VA patients. Fundamentally, I have no disagreement with their report.

Certainly I have no disagreement with their findings or their recommendations. I concur wholeheartedly in the recommendations and am eager to seek implementation of those.

I think the two points where I might, for the record, clarify a difference of opinion, if you will, would be first on the emphasis within VA. Clearly, now, we have a very great emphasis on noninstitutional care and services.

And the second area where I would disagree is this—I believe the quote about being unrealistic to access these services.

The services the GAO looked at are six services, which are recognized and described in program language. They are clearly not services that are universally available. For example, our own program criteria for hospital-based primary care, one of the services they looked at, clearly articulates that the veteran must live within 35 miles of the hospital-based primary care program.

That is because in that particular program, the hospital-based or, excuse me, the home-based primary care provider actually makes home visits. And to make that a pragmatic realistic program, veterans have to reside within a certain geographic range to be able to avail themselves of that program.

Another example is adult day health care, where we often contract for that service. It may not be economically feasible for VA to staff and operate an adult day health care program in an area where there aren't sufficient veterans to justify that investment of effort.

In that situation, we would seek to contract for an adult day health care service for eligible veterans who would benefit from such a program. But, if there is not a qualified program who meets

our fairly rigorous contracting standards, then it would be impossible for us to contract and acquire that.

So it is unrealistic to think that all veterans in all locations will have access to all six services simply because they don't exist and can't be made to exist. I do agree, however, with Ms. Bascetta's opinion that equitability of access should be similar in similar geographic regions of the country. I certainly agree with that.

To go back to the area of emphasis, let me point out that noninstitutional care is a particular emphasis of mine. And, Mr. Chairman, I am glad you brought up the use of technology. When I was the network director in Florida, going back to 1999, I actually took $5 million of my allocated funding in Florida and created the first of a community care coordination program specifically focused on using the interactive technologies you have spoken of.

The advantage of interactive technology is it allows us to reach well beyond the commuting distance of a practitioner so that in-home service is no longer bounded by the commuting range of a home-based caregiver.

Florida today has over 1,500 people enrolled in a program using interactive technologies to monitor health in the home. I might point out that those 1,500 patients aren't even counted in the data we show here, because they don't conveniently fit one of the programs.

The use of telehealth technology in the home is not a home-based primary care program, because it preserves the existing relationship with the primary care or specialty provider in the hospital or outpatient clinic setting. So it doesn't fit one of the convenient categorizations of programs, and therefore is not reflected.

We have had a substantial growth in noninstitutional care services. We have increased from 11,000 to 17,000. The home—the program I spoke of in Florida that I am quite proud of, has extensive data that is available, in fact, it has been accepted for publication and will be published in a medical journal just next month.

We have replicated that with the creation of a new care coordination program office in our VA headquarters. We have just selected a chief officer for that office, and he is in the process of relocating to Washington to take over the leadership of that care coordination program.

Last fall, at the end of fiscal year 2002, I actually made available additional moneys to fund new care coordination sites using the telehealth technology, and I have made a commitment to provide additional funding this year in the amount of $5 million to provide additional equipment to begin to expand and build upon that program. So there is a tremendous amount of emphasis.

With regard to the bed census, we have put in place VISN specific performance monitors to meet the nursing home requirements of the Millennium bill, which is to maintain an average daily census of 13,391 patients, the number of patients that received VA nursing home care in 1998.

I would point out that since 1998, the number of Veterans each year who receive VA nursing home care has actually increased, even though the average daily census has decreased. And the reason is that the length of stay has been reduced. We are very proud, very proud of the fact that patients who receive care through VA's

nursing home beds, in over 70 percent of the cases are discharged to home, because they have been restored to a level of functionality that allows them to return to an independent living arrangement in the home.

This is not custodial long-term care, and we are quite proud of the outcomes. But, because we are achieving and attaining these outcomes, we are able to provide inpatient long-term care services through our VA staff nursing homes to more patients, even though the average daily census has admittedly declined.

With the implementation of the performance measures, though, that I spoke of, the actual average daily census has now increased over 12,000, which represents a substantial increase over the nadir of approximately 11,700 last year. So it is going back up with the implementation of those performance measures.

We have also implemented VISN adjusted performance monitors for home-based and community care services, the noninstitutional care services I spoke of. And with that implementation and emphasis we expect to see the VISNs improving in their implementation of those services. We have developed directives, a new emphasis letter will be going out very shortly to reemphasize the importance of these programs.

I should also point out that when I was the network director in VISN 8, I created a program for home respite, a program that was—that became a national program, using volunteers to provide respite services in the home.

There was talk about not being in touch with what our patients need. We actually conducted focus groups with patients, with their providers and with their primary caregivers to understand what the barriers to home care were.

And respite was one of the highest priorities identified, which is part of the reason we created the Volunteer Home Respite Program, which has been a very successful model.

So I can't, in good conscience, take some of the criticism that has been leveled at the Under Secretary For Health, because I do consider myself an avid proponent for noninstitutional care and for geriatric care in the VA.

I have been aggressive and will continue to push for this with the new care coordination office, with the new performance measures, with the emphasis that we are giving it, and with Dr. Burris's leadership, we expect to continue to enhance care and services in both institutional and noninstitutional settings.

One way I hope we will be able to do that in the future is to be able to provide institutional care when it becomes essential in an assisted living facility where the veteran will be able to maintain the pair bond with his or her spouse.

Right now, institutional care in the VA, of necessity, forces a separation of husband and wife when institutional care is provided. It is something that I believe is very, very wrong with the way we provided institutional care.

So when seeking care, coordination and providing health services in an ALF facility, we are working on ways to be able to main that that spousal relationship when the time for institutional care becomes unavoidable.

Mr. Chairman, I am deeply committed to implementing the recommendations of the GAO report. And Dr. Burris and I would be happy to answer any questions you might have.

Mr. SIMMONS. Thank you very much.

[The prepared statement of Dr. Roswell appears on p. 59.]

Mr. SIMMONS. I have a couple of questions that I would like to ask. In looking at your testimony, page 6, attachment 1, the aggregate numbers for noninstitutional care, the total numbers, go from 1998 to 2004, from 11,000 to 25,000.

Some of the subcategories in that chart show substantial growth over time. Others do not. For example, VA adult day health care is pretty much flat-lined around 400 for the Nation, which I would suspect is a pretty low number considering the health of adult day care—considering the positive response we get in my district to adult day health care programs on the civilian side.

I also notice that home hospice only begins to be estimated in 2004. Again around 400, under 500 folks. I wonder if you could comment briefly on those two programs.

And then I have one additional question. In May of last year, Secretary Principi responded to Chairman Smith and Ranking Member Lane Evans on the issue of implementation of Public Law 106–177 and the issue of VA nursing home capacity.

And there has been correspondence since that time that suggests that maybe earlier commitments to nursing home capacity have been reconsidered by the highest echelons of the VA. I would like to hear your response to that question and whether or not that is the case. I look forward to your answer.

(Subsequently, the Department of Veterans provided the following correspondence that Chairman Simmons is referring to:)

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 8, 2002

The Honorable Christopher H. Smith
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

I am writing in response to your co-signed letter regarding the plan I submitted to you on March 20, 2002, detailing how the Department of Veterans Affairs (VA) would meet the VA nursing home capacity, as required by P.L. 106-117, by foregoing expansion or reducing other programs. I appreciate your plan to recommend that additional funds be appropriated to restore approximately half of the VA nursing home capacity in fiscal year 2003, with the balance restored in fiscal year 2004. If additional funds are added to VA's medical care appropriation, I can assure you that the funds needed to restore the VA nursing home capacity to the 1998 level will be used for that purpose and that VA's performance in achieving that target will continue to be monitored.

In response to your request for verification of VA nursing home per diem costs, we have initiated an in-depth analysis of the reported costs and of the complexity level of veterans in VA nursing homes. We expect this analysis to be completed by early May and will provide a report on the findings to the Committee by the end of May.

I look forward to continued discussions about how best to meet the nursing home, as well as home and community-based care needs of veterans. A similar reply has also been sent to Congressman Evans.

Sincerely yours,

Anthony J. Principi

Anthony J. Principi

Dr. ROSWELL. Thank you, Mr. Chairman. Well, you have asked, I believe three questions. And let me take them in order. With regard to adult day health care, if you will look at the row just below the one you referenced for contract adult day health care, you will see a three-fold increase in the number of adult day health care patients projected by contract.

The reason is that we found, as I alluded to in my opening statement, that trying to provide adult day health care with VA staff requires, of necessity, that we have a sufficient number of veterans to justify the hiring of the full staff. It is actually economically more attractive, and it allows us to extend the geographic range of that service in most cases by contracting for that service. So it is a more efficient way to do that.

With regard to home hospice——

Mr. SIMMONS. If I can just interrupt on that point to get clarification. It is my understanding that VA facilities across the country have excess capacity in the way of rooms, or even floors.

So what you are saying is that it is entirely a staffing issue, not a capacity issue at those facilities?

Dr. ROSWELL. The problem, if you will, with adult day health care, is it has to be convenient. It is a day program. Adult day health care offers primarily socialization. Limited health care, some assistance with feeding, but it really—there are three major needs for geriatric long-term care: Socialization needs, which are very important to maintain cognitive function and quality of life. We also need to provide health care. And we need to provide assistance with daily livings.

An adult day health care program primarily provides socialization during the day. Of necessity, it has to be sufficient, it has to be within reasonable commuting distance for the veteran who is almost universally brought to it by the caregiver. So if it is not close or convenient for the caregiver to get the veteran to the adult day health care program, then it really serves no meaningful purpose.

The problem is that often where we have excess physical capacity, as we are now exploring through our Cares Program, we don't have a sufficient population to justify adult day health care. We actually have adult day health care programs at VA facilities that have not been particularly successful because they are simply not close enough for veterans to reach it in a commuting basis.

The ideal way is to provide adult day health care within a reasonable commute, 2 or 3 miles at most ideally, of where the veteran lives. To do that, it is much more efficient to contract for that care.

Mr. SIMMONS. Thank you.

Dr. ROSWELL. Your second question had to do with hospice care. And again, we have certainly emphasized hospice care. We currently provided hospice care in virtually all of our medical centers on an inpatient basis, but we recognize that home hospice is an important service. We are developing programs and guidelines.

The reality is that many veterans are receiving the equivalent of home hospice care today, but because we haven't structured and formulized the program, it is only phased in in 2004.

Finally, you talked about the Mil Bill requirements to maintain the 1998 nursing home average daily census. Again, I spoke to that in my opening comments, pointing out that we are actually treating

more patients in our nursing home beds than we did in 1998, although the average daily census is lower. The Mil Bill is to maintain the average daily census, not the operating beds nor the number of veterans served each year.

Because veterans are receiving shorter lengths of stay, because their rehabilitation is being completed more quickly, they are turned to home at an earlier date, and the census drops.

The reality is, that in most cases, VA nursing home beds don't provide long-term care. They provide post-acute hospitalization rehabilitation. Those beds are collocated, in the overwhelming majority of places, with our acute care facilities. When a veterans has significant rehabilitation needs, or when it is a frail elderly veteran who needs careful assessment to be able to determine a geriatric care plan that allows the veteran to resume a more functional independence, those patients receive those care in our VA staff nursing homes.

But, as I said, one of the greatest outcomes possible in those nursing home beds is a discharge to the home environment, which occurs in almost 80 percent of the cases. And that reflects a different level of care than custodial long-term care.

So, yes, the 2004 budget policy does, in fact, propose a fairly radical departure from the requirements of the Mil Bill. The 2004 budget policy proposal suggests that VA long-term care should be reserved for 70 percent service connected, who by law are entitled to that care, and be used for this post acute rehabilitation care that I spoke of, as well as respite care and for geriatric evaluation and management plus hospice care, reflecting more accurately the actual utilization of those services.

Obviously, that is a decision that the Congress must make in determining whether or not to change, and obviously the 2004 budget policy would propose a change in the current statutory requirement to maintain that 1998 census. Because that change has not yet been enacted, we are continuing to attempt to move towards the Mil Bill requirements. Our goal by the end of this fiscal year is to have a census of 12,550 patients, which is not the full 13,391, but it is a significant increase over the 11,700, which was the average daily census last year.

With the implementation of VISN specific performance measures, we are on target to hit that this year.

Mr. SIMMONS. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much. I know you had some concerns with the dialogue that was occurring and some, I guess, some disagreement. Your statement that the VA has taken aggressive action, quote, to implement the extended care provisions of Public Law 106–117, the Millennium Act, seems to conflict with a January 3rd report that the committee received this past March.

And on the cover letter of that report, about the VA's experience under the Millennium Act, Secretary Principi concludes, between the enactment of Public Law 106–117, November of 1999 to September 2001, there is evidence of only small changes in the VA's long-term care services that were a direct result of the Act versus what the VA had already planned to provide for veterans.

And so, you know, there seems to be also agreement on the part of the Secretary that we have not seen the action that we should have.

Dr. ROSWELL. Mr. Rodriguez, I can't speak for the Secretary. But, I think, I believe what you said was, he showed there was a small difference between what we originally planned and what the Mil Bill required us to do. We have always had a commitment, even before the Mil Bill made it a statutory requirement, to expand our noninstitutional care and services.

In the very tables that the chairman referred to, show that aggressive growth from 11,000 patients receiving noninstitutional care in 1998 to a projected 26,000 next fiscal year, in 2004. We are on a track to do that.

Now, we have taken some actions, but I believe that the Government Accounting Office is correct. We have not been as aggressive as we should have been over the past number of months. But, the commitment is there now. I have that commitment. Dr. Burris shares my commitments. We are aggressively implementing the recommendations of the GAO and fully expect to achieve this noninstitutional census.

Mr. RODRIGUEZ. Let me just make sure we get this correct. From 1998, what you just quoted, to 2004, which is an estimate, it is not that you have gotten there, you just hope to get there, but that is noninstitutional, which I would presume that that is part of the problem that is occurring there, because we get reports that your non—you are pushing patients out to outpatient care, which is actually, in a way, you know, one of the complaints that we get versus inpatient care, and you are saying that you are increasing in that area.

Yes, we agree that you are increasing in that area. But, that is one of the easiest ways to increase, because in a way you are kicking them out of the hospitals, more long-term care into outpatient care. Whether you are providing care or not, I don't know. But you have them labeled as outpatient care.

The actual figures that we have is 11–7 to 17, and the other one, the 20-something is an estimated one. Is that correct?

Dr. ROSWELL. Yes. That is correct. The—I do understand your concerns. Let me point out that our institutional, our inpatient census actually grows over the same period. But the proportion of institutional care being provided in State nursing homes increases most significantly.

Now, I would point out that that is probably the most cost efficient way to provide institutional long-term care that is primarily custodial in nature, in other words that is long-term as opposed to the rehabilitation.

Mr. RODRIGUEZ. And I would agree with you there too. But I would also ask, and ask your perspective on, that if we want to provide care, that it takes a combination both of inpatient and outpatient care.

And what disturbs me is the fact that if—the disparity that exists from one region to another, from one area to another, and, of course, now the possibility of everybody cutting and making even—you are saying 70 percent for nursing home care, where they have

to be 70 percent of what—of disability? Is that—was that 70 percent you talked about?

Dr. ROSWELL. The Mil Bill mandates lifelong care, assuming the veteran needs it and desires it, for any veteran who is disabled at a level, a compensable disability of 70 percent or greater, or if they are service connected——

Mr. RODRIGUEZ. 17 percent?

Dr. ROSWELL. 70 percent for any condition, or any level of service connection if the service condition generates the need for long-term care. That is another provision of the Mil Bill. The Mil Bill, of course, is a complex set of legislation that has many provisions. But, that mandates that we provide institutional long-term care for as long as necessary for those veterans who choose that.

Mr. RODRIGUEZ. Do you have any comments in terms of the disparity that exists out there?

Dr. ROSWELL. Well, I think there is a disparity. Let me point out that the eligibility reform legislation, going back to 1996, creates a uniform health care benefit for all veterans who are eligible to enroll in and receive that benefit.

The uniform health care benefit of the Eligibility Reform Act in 1996 does not include institutional long-term care. It was only the Mil Bill that included—that added noninstitutional services to the uniform health benefit. But institutional long-term care is not still not a part of the uniform health benefit, and therefore by law, veterans who are eligible to enroll in and receive the full uniform health care benefit aren't entitled to institutional long-term care.

But, recognizing that certain veterans had greater priority, the Congress created an entitlement, if you will, for 70 percent service connected or greater veterans for long-term care. It is not a part, though of the enrollment uniform benefit.

Mr. RODRIGUEZ. Thank you.

Mr. SIMMONS. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Mr. Chairman. I want to probe maybe two different directions. If I recall from your testimony, you said part of the difficulty in reconciling the GAO's findings, and maybe current performance, is a little bit of apples and oranges that you said some patients, some veterans don't fit neatly into various categories, and are not necessarily being—you are not being given credit maybe is one way to put it.

If indeed that is—if indeed that is the case, how do we get to apples to apples? I mean, this is not a very glowing report from the GAO. It is pretty serious stuff. How do we reconcile that?

Dr. ROSWELL. Well, you are correct. Part of it, and I don't blame the GAO for that, and I certainly don't blame the Congress for that, it is our fault. We have created new models of care, such as the care coordination model I spoke of, and don't have a convenient way to categorize that. And so I have asked Dr. Burris to work with the director of new care coordination office, Dr. Adam Darkins, to develop a new way to capture that workload and show that as extended care.

Of the 1,600 patients today who are receiving care in their home using the interactive technologies you and the chairman spoke of, none of those are reflected on these data, because they are not receiving home-based primary care, this is a different kind of care.

They are not receiving adult day health care, they are not receiving home health aid services.

In a few cases they may be, and they may be counted. But my point is, of the six categories the GAO looked at, the care coordination, or telehealth care, whatever you want to call it, was not one of those categories, and so they weren't counted.

By creating a program office and monitoring that workload through the office of geriatrics and extended care we will be capturing all of that in future.

Mr. BEAUPREZ. Okay. I hope so. Because I don't think anybody is necessarily out to distort numbers, to either make them look better than they are, nor necessarily worse than they are, but this committee obviously would like to know what they are, and accurately so.

So in that vein, guess what—the other direction I would like to probe, is part of the question still remaining to me, again, given the report, it doesn't sound very good. Quite concerning, in fact.

And, you know, averages and progress and all of that is great, unless it happens to be you that is being left out in the cold. You, a veteran who is really looking for care and is not getting it. So one way of saying that, I guess, or asking the question is, who is falling through the cracks? How many are they? And what are we going to do about it? And kind of a follow-up question, within the VISNs or some geographic analysis, do we know where the hot spots are, where we have the most problems, and within the network are we attacking those with some degree of prioritization or something?

Dr. ROSWELL. I think we have reasonably good data. First, let me tell you that we recently asked, or I recently asked one of Dr. Burris's staff to survey our VA nursing homes and identify what the magnitude of waiting lists for VA nursing home placement was.

And I will defer to Dr. Burris. But, at the time I was told that there was virtually no waiting list in any region of the country. I know that when I talked to our VISN directors, when I talk to our medical center directors, I routinely ask them when I visit a medical center, do you have a waiting list for your nursing home? And almost invariably, now recently I had one director tell me, yes, I do have a waiting list.

But, it is the first time that I have gotten that answer in quite some number of months. That was in Philadelphia, for the record.

But, for the most part, there really isn't a waiting list for VA nursing home beds, which reflects that veterans who may avail themselves of that care need that care, presumably are getting it.

Mr. RODRIGUEZ. Will the gentleman yield just on that? That can also be a little misleading. I come from Texas. I think we only have two or three nursing homes. So when you don't have them, to say that there is not a waiting list, hell, there is nowhere to apply to get on a waiting list.

I don't have them in Bexar County, population of over a million, we don't have a nursing home in Bexar County. We don't have one in Dallas, I think, the 9th largest city in the Nation. We don't have one in Houston. We got one in Wilson County, we have one in Temple. We have I think three or four in the whole State.

So it is kind of misleading when you say—I just wanted to just clarify that. Okay.

Mr. BEAUPREZ. Certainly.

Dr. ROSWELL. Maybe we should get some information for the record to you. I was referring to VA, not State nursing homes, but VA nursing homes. And I am pretty sure there are VA nursing home beds in Dallas.

Mr. RODRIGUEZ. No, sir. I would ask that you educate yourself about Texas.

Dr. ROSWELL. I will do that. I used to be the chief of staff at Dallas when we opened a 120-bed nursing home. So it might have closed since then. I will certainly do that. I apologize.

Mr. RODRIGUEZ. If I am wrong, I will apologize. But my impression is, that we have only got three or four in the whole State.

Mr. BEAUPREZ. Did the gentleman say don't mess with Texas?

Mr. RODRIGUEZ. He can mess with it if we has got resources for it.

Mr. BEAUPREZ. Well, it does raise, if I might, Mr. Chairman.

Mr. SIMMONS. Please.

Mr. BEAUPREZ. It raises, I guess to me still a remaining question. Do we know who is falling through the cracks? And I think that is part of the dilemma. I am hearing you say that your—through the network you are being told that, save the one exception, there is not a waiting list.

I wonder about some of other findings in the GAO's report. Do we know how many are falling through the cracks, and how serious the problem is? The GAO report is reasonably alarming. Your testimony makes me think that perhaps all is well. And I am trying to reconcile that in my mind.

Dr. ROSWELL. First of all, let me say that I was speaking only to institutional long-term care. Let me again clarify that there are really three types of institutional long-term care VA uses: VA staff nursing homes, contract community nursing homes and State veterans nursing homes. The total number of institutional census is increasing in those, and the number of bed availability is increasing.

In reality there is a fourth very large category, and that is Medicaid funded or self-pay. Many veterans who are placed on a contract community nursing—contract for community nursing home care, do so as their eligibility for Medicaid benefits is being processed, and then Medicaid takes over and provides that long-term care.

The combination of those three levels of institutional care, coupled with the availability and access for Medicaid funding for nonVA nursing home care seems to be meeting the demands, because we don't have waiting lists for institutional care.

The GAO in this report looked at noninstitutional services, some of which were just authorized with the passage of the Mil Bill. And there I concede that we have not yet established equitable access to all of the range of noninstitutional programs and services that are currently authorized.

What I was trying to clarify is, that I don't think it stops there. I think it goes well beyond that. Because I think that there are new models of long-term noninstitutional care, such as the care co-

ordination telehealth I spoke of, which will represent a significant new level of noninstitutional care.

And as we become more proficient in providing these types of noninstitutional care, we actually further reduce our reliance upon institutional care. For example, in the program in Florida I spoke of, where we actually have completed a statistical evaluation of it, 88 percent of the time the risk for nursing home places was reduced or eliminated through the care coordination. There was a significant drop in the number of nursing home placements by virtue of having access to care through the telehealth care coordination program.

But, that outcome cannot be made universal until we deploy that care coordination program nationwide. Currently it is deployed in four VISNs and we are moving to the other 17 VISNs later this year with the activation of the new care coordination office.

We anticipate that by this time next year, we will have close to 10,000 patients receiving care through telehealth care coordination. Again, though, they are not even projected in here, because it is not one of the categorize we traditionally or even currently at this date count as a form of noninstitutional long-term care.

But, I can assure you every one who receives the telehealth care coordination, will have a substantial reduction in their risk for nursing home placement. And I will also assure you that we will put in place the mechanisms to capture that.

Mr. BEAUPREZ. Mr. Chairman, I just would close by stating what I think is certainly your commitment. It is my commitment, my sense that it is the whole committee's commitment. One, we ought to make sure that our evaluation process is accurate, that the information we are getting is correct.

But, as committed as we all are to the care of our veterans, certainly it would ratchet up in my mind to those most needy and late in life, if we are going to preserve the dignity of anyone, it definitely ought to be those, especially as they maybe approach their last days.

I would suggest that we stay very tenacious in that objective. And, Mr. Chairman, I thank you for holding the hearing. But I would hope that we have opportunity for updates of progress in the near future.

Mr. SIMMONS. Absolutely. I thank the gentleman. Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman. Dr. Roswell, I got a myself a little confused there when you were talking with Mr. Rodriguez about the status of nursing home waiting lists and so on. When you are saying there is no waiting lists for nursing homes, are you talking about chronic long-term or care or are you talking about nursing homes in the VA that fit the category of veterans you were talking about earlier, just out of the hospital, in a fragile status for evaluation? Which are you talking about?

Dr. ROSWELL. I didn't categorize it that way when I asked for the survey, nor do you routinely ask that. Typically when I visit a facility, I ask what kind of care they provide. We do provided some long-term, if you will, custodial care in our staff nursing homes.

Mr. SNYDER. But, there is not a lot of that, is there, in the Federal system? I mean, because I think one of the problems we have is that——

Dr. ROSWELL. Dr. Burris just pointed out that approximately 35 percent of the total VA nursing home census, roughly 35 percent of the 12,000 patients currently in VA nursing homes are there for extended stays.

So the majority of patients are there for the rehabilitation care, the respite care, the gym care, the hospice care.

Mr. SNYDER. That doesn't necessarily mean, though, that those beds are custodial beds, though, does it not? Those facilities may have a policy that once a patient—once those 35 percent or whatever they are, as they gradually empty out, those beds may be graduating to the more acute situation; is that a correct statement?

Dr. ROSWELL. I believe that is a correct statement. Typically, if we identified—in many VA hospitals, if we identified a need for this long-term or maintenance care, instead of placing the patient on a long-term basis in the VA home, they likely would be placed on a contract within a community nursing home.

And then, at some point, convert to Medicaid funding for that need. The reason that would happen is, that the average per diem cost for a VA nursing home, our costs, our staffing cost nationwide, is about $394.

The average per diem cost for a contracted community skilled nursing home bed is approximately $185.

Mr. SNYDER. I am still trying to understand Mr. Rodriguez's question and your answer. Is it possible that what is going on is that you look at what is going on in Dallas or San Antonio and say there is no waiting list, but, in fact, there may be no waiting list for these kind of, I will say acute care, that is acute care, fragile evaluation, and what he is talking about is trying to find a placement for long-term custodial care. Could that be an explanation?

Dr. ROSWELL. Dr. Snyder, I think that in certain circumstances, what you are talking about could occur. But, let me point out that we have also surveyed the State directors of Veterans Affairs, and don't identify waiting lists for the State veterans' homes either where maintenance care is a more typical type of care being provided.

In fact, the average daily occupancy as a percentage of total beds is well below a target of 95 percent in both VA staff nursing home beds and State veterans homes.

I would also point out that in this country, just a decade ago, there were approximately 17,000 community nursing homes. Today that number has dwindled to approximately 13,000. So it would appear.

Mr. SNYDER. Our legislature just adjourned a couple of weeks ago, and one of their priorities was getting funding in order to qualify for a State nursing home for veterans. So I think they thought that there was a need.

I wanted to ask about the letter in the report here from Secretary Principi. We are talking about coordination and word getting down from on high to the people in the field. And it appears that there wasn't even good coordination between Secretary Principi and the two of you; is that a fair statement?

Dr. ROSWELL. Oh, no. There was coordination.

Mr. SNYDER. I read this letter. I don't sense any equivocation at all about agreeing with what was in the report. You were very clear that there were things that you disagree with.

Dr. ROSWELL. I thought I made it clear in my opening comments, I apologize if I don't.

Mr. SNYDER. I heard what you said.

Dr. ROSWELL. I agree with the findings. I agree with the recommendations. I agree with the need to implement that. I am only pointing out for the committee that I am personally very committed to implementing that, that we have taken actions following Secretary Principi's letter to put in place performance measures across all of the VISNs.

We have created a new program office. We have a new directive going out to reemphasize the importance of making sure that we have access to this, a variety of new handbooks are being developed.

So there is a lot of emphasis ongoing now. I acknowledge that emphasis may have been lacking in the past. I don't think there is a fundamental difference, I don't believe there is, in what I have said, and what Secretary Principi said in his letter to the GAO.

Mr. SNYDER. Because some of findings of GAO are discussions about priorities and emphasis and pressures. Those imply that they are coming from on high, which is you. Do you agree with those findings also?

Dr. ROSWELL. I think there has been a—I think part of the variability that the GAO found is because of a variable management emphasis.

Mr. SNYDER. From facility to facility?

Dr. ROSWELL. From facility to facility and even from VISN to VISN.

Mr. SNYDER. Can I ask one more question? This doesn't have to do with the report, but it is probably long-term care 101. I think it is kind of assumed that caring for somebody at home is automatically less expensive than somebody being in a long-term bed. I am not convinced that is true. It may be true. I may be just dumb as hell and don't know it.

Because, I think sometimes how programs save money on long-term care at home is they just cut back on the hours and don't provide adequate services. If you are short on money, say, okay, you are not going to get 20 or 12 hours this week of housekeeping services, we are going to cut you back to 10 hours. You are still at home. We are still cost effective.

But the quality of life may be inadequate. Is it clear to you that it is clearly more cost effective to have people at home? I think it is better quality of life to have people at home. I think that is what we ought to aim for, what Ms. Bascetta talked about the needs.

I get a little apprehensive if we base it all on cost, because there are nursing home operators that say we can do it cheaper in an institution than you ever can at home for a lot of patients. Is there a clear answer to that?

Dr. ROSWELL. Certainly the point is well taken, that when there are economic constraints, that curtailment of home services is a factor that, you know, we would hate to see that happen.

Clearly there are exceptional patients that can be cared for less costly in an institutional setting. A good example might be a ventilator patient, trying to manage a ventilator patient in the home is a very difficult undertaking.

And it probably would be easier and, in fact, less costly, on a per diem per patient basis to do that in a chronic ventilator care facility. So you are absolutely correct. There are circumstances where your hypothesis, I believe, would be validated by actual findings.

I do want to emphasize a point you made, because we do have good data on that. And that is, that patients do, in fact, prefer to remain in the home environment. They consistently tell us that.

Mr. SNYDER. To me that is the key, which is, we all—I think almost always prefer to have ourselves or our relatives at the home. Thank you, Mr. Chairman.

Mr. SIMMONS. Thank you. Dr. Burris, you have been sitting there very quietly. I don't want the moment to pass without putting a question to you.

First of all, I did not catch your bio in our enclosures, so I will invite you to say a word or two about your background. I believe that you have a distinguished career in geriatrics and at Georgetown, and I guess my question to you then, as somebody who has that academic association, you have heard the discussion earlier, the comment made by GAO that there appears to be a lack of policy and data.

As somebody who has spent time in the academic world, data searching and analysis is usually a precondition to policymaking.

We have had a hearing this afternoon where there has been a good deal of discussion about the policy, the data supporting the policy, whether the data is there and, in fact, whether we can frame the success of this policy in our oversight of the policy without clear and consistent data.

Would you indulge us for a few moments and tell us a little bit about your background and what your thoughts would be about the discussion that we have had this afternoon.

Dr. BURRIS. Thank you, Mr. Chairman. I trained, I did part of my medical training in the Department of Veterans Affairs, as do about half of all physicians in the United States. I then joined the faculty at Georgetown University as an internist and geriatrician.

Practiced medicine at Georgetown for several years, and then returned to the VA at the Washington VA Medical Center, where I was one of the two physicians who opened the new nursing home care unit there in the mid 1980s. We took care of 120 veterans ultimately in that facility. I was then recruited back to Georgetown to serve as an associate dean for research operations. And came back to VA again as the deputy to the chief research and development officer in 1997.

I have just recently joined the Office of Geriatrics and Extended Care in January of this year. And am very pleased to get back to the field of geriatrics. I do also maintain an appointment as a clinical professor of medicine and pharmacology at Georgetown University School of Medicine. Georgetown doesn't have a geriatrics department.

Mr. SIMMONS. What are your thoughts on the discussion involving policy and data versus money, or whether we have sufficient data to frame an adequate policy in this area?

Dr. BURRIS. Policy must be data driven. That certainly has been a clear principle of VA under both Dr. Kaiser and Dr. Roswell. And it is absolutely critical in making good decisions.

We found, in looking at the level of demand we were actually experiencing for long-term care services, that it seemed to be out of sync with the predictions that we were getting from our existing long-term care planning model. And at Dr. Roswell's direction, we have initiated a process to refine the long-term care planning model to try to give us better data about what the real needs that veterans have are.

We are looking at such things as the fact that there has been a trend toward diminished disability in older people nationally over the last 10 or 15 years. There has been a trend, as has already been referred to toward diminished utilization of nursing homes, in part due to shorter stays, in part due to the availability of home and community-based services.

And we are also going to be looking at the effects of gender and marital status on the need for nursing home care use. So I think—and that process is on a short fuse to give us a first iteration of a revision of the model by the end of June, and then some further refinements not later than next March, so that we will have better data for next year's budget cycle.

And the data for June will feed into the strategic planning process that VHA will be engaging in over the summer and also will be used in the care planning process when they return to look at the long-term care aspect of that. That was not included in this current round of planning.

In terms of the question of the gaps in service, we do have information as to where the different long-term care noninstitutional services are located. Our office is presently engaged in a mapping exercise to really identify geographically where the facilities are relative to where the concentrations of older veterans are.

We are doing that with assistance from the Office of Policy and Planning, and the VA actuary. That again will help us to identify where we need to place additional services.

Mr. SIMMONS. Thank you for that response. As somebody with a military background, I am always interested in maps and graphs. We would be interested in seeing that map once you have completed that, if that is agreeable.

Dr. BURRIS. Certainly, we would be happy to provide that.

Mr. SIMMONS. I appreciate that. It looks like we are in for another set of votes. Are there any other questions for this panel?

Mr. RODRIGUEZ. Yes, let me ask you, I would presume that any area within this country that there is some guidelines already as to the types of services a good hospital or good system would provide, and that they are already out there, and that yes you do need data, but you also would—that the best system is one that provides comprehensive services, a combination of long-term, short-term, a variety of others.

And that that would just come naturally. Secondly, I would be concerned for you to jump to the conclusion, just because there is

not people lining up to nursing home care, that that is not needed. You know, I would also caution you as to maybe why they are leaving your nursing home and going elsewhere.

And also, you know, I think the chairman put it in perspective when he said, if you don't have a movie theater nobody is going to be lined up out there to go if it is not there. So, you know, I will get, because I know in Texas, of the State veterans, we only have four, we are trying to get seven and build some others.

And right now that is still in limbo. I am not sure of the others. And I think that that is where we are in conflict or in question, because I don't even—I am not even familiar with the others, if we have them or not. I will check it out.

And so, but I would hope that before comments are made that there is no need for nursing home because there is not a waiting list, that we check that out before that happens. Thank you.

Mr. SIMMONS. I thank you gentlemen. I thank the panel. I will announce that we have a 15-minute vote followed by three 5-minute votes. If my math serves me correctly that is 30 minutes. I would like to announce the next panel, which, consists of several representatives from veterans service organizations.

We have Peter Gaytan, Principal Deputy Director of The American Legion; Thomas Miller, Executive Director of Blinded Veterans of America; Joy Ilem, Assistant National Legislative Director, Disabled American Veterans; Richard B. Fuller, National Legislative Director, Paralyzed Veterans America; and Mr. Paul A. Hayden, National Legislation Service Veterans of Foreign Wars. I think I have gotten everybody in there. This is a large panel. We would look forward to hearing from you in about 25 minutes.

STATEMENTS OF PETER GAYTAN, PRINCIPAL DEPUTY DIRECTOR, THE AMERICAN LEGION; THOMAS MILLER, EXECUTIVE DIRECTOR, BLINDED VETERANS OF AMERICA; JOY ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; RICHARD B. FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND PAUL A. HAYDEN, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. SIMMONS. The subcommittee stands in recess.

[recess.]

Mr. SIMMONS. After talking with the panel, and in consultation with the minority staff, we have determined that the third panel is prepared to submit for the record. They are agreeable to that, thus excluding themselves from being grilled by the members of the committee. So I guess it is a win-win for them.

We have learned that the votes will run us about 55 minutes. So rather than extend the afternoon for everybody, we will accept your offer of testimony. I accept the minority staff's agreement that this is the way to go. I will submit follow-up questions for the record on behalf of myself and the members of the subcommittee.

(See p. 91.)

[The statement of Mr. Gaytan appears on p. 69.]

[The statement of Mr. Miller appears on p. 77.]

[The statement of Ms. Ilem appears on p. 80.]

[The statement of Mr. Fuller appears on p. 84.]

[The statement of Mr. Hayden appears on p. 89.]

Mr. SIMMONS. I thank everybody for their participation. I think we have learned quite a lot about this problem, and I think it is not yet solved. Thank you all very much.

The subcommittee is now adjourned.

[Whereupon, at 3:54 p.m., the subcommittee was adjourned.]

APPENDIX

Honorable Rob Simmons
Chairman, Subcommittee on Health
Veterans' Affairs Committee

Oversight Hearing on Long-Term Care Programs in VA
Thursday, May 22, 2003

The purpose of today's hearing is to review the current status and future of long-term care programs for veterans in VA. We will examine existing VA long-term care programs and expenditures and appraise VA's strategy for addressing future long-term care needs of aging and disabled veterans. The Millennium Health Care and Benefits Act (P.L. 106-117) requires VA to operate and maintain certain long-term care programs in nursing home care, and enhance others such as geriatric evaluation, domiciliary care, adult day health care, respite, and palliative and hospice programs, on both institutional and non-institutional bases. Although VA's long-term care services have undergone some positive changes in recent years, VA's commitment to long-term care has not kept pace with veterans' needs. The General Accounting Office will be speaking to this issue in their testimony today.

VA's single biggest challenge in health care today and for the next decade is how to best address the steadily increasing number of elderly veterans who need care.

We need to review what VA is doing to position itself to meet the needs of hundreds of thousands of veterans who clamber for VA's specialized services--treatment options for Alzheimer's, Parkinson's and other central nervous system diseases; for strokes and other debilitating heart and circulatory diseases; for cancers of all descriptions, to name a few.

We know and appreciate the problems VA created for itself six or seven years ago when it began shifting VA's care base to primary, and opened the floodgates--VA is full to overflowing with enrolled veterans. Many of these aging veterans' health care problems really can't be resolved by an outpatient approach, regardless of intensity.

We support advances in home care and other alternatives to institutional solutions such as VA nursing home care, but it still holds true that aging veterans are going to need nursing home beds in a much larger proportion than veterans use them today as this "bow-wave" of aging sweeps across the good ship VA.

We need to examine VA's response so far. One might think VA would be mounting a very significant retrofitting of some of its massive empty space to gear up for long-term care. But VA is in fact not doing this, and we are going to explore why.

Dr. John Rowe, now President of Aetna Insurance, chaired a crucial committee in 1997-98 called the VA Federal Advisory Committee on Long Term Care. The report it filed, "VA at the Crossroads," is very interesting reading 5 years later. Even before, almost 20 years ago, in 1984, VA studied this phenomenon in its own way with a report entitled "Caring for the Older Veteran."

Today we will query VA about what it has done to position itself for the huge growth in long-term care needs of America's veterans, as well as what has not been done - especially on alternatives to provide direct nursing home services. We will also hear the concerns and recommendations of our veterans' organizations.

With the culmination of the testimony we will hear today and the recommendations made by the Department of Veterans Affairs, the General Accounting Office, and veterans service organizations, we hope to make some significant progress in enhancing long-term care services in VA.

Ciro Rodriguez
Ranking Democratic Member
Subcommittee on Health
Committee on Veterans Affairs
Long-Term Care Programs in the Department of Veterans Affairs
May 22, 2003

Mr. Chairman, thank you for holding this important hearing. It has been five years since the VA published its definitive study on addressing needs for veterans' long-term care. It has been three and ½ years since we passed the Veterans Millennium Health Care and Benefits Act. During this time, much has changed in VA's health care delivery. VA continues to shift care from inpatient to outpatient and community providers. It is also finding ways to shift responsibilities for financing long term care and rehabilitative services to state and community providers.

I am becoming increasingly alarmed that VA is inadequately prepared to address the rising tide of need for long-term care options in the veterans' community. After its own long-term care planning model identified the need to create 17,000 beds, VA's recent Capital Asset Realignment for Enhanced Services left planning for these needs by the boards. It seems to me that VA has become so overwhelmed by the demand for this type of care that, instead of trying to address it constructively in some manner, it is throwing its hands up and walking away. The result of leaving long-term care out of the planning model, in my view, is a system that will be inappropriately sized to address the needs of the growing elderly veteran population.

The Secretary has also told Congress that he wishes to limit the availability of VA nursing home care to veterans with service-connected conditions rated 70% or more. The Millennium Bill requires the Secretary to provide care to these veterans. The Millennium Bill also requires the Secretary to maintain the "staffing and level" of extended care services at the fiscal year 1998 level. This requirement includes VA nursing home care beds. VA has claimed to be chaffing under the requirement and wants to include the state and community beds it sponsors in its count. Those of us who initially supported the requirement in the bill believe this would undermine its intent—to preserve the in-house expertise VA has developed in managing the needs of elderly veterans. Nevertheless, VA has allowed its in-house capacity to drop since the law was enacted. On an average day in the next

fiscal year, VA expects to provide nursing home care to about 8500 veterans—almost 5000 fewer veterans than it did in FY 1998.

VA nursing homes have traditionally been one of the only choices for certain veterans who are no longer able to be cared for at home. Some of the veterans VA once cared for are difficult to place because of aggressiveness, severe dementia, or physical needs, such as paralysis or ventilator dependence. One has to wonder what is now happening to these veterans, many of whom VA is likely discharging to whatever Medicaid-sponsored nursing home is willing to take them.

In recent years, it has been troubling to see VA discharging veterans who have reached their "maximal level of functionality"—a fancy way of saying these folks are not going to get any better. Many of these are veterans, and sometimes their aging caregivers, no longer have the ability to advocate for themselves or their loved ones. Veterans who have progressive degenerative conditions, such as Alzheimer's Disease, have little chance of being able to successfully return home for any substantial length of time. These veterans have conditions that, by their nature, will worsen over time. An admission to a VA nursing home—once likely to be the veterans' final home—now simply forestalls the inevitable spend-down to Medicaid and placement in what is likely to be an inferior community nursing home setting. It may even upset the veteran more by inducing "transfer trauma." Once a veteran, especially one with dementia becomes accustomed to a routine, upsetting that routine can have detrimental effects.

None of us would choose to be in a nursing home. Unfortunately, staying at home is not always possible—many of our own families are inevitably faced with this fact. Caregivers age or become debilitated themselves or the veteran simply needs more care and supervision than family members or friends are able to provide.

Many veterans once had an enviable option. VA nursing homes have earned an excellent reputation for quality of care, but for an increasingly large segment of the population, long-term placement in a VA nursing home is no longer possible.

I believe there should be a role for VA in providing custodial care to veterans who do not have a potential for regaining functionality. Further, the law says that VA must maintain this capability. VA may say that

veterans' demand for nursing home placement is diminishing, but it may be that veterans no longer seek services from VA once they find it is not a long-term option. As veterans age, we owe it to them to respond to their needs for this type of care—care when they may need it most. VA must have a range of long-term care options—I am particularly eager to hear more about how VA might provide assisted living options—but without long-term nursing home care as a vital part of the care continuum, it will fail to address a critical need of the aging veteran population.

Mr. Chairman, I hope that this will be the first of a series of hearings that we hold to investigate VA's involvement in long-term care. I look forward to the testimony of our witnesses.

LANE EVANS
Ranking Democratic Member
Committee on Veterans Affairs

Health Subcommittee Hearing
Long-Term Care Services in the Department of Veterans Affairs

May 22, 2003

Good afternoon Mr. Chairman. Today I am releasing a report prepared at my request by the General Accounting Office (GAO) demonstrating significant service gaps in the delivery of non-institutional care services to veterans.

The report is particularly critical since VA claims it wants to increase non-institutional options in favor of a diminished nursing home program. Veterans who are 65 years of age or older comprise the fastest growing segment of the population. There is no question that veterans' needs for some type of long-term care are growing.

Congress passed legislation in 1999 which added home respite, adult day health care, and outpatient geriatric evaluation to VA's uniform benefits package.

The GAO report examined these services in addition to homemaker or health aide services and skilled home health care (visiting nurses). Not all VA facilities offer the services, and even if they are offered, some services are limited to certain geographic areas. Very few (about 5%) of VA medical centers offer all of these services.

The report further found that some facilities use different eligibility criteria for services. In addition, other VA medical centers "cap" the amount of some types of care it will offer according to available funding resulting in waiting times and unmet needs.

Overall, these reports don't paint a pretty picture of veterans' access to non-institutional long-term care.

A 1998 report by a federal advisory committee—*VA Long-Term Care at the Crossroads*—recommended VA maintain all its nursing home programs—

its own beds, in addition to those it funds in the community—and address new demand from the aging veteran population through home and community-based options and state veterans' homes. It recommended tripling the investment in home and community-based care, including enriched housing. In 1997, this amounted to $353 million. Five years later, in 2002, VA estimates it spent $721 million on these types of care, $338 million **less** than the recommended amount. Even while some spotty progress has been made in delivering these services, the nursing home program is dwindling. In 1997, VA supported an average daily census of 13,289; in 2002, census decreased to 11,969. Further, Secretary Principi has announced his intention to limit nursing home care to veterans with service-connected conditions rated 70% or more. With this policy change, by 2004 VA plans to have a census of 8500.

VA is light years away from having an adequate response to the growing needs of our elderly veterans. Long-term care services are an important part of the VA's care continuum and deserve greater attention.

Mr. Chairman, I urge you to remain vigilant about veterans' access to VA long-term care programs. I hope this is the first of many hearings.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 1:30 p.m.
Thursday, May 22, 2003

VA LONG-TERM CARE

Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions

Statement of Cynthia A. Bascetta
Director, Health Care—Veterans' Health and Benefits Issues

GAO-03-815T

May 22, 2003

GAO
Accountability·Integrity·Reliability

Highlights

Highlights of GAO-03-815T, a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

VA LONG-TERM CARE

Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions

Why GAO Did This Study

With the aging of the veteran population, the Department of Veterans Affairs (VA) is likely to see a significant increase in long-term care need. VA uses noninstitutional long-term care services, such as home health care and adult day health care, and institutional care to meet this need. GAO identified limits in veterans' access to six noninstitutional long-term care services and factors that contribute to these limitations in its report *VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care* (GAO-03-487, May 9, 2003). The report is based, in part, on a survey of all 139 VA facilities. Today's testimony discusses conclusions and highlights recommendations GAO made in the report to improve access to VA noninstitutional long-term care services.

What GAO Recommends

In its report GAO recommended that VA:

- ensure that facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services, and
- refine current performance measures to help ensure that all VA facilities provide veterans with access to required noninstitutional services.

VA concurred with the recommendations.

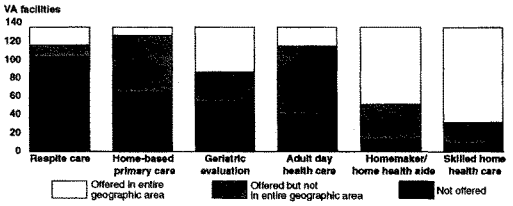
www.gao.gov/cgi-bin/getrpt?GAO-03-815T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

What GAO Found

Veterans' access to the six noninstitutional services GAO reviewed is limited by service gaps and facility restrictions. Of VA's 139 facilities, 126 do not offer all six of these services—adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care. Veterans have the least access to respite care, which is not offered at 106 facilities. By contrast, skilled home health care is not offered at 7 facilities. Veterans' access is more limited than these numbers suggest, however, because even when facilities offer these services they often do so in only part of the geographic area they serve. In fact, for four of the six services the majority of facilities either do not offer the service or do not provide access to all veterans living in their geographic service area. Veterans' access may be further limited by restrictions that individual facilities set for use of services they offer. For example, at least 9 facilities limit veterans' eligibility to receive noninstitutional services based on their level of disability related to military service, which conflicts with VA's eligibility standards. Many facilities restrict the number of veterans who receive services resulting in veterans at 57 of VA's 139 facilities being placed on waiting lists for noninstitutional services.

Noninstitutional Long-Term Care Services Not Available to All Veterans, Based on Geographic Areas, at VA's 139 Facilities as of Fall 2002



Source: GAO.

VA's lack of emphasis on increasing access to noninstitutional long-term care services has contributed to service gaps and individual facility restrictions that limit access to care. Faced with competing priorities and little guidance from headquarters, field officials have chosen to use available resources to address other priorities. While VA has implemented a performance measure for fiscal year 2003 that encourages networks to increase veterans' use of five of the six noninstitutional services, it does not require networks to ensure that all facilities provide veterans access to noninstitutional services.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs (VA) noninstitutional long-term care services and how veterans' access to these services could be improved. Meeting the long-term care needs of veterans is growing in importance as the number of veterans most in need of these services—those 85 years old and older—is expected to increase from 640,000 to 1.3 million by 2012. To provide assistance to veterans with chronic illness or physical or mental disability, VA provides a continuum of noninstitutional and institutional services. Noninstitutional services are provided to veterans in their own homes or in community settings, and include specific services to meet the requirements of the Veterans Millennium Health Care and Benefits Act.[1]

VA provides noninstitutional services directly through its own employees and by contracting for services. In fiscal year 2002, VA spent approximately $283 million on noninstitutional long-term care services and served an average daily census of about 24,000 veterans. By contrast, VA spent nearly $3 billion on institutional long-term care provided in nursing homes and other settings and had an average daily census of more than 43,000 veterans.

My remarks are based on a recent report and other issued work.[2] We surveyed each of VA's 139 medical facilities to obtain data on the availability of six noninstitutional long-term care services,[3] and identified any limits in access and reasons for these limitations. These services included three VA provides to meet the requirements of the Millennium Act—adult day health care, noninstitutional geriatric evaluation, and noninstitutional respite care—in addition to home-based primary care,

[1]In November 1999, the Congress passed the Veterans Millennium Health Care and Benefits Act, which required that VA provide veterans access to three services—adult day health care, geriatric evaluation, and respite care. VA chose to meet the Millennium Act requirements by issuing a directive in October 2001 requiring that facilities provide adult day health care, noninstitutional geriatric evaluation, and noninstitutional respite care to veterans in need of such services.

[2]U.S. General Accounting Office, *VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care*, GAO-03-487 (Washington, D.C.: May 9, 2003). Also see Related GAO Products.

[3]Although VA has 172 medical centers, in some instances 2 or more medical centers have consolidated into health care systems. Counting health care systems and individual medical centers that are not part of a health care system as single facilities, VA has 139 facilities.

skilled home health care, and homemaker/home health aide. We also interviewed VA officials and examined documents related to these issues.

In summary, we found that veterans' access to the six noninstitutional services we reviewed is limited by the lack of service availability and restrictions on their use. Of VA's 139 facilities, 126 do not offer all six services. Veterans have the least access to noninstitutional respite care, which is not offered by 106 VA facilities. By contrast, skilled home health care is not offered by 7 facilities but is provided by the remaining 132. Veterans' access to care is more limited, however, because even when facilities offer these services they often do so in only parts of the geographic area they serve. More than half of VA facilities do not offer four of the six services—noninstitutional respite care, home-based primary care, adult day health care, and noninstitutional geriatric evaluation—at all, or only offer such services in parts of the geographic areas they serve. Veterans' access may be further limited by restrictions that individual facilities place on the services they offer. For example, we found that 9 facilities, in conflict with VA's eligibility standards, limited veterans' access to noninstitutional services based on their level of disability related to military service. In addition, restrictions placed by many facilities on the number of veterans who can receive these noninstitutional services have resulted in veterans at 57 of VA's 139 facilities being placed on waiting lists for noninstitutional services.

VA's lack of emphasis on increasing access to noninstitutional long-term care services and a lack of guidance on the provision of these services have contributed to service gaps and individual facility restrictions. VA headquarters has not emphasized increasing access to these services by establishing measurable performance goals as it has for other priorities such as maintaining workloads in VA nursing homes. Without such performance measures, field officials faced with competing priorities have chosen to use available resources to address other priorities. VA has implemented a performance measure for fiscal year 2003 that encourages networks to increase veterans' use of five of the six noninstitutional services, but it does not require networks to ensure that all network facilities provide veterans access to noninstitutional services. Moreover, VA has not provided facilities with adequate guidance on the provision of noninstitutional respite care, even though most have had little experience in providing the service. Some networks and facilities are confused about how to provide noninstitutional respite care and as a result some are not providing the service. VA has also not provided adequate guidance on which noninstitutional services are required. In particular, VA has not specified whether the home health services requirement includes one, all,

or some combination of home-based primary care, homemaker/home health aide, and skilled home health care. In the absence of VA headquarters guidance on what home health services are required, VA facilities vary in their interpretations of what services they must provide.

To help ensure that veterans have access to noninstitutional long-term care services and that such services are offered uniformly throughout VA, we are recommending that VA take actions to increase emphasis on provision of these services, provide adequate guidance on their provision, and ensure that VA's eligibility standards are used to determine eligibility. Specifically, we are recommending that VA (1) ensure that facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services, (2) define and provide guidance on noninstitutional respite care, (3) specify in VA policy whether home-based primary care, homemaker/home health aide, and skilled home health care are to be available to all enrolled veterans, and (4) refine current performance measures to help ensure that all VA facilities provide veterans with access to required noninstitutional services. In commenting on a draft of our report, VA concurred with our recommendations, discussed preliminary actions it plans to take, and stated that it will provide a detailed action plan to implement our recommendations.

Background

Changes in VA's eligibility standards have resulted in an increase in the number of veterans who are eligible to receive VA health care, including noninstitutional long-term care services. The Veterans' Health Care Eligibility Reform Act of 1996[4] authorized VA to provide health care services not previously available to veterans without service-connected disabilities or low incomes.[5] As required by the act and due to an anticipated increase in demand for VA health care from these changes in eligibility, VA has eight priority categories for enrollment, with higher priority given to veterans with service-connected disabilities, lower incomes, or other recognized statuses such as former prisoners of war. If sufficient resources are not available to provide care that is timely and

[4]Pub. L. No. 104-262 §§ 101, 104, 110 Stat. 3178-79, 3182-83 (1996).

[5]A service-connected disability is an injury or disease that was incurred or aggravated while on active military duty. VA classifies veterans with service-connected disabilities according to the extent of their disability. These classifications are expressed in terms of percentages---for example, the most severely disabled such veteran would be classified as having a service-connected disability of 100 percent. Percentages are assigned in increments of 10 percent.

acceptable in quality for all priority groups, the act requires VA to limit enrollment nationally, consistent with the eight priority groups. If needed, enrollment restrictions would begin with the lowest priority category. On January 17, 2003, VA announced that it would no longer enroll priority 8 veterans, those in the lowest priority category, for the duration of the year.[6]

VA long-term care includes a continuum of services for the delivery of care to veterans needing assistance due to chronic illness or physical or mental disability. Assistance with veterans' needs takes many forms and is provided in varied settings, including institutional care in nursing homes or home and community-based noninstitutional care. Long-term care also includes respite care services that temporarily relieve a caregiver from the burden of caring for a chronically ill and disabled veteran in the home.

VA's long-term care infrastructure, including nursing homes it operates, was developed when the concentration of veteran population was distributed differently by region. When VA developed its long-term care infrastructure, it relied more on nursing home care and less on home and community-based services than current practice. To help update VA's long-term care policy, the Federal Advisory Committee on the Future of VA Long-Term Care recommended in 1998 that VA meet the growing demand for long-term care by greatly expanding home and community-based service capacity while maintaining its nursing home capacity at the level of that time.[7]

VA has delegated decision making regarding financing and service delivery for long-term care and other health care services to its 21 health care networks. VA allocates resources for health care to each of the 21 networks, including resources used for long-term care. In turn, VA's networks have budget and management responsibilities that include allocating resources received from headquarters to facilities within their networks—including resources used to provide long-term care services.

[6]Priority 8 veterans are primarily veterans with no service-connected disabilities who have incomes above established limits for geographic regions set by the U.S. Department of Housing and Urban Development to reflect regional costs of living. Priority 8 veterans enrolled prior to January 17, 2003, remain enrolled to receive VA health care benefits.

[7]*VA Long-Term Care At The Crossroads: Report of the Federal Advisory Committee on the Future of VA Long-Term Care* (Washington, D.C.: June 1998).

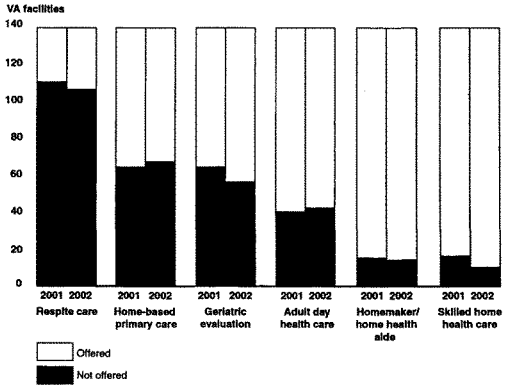
Veterans' Access Is Limited by Gaps in Service Availability and Facility Restrictions on Service Use

Veterans' access to the six noninstitutional services in our review—adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care—is limited due to gaps in availability and facility restrictions on use of the services. Of VA's 139 facilities, 126 do not offer all six noninstitutional services. Facilities that do offer a service do not always offer the service to veterans in the entire geographic area they serve. Further, veterans' access to the six noninstitutional services may be limited by restrictions that individual VA facilities place on service use. Some of these facility restrictions conflict with VA eligibility standards which state that most services are to be available to all enrolled veterans regardless of priority group.

Access to Care Is Limited by Service Gaps Across VA

Access to care is limited because many VA facilities do not offer the six noninstitutional services in our review. Of VA's 139 facilities, 126 did not offer all of the six noninstitutional services in fall 2002 with little progress made in expanding the availability of services from fall 2001. (See fig. 1.) The least commonly available service of the six we reviewed in 2001 and 2002 was noninstitutional respite care. This service was not available at 110 facilities in fall 2001, and as of fall 2002, noninstitutional respite care was not available at 106 facilities. In contrast, the most widely available service we reviewed was skilled home health care, which was offered at all but 7 facilities.

Figure 1: Noninstitutional Long-Term Care Services at VA's 139 Medical Facilities

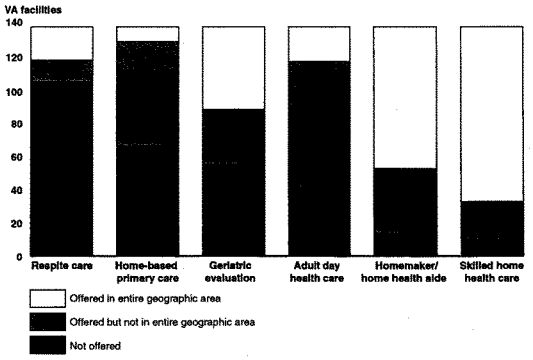


Source: GAO.

Note: Includes services provided directly by facilities or through contracts with other providers as of fall 2001 and fall 2002.

Veterans' access to these services is further limited because among facilities that offer services, many do so in only parts of the geographic area they serve. Our fall 2002 survey showed that for four of the six services—noninstitutional respite care, home-based primary care, adult day health care, and noninstitutional geriatric evaluation—the majority of the facilities either did not offer one or more of the services or did not offer them in the entire geographic area they serve. As shown in figure 2, 42 facilities did not offer adult day health care and an additional 76 facilities did not offer adult day health care in their entire geographic service area. As a result, where veterans live in a facility's geographic service area determined whether they had access to the services offered by the facility. The remaining 21 facilities reported that they offered adult day health care in all parts of their geographic service areas.

Figure 2: Noninstitutional Long-Term Care Services, Based on Geographic Areas, at VA's 139 Medical Facilities



Source: GAO.

Note: Includes services provided directly by facilities or through contracts with other providers as of fall 2002.

The Millennium Act and VA policy also allow facilities to make available to veterans the services required as a result of the Millennium Act—adult day health care, noninstitutional respite care, and noninstitutional geriatric evaluation—through other providers or payers while still overseeing the care delivered using a case management approach.[8] In these cases, VA could arrange for these services from non-VA sources but would not pay for them. However, VA headquarters has neither issued guidance on the use of case management to meet this requirement under the Millennium Act nor has it monitored the extent to which facilities use this option. Further, the benefit of VA case management in assisting veterans to access these three services is limited to those veterans who have some other sources to pay for the care. That is, if veterans are not eligible for care

[8]Case management includes assessment of the veteran's care needs, care planning and implementation, referral coordination, monitoring, and periodic reassessment of the veteran's care needs.

covered by another payer, such as Medicaid, or cannot pay themselves, case management assistance is not likely to result in access to the three services.

Veterans' Access to Care Is Further Limited by Individual Facility Restrictions

Some facilities limit access to services based on veterans' service-connected disability levels. For example, we found that nine VA facilities imposed their own eligibility restrictions on access to noninstitutional services based on veterans' service-connected disabilities. Because we did not systematically ask in our survey if facilities had restrictions based on service-connected disabilities, it is possible that additional facilities may impose similar eligibility restrictions. Such restrictions conflict with VA eligibility standards and result in inequitable access for veterans enrolled at these facilities. VA's eligibility standards state that most services are to be available to all enrolled veterans, regardless of priority group.[9]

Many facilities also limit the number of veterans who may receive a service at a particular time. As a result, when more veterans need service than the established facility limit, these veterans have to wait for service until space or resources become available. In our survey, 57 of VA's 139 facilities reported that veterans are on waiting lists for one or more of the six noninstitutional services we reviewed as a result of restrictions placed on the number of veterans who may receive a service.

We are recommending that VA ensure that its facilities follow VA's eligibility standards when determining eligibility for noninstitutional long-term care services. The examples we found clearly point out the need for VA to take such action to ensure that facilities follow VA eligibility standards so that similarly situated veterans have access to similar care across the country. VA concurred with this recommendation and stated that the Veterans Health Administration will add eligibility sections in each new directive and handbook concerning Home and Community Based Care Programs. In addition, VA stated that it will provide a detailed action plan to implement this and other recommendations we made on VA's noninstitutional long-term care services.

[9]Although VA issued a regulation on September 17, 2002, granting priority for appointments to veterans with service-connected disabilities of at least 50 percent and veterans needing care for a service-connected disability, the regulation does not change other veterans' eligibility to receive services.

Lack of Emphasis and Inadequate Guidance Contribute to Limited Access

A lack of VA emphasis on increasing access to noninstitutional long-term care services and inadequate VA guidance on providing these services have contributed to limited access for veterans. Until fiscal year 2003 VA had not provided measurable standards for the provision of these services or oversight to monitor their provision as it had for high-priority services. VA guidance on the provision of noninstitutional long-term care services has left unclear to some facilities how noninstitutional respite care service is to be defined and provided and whether all of the home health services in our review are a part of what VA requires be made available to veterans who need them.

VA Has Not Emphasized Increased Access to Noninstitutional Long-Term Care Services

VA network and facility officials told us that VA headquarters has not emphasized increased access to noninstitutional long-term care services but emphasized other priorities. As a result, these officials said they use their resources for the priorities VA headquarters emphasizes rather than noninstitutional services. For example, officials in 9 of VA's 21 networks told us that VA headquarters' emphasis on the performance measure that requires networks to maintain workload in VA nursing homes has led them to devote resources to nursing home care that they might otherwise have used to provide noninstitutional services. One network director told us that the "pressure" from VA headquarters to maintain nursing home utilization is much greater than that to offer noninstitutional services. In another network, an official at a VA facility not offering three of the services in our study told us that these services were "victims of competition for resources." In other words, the facility had not funded these three noninstitutional services because facility officials had chosen to devote resources to other services. Another network director told us that, if forced to choose between funding different services, the network would allocate resources to services included in a performance measure.

One way VA emphasizes services is through performance measures, which VA establishes to monitor network officials' progress toward meeting certain VA strategic goals, such as increasing veterans' access to services. VA has demonstrated that requiring network officials to meet measurable performance standards can promote change. For example, since their inception in fiscal year 1996 VA has included a performance measure for providing immunizations to prevent pneumonia to veterans age 65 and older and those at high risk of the disease. VA increased the percentage of such veterans who received the immunization from 26 percent in fiscal year 1996 to 81 percent in fiscal year 2002.

In October 2002, VA introduced a performance measure for noninstitutional long-term care which requires all networks to provide noninstitutional services to a portion of their enrolled veterans needing such services.[10] The fiscal year 2003 goal for this measure will require the majority of networks to increase utilization of their noninstitutional services. The performance measure includes five of the services in our review but does not include noninstitutional geriatric evaluation. However, the performance measure does not require networks to ensure that veterans have access to noninstitutional long-term care services at all network facilities. Instead, network performance targets can be achieved if networks increase utilization at facilities that already offer noninstitutional services.

We are recommending that VA refine current performance measures to help ensure that all VA facilities provide veterans with access to required noninstitutional services. Without refinements that include individual facility performance, existing measures will not hold networks accountable for providing required services at each facility. VA concurred with this recommendation and stated that the Veterans Health Administration will develop performance measures to underscore the importance VA places on its noninstitutional long-term care programs. In addition, VA stated that it will provide a detailed action plan to implement this and other recommendations we made on VA's noninstitutional long-term care services.

VA Has Provided Inadequate Guidance on the Provision of Noninstitutional Respite Care

VA headquarters has provided inadequate guidance to networks and facilities on the provision of noninstitutional respite care to address confusion in the field about what this service is and how it should be provided. This confusion exists, in part, because VA has limited experience with noninstitutional respite care and VA traditionally provided respite care in institutions such as nursing homes. Noninstitutional respite care, by contrast, is provided only in noninstitutional settings, such as a veteran's own home.

Although noninstitutional respite care has been required by VA for over a year, VA has not issued adequate guidance on the provision of noninstitutional respite care and VA staff told us they were unsure how to

[10]According to VA, when it plans for noninstitutional services it assumes that the vast majority of veterans will choose to use their Medicare benefits for home health care.

develop a noninstitutional respite care service. VA issued a directive in October 2001 that requires all facilities to provide noninstitutional respite care to veterans in need of the service yet it inadequately defines noninstitutional respite care and does not provide facilities with information regarding how to provide the service. For example, the directive states that noninstitutional respite care may be provided in a home or other noninstitutional settings. However, it does not specify which noninstitutional settings may be used for the purpose of respite care. In fact, officials in 6 of the 21 networks indicated that there was confusion in their networks about how to establish noninstitutional respite care programs and 1 of these networks reported this was the reason facilities in the network were not providing the service. Further, in our survey, six facilities reported that they offer noninstitutional respite care in community nursing homes, which are institutional settings, thus not meeting the requirement for noninstitutional respite care. VA headquarters officials said they are developing a handbook that will define and provide guidance on the provision of noninstitutional respite care.

We are recommending that VA define and provide guidance on noninstitutional respite care so that facilities can be clear on what noninstitutional respite care is and how and where it is to be provided. VA concurred with this recommendation and stated that it will provide a detailed action plan to implement this and other recommendations we made on VA's noninstitutional long-term care services.

VA Guidance Does Not Specify Which Home Health Services Are Required

VA requires that facilities offer a home health services benefit as part of its medical benefits package.[11] VA headquarters officials told us that the home services benefit includes home-based primary care, homemaker/home health aide, and skilled home health care. However, VA policy does not specify whether one, some combination, or all three home health services are required under the home health services benefit. Currently 138 out of VA's 139 facilities offer at least one of these three home health services, 59 facilities offer two of the three services, and 66 facilities offer all three. Without clear guidance to facilities on what services they must make available in order to fulfill the home health services benefit, facilities vary in their interpretation of what is included in the benefit and headquarters cannot ensure that veterans have access to the services to which they are entitled.

[11]The medical benefits package is the set of services to be available to all enrolled veterans.

Because facilities and networks vary in their interpretation of what is included in the home health services benefit, facilities do not uniformly offer the same home health services. For example, at one facility we visited, an official told us that the facility interpreted the home health services benefit to mean that veterans must have access to skilled home health care—which the facility made available to all veterans. The facility restricted veterans' access to its homemaker/home health aide and home-based primary care services because facility officials did not believe these services were required under VA's home health benefit. Similarly, in another network an official told us that the network interpreted the home health services benefit to include all three home care services—home-based primary care, homemaker/home health aide, and skilled home health care. As a result, access to these three services varies according to facility interpretation of what is required.

We are recommending that VA specify in VA policy whether home-based primary care, homemaker/home health aide, and skilled home health care are to be available to all enrolled veterans. VA concurred with this recommendation and VA stated that it will provide a detailed action plan to implement this and other recommendations we made on VA's noninstitutional long-term care services.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or other members of the subcommittee may have.

Contact and Acknowledgements

For further information regarding this testimony, please contact me at (202) 512-7101. James C. Musselwhite also contributed to this testimony.

Related GAO Products

VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care. GAO-03-487. Washington, D.C.: May 9, 2003.

Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs. GAO-03-756T. Washington, D.C.: May 8, 2003.

Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably. GAO-02-1121. Washington, D.C.: September 26, 2002.

VA Long-Term Care: The Availability of Noninstitutional Services Is Uneven. GAO-02-652T. Washington, D.C.: April 25, 2002.

VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven. GAO-02-510R. Washington, D.C.: March 29, 2002.

Veterans' Affairs: Observations on Selected Features of the Proposed Veterans' Millennium Health Care Act. GAO/T-HEHS-99-125. Washington, D.C.: May 19, 1999.

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Statement of
the Honorable Robert H. Roswell, MD
Under Secretary for Health
Department of Veterans Affairs
On
VA's Long-Term Care Programs
Before the
Committee on Veterans' Affairs
Subcommittee on Health
U. S. House of Representatives
May 22, 2003

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss VA's long-term care programs and issues related to the GAO report "VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Non institutional Care" (GAO 03-487). With me today is Dr. James F. Burris, VA's Chief Consultant for the Geriatrics and Extended Care Strategic Health Group.

Mr. Chairman, the need for effective and accessible long-term care services for veterans can hardly be overstated. Although we are currently projecting that between 2000 and 2010 the veteran population will decline from 24.3 million to 20 million, over that same period, the number of veterans age 75 and older will increase from 4 million to 4.5 million, and the number of those over 85 will triple to 1.3 million. These veterans, particularly those over 85, are the most vulnerable of the older veteran population and are especially likely to require not only long-term care, but also health care services of all types. VA patients are not only older in comparison to the general population, but they generally have lower incomes, lack health insurance, and are much more likely to be disabled and unable to work. The projected peak in the number of elderly veterans during the first decade of this century will occur approximately 20 years in advance of that in the general U.S. population. Thus the current demographics of the veteran population are one of the major driving forces in the design of the VA health care system.

As the VA health care system redefined itself in recent years as a "health care" system instead of a "hospital" system, VA's approach to geriatrics and extended care evolved from an institution-focused model to one that is patient-centered. Institutional

long-term care is very costly and may impair a long-standing spousal relationship and reduce overall quality of life. We believe that long-term care should focus on the patient and his or her needs, not on an institution. Such a patient-centered approach supports the wishes of most patients to live at home and in their own communities for as long as possible. Therefore, newer models of long-term care, both in VA and outside of VA, include a continuum of home and community-based extended care services in addition to nursing home care.

In those situations where long-term care in the veteran's home is not practical, assisted living facilities may meet the needs of veterans and their spouses. VA recognizes that assisted living facilities are used in the private sector as a lower cost alternative to institutionalization, and more importantly, as an option which keeps the pair bond between the husband and wife intact, providing a higher quality of life. VA currently is operating an assisted living pilot project and will evaluate the impact of the pilot in terms of quality of care, veteran satisfaction, and cost.

The technology and skills now exist to meet a substantial portion of long-term care needs in non-institutional settings, and VA is exploring utilization of new technologies, such as telemedicine, to expand care of veterans in the home and other community settings. Technology is increasingly available to provide the limited health care that is needed to support long-term care for many veterans in their homes or in assisted living facilities. Technology can be used to monitor how patients feel and whether they are taking their medications properly. Technology can also be used to monitor various health status indicators in the patient's home, such as blood pressure, blood glucose levels for diabetics, and weight for patients with heart failure. With tele-health support, many of our nation's veterans will be able to stay in their homes or in assisted living facilities with their spouses in the towns where they have a support network. Clearly, by using interactive technology to coordinate care and monitor veterans in the home or assisted-living environment, we can significantly reduce hospitalizations, emergency room visits, and prescription drug requirements, while providing veterans with a more rewarding quality of life and greater functional independence.

I have directed the establishment of a new Office of Care Coordination in the Veterans Health Administration (VHA) to capitalize on these new technologies and the broad range of home and community-based long term care services now available in the VA health care system. The Office of Care Coordination will work closely with the Geriatrics and Extended Care Strategic Health Group and other patient care services to use information and telehealth technologies to integrate the care of patients across the continuum of care and provide the appropriate level of care when and where the patient needs it.

In its 1998 report, "VA Long Term Care at the Crossroads," the Federal Advisory Committee on the Future of Long-Term Care in VA made 20 recommendations on the operation and future of VA long-term care services. These recommendations served as the foundation for VA's national strategy to revitalize and reengineer long-term care services. A major recommendation was that VA should expand home- and community-based care while retaining its three nursing home programs (VA, contract community, and State Home). VA is making progress in implementing that strategy.

From 1998 to 2002, VA's average daily census (ADC) in home- and community-based care increased from 11,706 to 17,465. VHA has a budget performance measure that calls for an ambitious 22 percent increase in the number of veterans receiving home and community-based care between FY 2002 and FY 2003. Non-institutional home and community-based care (H&CBC) workload has also been established as a VHA performance monitor and is reported in the Monthly Performance Report along with the nursing home workload. Each VISN has been assigned targets for increases in their non-institutional LTC workload. VA plans to achieve a level of 30,119 ADC in home- and community-based programs in FY 2006. VA will expand both the services it provides directly and those it purchases from affiliates and community partners. VA expects to meet most of the new need for long-term care through home health care, adult day health care, respite, and home-maker/home health aide services. Attachment 1 to my statement documents the growth in actual and projected workload from 1998 through 2004 in VA's non-institutional long-term care programs.

The recent GAO report, "VA LONG-TERM CARE: Service Gaps and Facility Restrictions Limit Veterans' Access to Non-Institutional Care" (GAO-03-487) implies that

every veteran should have equal access to each of the non-institutional long-term care services in the VA health benefits package regardless of location or circumstances. We believe that is unrealistic. Some services could be offered only if appropriate providers are available in the local community. Delivery of others would be cost-effective only if there is a sufficient population of eligible veterans in the geographic area. Still others will require the implementation of care coordination on a broader scale. Certainly there is room for improvement, but a completely homogeneous system of long-term care is impractical and probably even impossible for reasons over which VA has no control.

VA agrees with GAO's overall conclusion that implementation of non-institutional long-term care services is not yet complete, and that access to some of these services is uneven across the system. However, we do not agree with GAO's conclusion that there has been a lack of emphasis by VA on increasing access to non-institutional long-term care services. This is shown not only by the actual and projected growth in non-institutional long-term care workload (Attachment 1), but also through our aggressive actions to implement the extended care provisions of Public Law 106-117, the "Veterans Millennium Health Care and Benefits Act." I understand that your interest in VA's extended care services goes beyond the specific services discussed in GAO's recent report, and Attachment 2 of the statement outlines our efforts in implementing all of the related provisions of the Millennium Act.

VA has several additional initiatives in progress or planned that will further respond to the recommendations in the GAO report. We will shortly issue a new Respite Care Handbook to provide guidance to VA field facilities. Several other handbooks and directives are being drafted and will be issued this fiscal year. A workgroup is refining our Long-Term Care planning model to adjust for gender differences, declining disability among the elderly, and lower rates of nursing home utilization. Several training initiatives are underway. As I mentioned earlier, a new Care Coordination office is being established. Performance monitors have been established and additional measures are under consideration to track our progress in enhancing access to non-institutional services. And of course, we are continuing the congressionally mandated pilots on Assisted Living and comprehensive long-term care

for the elderly. Attachment 3 to my statement summarizes the ongoing and planned initiatives that constitute VA's action plan for responding to GAO report 03-487.

Mr. Chairman, VA's plans for long-term care include an integrated care coordination system incorporating all of the patient's clinical care needs; more care in home- and community-based settings, when appropriate to the needs of the veteran; emphasis on research and educational initiatives to improve delivery of services and outcomes for VA's elderly veteran patients; and development of new models of care for diseases and conditions that are prevalent among elderly veterans. VA must also leverage its leadership in computerization and advanced technologies to better provide patient-centric care. This completes my statement. I will now be happy to address any questions that you and other members of the Subcommittee might have.

Attachment 1

This chart documents VA's progress in implementing non-institutional long-term care programs since 1998 (the base year for the Millennium Act).

Long-Term Care, Average Daily Census 1998-2004							
	Actual					Estimate	
	1998	1999	2000	2001	2002	2003	2004
Home-Based Primary Care	6,348	6,828	7,312	7,803	8,081	10,024	13,024
Contract Home Health Care	1,916	2,167	2,569	3,273	3,845	3,959	4,070
VA Adult Day Health Care	442	462	453	446	427	442	458
Contract Adult Day Health Care	615	809	697	804	932	1,352	1,962
Homemaker/Home Health Aide Services	2,385	3,141	3,080	3,824	4,180	4,247	4,315
Home Respite	-	-	-	-	-	1,284	1,552
Home Hospice	-	-	-	-	-	-	492
Non-Institutional Care- Total	11,706	13,407	14,111	16,150	17,465	21,308	25,873

VA also provides administrative support for the Community Residential Care program and clinical services to veterans enrolled in it, but not direct support for the program. Average Daily Census in the program is estimated at 6,821 in 2004. Here and elsewhere in our statement, our ADC numbers do not include those in the Community Residential Care program.

Attachment 2

In January 2000, approximately one month after the enactment of Public Law 106-117, the "Veterans Millennium Health Care and Benefits Act', VA initiated an extensive effort to implement the extended care provisions of that law. To date, all of the following actions have been accomplished:

1. Section 101(a) of Public Law 106-117 added new § 1710A to title 38 United States Code. New § 1710A required that VA provide nursing home care to any veteran who needs it for a service-connected disability and to any veteran who needs nursing home care and who has a service-connected disability rated at 70 percent or more.

IMPLEMENTATION: VHA Directive 2000-007, Expansion of Eligibility for Nursing Home Care, dated February 29, 2000, originally implemented the new eligibility requirements for nursing home care. Currently, VHA Directive 2000-044, Eligibility and Expansion of Nursing Home Care, dated November 14, 2000, replaces VHA Directive 2000-007.

2. Section 101(c) of Public Law 106-117 added new § 1710B to title 38. New § 1710B(a) required that VA operate and maintain a program of extended care services for eligible veterans that would include geriatric evaluation, nursing home care, domiciliary care, non-institutional respite, adult day health care, and other non-institutional alternatives to nursing home care. (Home care, hospice/palliative care, and inpatient respite were already included in VA's standard benefits package in accordance with prior legislation).

IMPLEMENTATION: VHA Directive 2001-061, Non-Institutional Extended Care Within VHA, dated October 4, 2001, clarifies that outpatient geriatric evaluation, adult day health care and non-institutional respite care are included in the medical benefits package. VHA Directive 2002-016, Respite Care, dated March 19, 2002 expands respite care beyond VA Facilities. Proposed regulations on "Medical Benefits Package: Copayments for Extended Care Services" were published October 4, 2001. Final regulations were published May 17, 2002. VHA's Office of Information and Office of Geriatrics and Extended Care developed a new and revised set of LTC identifier codes and training materials to enable better capture and tracking of LTC services.

3. New § 1710B(c), as added by § 101(c) of Public Law 106-117, provided that VA may not provide extended care services to certain veterans for non-service-connected disabilities unless those veterans agreed to pay a co-payment as determined under § 1710B(d).

IMPLEMENTATION: Proposed regulations on "Medical Benefits Package: Copayments for Extended Care Services" were published October 4, 2001. Final regulations were published May 17, 2002, and became effective June 17, 2002. Implementation began end of July 2002.

4. Section 101(i) of Public Law 106-117 directed VA to submit to Congress by not later than January 1, 2003, a report of VA's experience under the extended care provisions of this section of Public Law 106-117. It specifies that costs and cost avoidance related to the provision of extended care under this law must be evaluated, and that recommendations by the Secretary for extension or modification of the provisions should be formulated.

IMPLEMENTATION: VA's Health Services Research Center of Excellence is conducting the evaluation and addressing the following areas: trends in veterans served, access, unintended effects, costs and utilization, forecasting trends in the absence of Public Law 106-117, patient-level cost and utilization analyses, use of Medicare and Medicaid services by VA extended care patients, quality, functional status, and implementation. An extension of the report deadline to December 2003 was requested to enhance completeness of report. Congress agreed to accept the January 2003 report as an interim report with a follow-up final report planned for December 2003.

5. Section 102 of Public Law 106-117 directed VA to conduct three pilot programs for the purpose of determining effectiveness of different models of all-inclusive care delivery in reducing use of hospital and nursing home care by frail elderly. The pilots were to be conducted for 3 years, and an evaluation report is due to Congress nine months after completion of the pilot programs.

IMPLEMENTATION: Denver, CO; Columbia, SC; and Dayton, OH VA facilities were selected as pilot sites. They began implementing the clinical demonstrations in mid 2001. VA Health Services Research Centers of Excellence will conduct the required evaluation. We expect that the report will be submitted by March 2005.

6. Section 103 of Public Law 106-117 authorized VA to carry out a pilot program in Assisted Living for the purpose of determining feasibility and practicality of enabling eligible veterans to secure needed assisted living services as an alternative to home care. The pilot was to be conducted for 3 years. An evaluation report is due to Congress 90 days before the end of the pilot program.

IMPLEMENTATION: VISN 20 (Oregon, Washington, Idaho, and Alaska) has been selected as the pilot site and began implementation of the clinical demonstration in early 2002. VA Health Services Research Centers of Excellence will make the required evaluation. We expect that the report will be submitted by October 2004.

7. Section 207 of Public Law 106-117 amended 38 U.S.C. § 8134 to require VA to develop regulations that prescribe for each State the number of nursing home and domiciliary beds for which grants may be furnished. The prescribed number for each state is to be based on the projected demand for nursing home and domiciliary care on November 30, 2009 (10 years after the date of Public Law 106-117)), by veterans who at that time are 65 years of age or older and who reside in the individual States.

Revised § 8134 also sets forth new criteria for determining the order of priority for grants for projects.

IMPLEMENTATION: Interim final regulations were published June 26, 2001. The interim regulations were utilized to establish the Priority List for FY 2002 and for FY 2003. Publication of final regulations is expected later this year.

Attachment 3. VHA Response Action Plan for GAO-03-487 as of April 24, 2003

Activity	Description	Timetable
Clarify eligibility standards and provide guidance	1. Information Letter on mandated nature of eligibility for H&CBC 2. Handbooks & Directives for program operations 3. Wait List policy to be included in directives and handbook for home-based primary care (HBPC) 4. Standards for Establishing Programs for HBPC 5. VHA Handbook 1140.2, Respite Care	May 2003 September 30, 2003 September 30,2003 September 30, 2003 Completed May 20, 2003
LTC Needs Analysis	1. Refining LTC model 2. Integrating new model into program planning	June 30, 2003 September 30, 2003
Education	Conferences 1. Health Services Research & Development 2. H&CBC: Leadership in Action 3. Pain Management Conference 4. Accelerated Clinical Training – Hospice and Palliative Care 5. Bridging Workforce Gap for our Aging Society	 September 2003 June 2003 Completed Mar 6, 2003 September 2003 April/May 2003
Care Coordination	1. Function: A patient centric approach to integrating the care of patients across the continuum of care and provide appropriate level of care when and where the patient needs it. 2. New Program Office established. 3. VISN 8 Community Care Coordination Service created in October 1999. Use findings of VISN 8 pilot to inform H&CBC	 May 2003 September 30, 2003
Monitor Performance	1. Maintain current access to LTC services 2. Monthly Performance Report to Deputy Secretary 3. Discuss formal Performance Measure and set specific program targets of nationwide coverage 4. Discuss incentives to expand access with 10Q, 10N, (17) Finance Office	Ongoing Ongoing September 30, 2003 July 30, 2003
Evaluate New Approaches	1. Pilot tests of effectiveness of comprehensive Long Term Care services at 3 sites, Columbia, SC, Denver CO., and Dayton, OH 2. Pilot test of effectiveness of assisted living substitute	FY 2005 October 2004

STATEMENT OF
PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE DEPARTMENT OF VETERANS AFFAIRS'
LONG-TERM CARE PROGRAMS

May 22, 2003

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to express The American Legion's views on the Department of Veterans Affairs' (VA) Long-Term Care programs. This hearing could not have been scheduled at a better time as many World War II and Korean War veterans' age into a population that exceedingly relies on critical geriatric care facilities and health care professionals.

It would be an incomplete picture to assess VA's Long-Term Care Programs without referencing it with the entire veterans' integrated health care system. Clearly, VA continues to demonstrate an inability to meet the growing demand for health services as an estimated 200,000 veterans still wait to receive their initial VA medical appointment. Inadequate funding and infrastructure forced VA Secretary Principi to prohibit enrollment of new Priority Group 8 veterans, effectively closing access for millions of eligible veterans to the VA health care system. The rising cost of pharmaceuticals and increased demands for qualified health care professionals are seriously impacting VA's ability to maintain effective and responsive quality health care services. Deterioration of VA's Medical School Affiliations combined with the current nursing shortage and the expected sharp decline in the number of volunteers in VAMCs could spell crisis for the veterans health care system. This is the backdrop in which VA's Long-Term Care programs must be reviewed and assessed.

Impoverishment Among Aging Veterans

There is currently a substantial aging veterans' population that is now and will continue to present significant demands on the Veterans Health Administration's (VHA's) budget well into the 21st Century. The ages of Word War II veterans range from 70 to well over 90 years old. The vast majority of these veterans live on fixed incomes with medical expenses exceeding their disposable income, especially those requiring maintenance medications to sustain their quality of life. Medical care quickly becomes a hardship for these veterans and their families. We do not need to remind the Committee that in such cases, many decisions are made about whether to buy heating fuel, food, electricity or telephone service or to pay for medicines and care required to merely to stay alive. The American Legion believes that it is a national disgrace that veterans

who stormed the beaches of Europe and the Pacific, were held Prisoners of War, contracted malaria and a host of other tropical diseases, not too mention exposure to ionizing radiation are forced to make such decisions. These are the veterans who rescued precious freedoms at a time when it seemed that the entire world was on the verge of totalitarianism. How do we, as a nation now, repay them for their sacrifices of body and psyche, of friends lost, and opportunities forsaken? We do so by keeping former President Lincoln's promise – "*...to care for him who shall have borne the battle...*". We can care for them at the end of their lives, when they are the most vulnerable and in greatest need.

For many years, The American Legion has expressed its commitment to developing comprehensive solutions to preserve and improve the VA health care system. This goal includes providing a coordinated continuum of Long-Term Care to meet the needs of the individual veteran. This continuum is linked to acute care and ambulatory care services provided as needed.

Long-Term Care within VA is a full continuum of primary care provided to veterans, over a period of time, who suffer from severe, chronic service-connected medical conditions associated with aging and disease processes. Within VA, Long-Term Care includes skilled nursing, nursing home care, home health care, adult day care, community residential and specialized rehabilitation, including Alzheimer's, dementia and other psychogeriatric services. Domiciliary care, assisted living, hospice, palliative and respite care and research into geriatric issues are all part of VA's Long-Term Care responsibility.

Mandatory Funding for VHA

The American Legion believes that the current discretionary appropriations mechanism that funds VA's Long-Term Care programs remains inadequate to meet the growing demands of the veterans' community. The American Legion believes that without significant budgetary reform, VA will continue to shift the burden of Long-Term Care onto families, communities and other federal programs. The American Legion continues to advocate mandatory funding for VA medical care. This budgetary move would enable VA to meet its obligation to provide geriatric and other health care services for aging and service-connected disabled veterans. The passage of the Veterans Millennium Health Care and Benefits Act (PL 106-117) charged VA to provide quality Long-Term Care through VA or by contract. The American Legion believes once VA accepts a veteran as a Long-Term Care patient, no matter when or under what provision of law, that veteran remains VHA's responsibility.

In January 1999, The American Legion responded to VA Long-Term Care at the Crossroads, a report of the Federal Advisory Committee (FAC) on the future of VA Long-Term Care released in June 1998. The American Legion took umbrage with several key points as conclusive and most beneficial to veterans. Based on its mission to anticipate VA's needs for Long-Term Care in an era of "no growth budgets," the FAC recommended outsourcing. Rather than VHA expanding its capability to provide Long-Term Care, the FAC advocated VA meet its fundamental Long-Term Care obligation by outsourcing new patients to private sector nursing facilities. The FAC's report failed to address a significant dynamic that was taking place during the tenure of the Committee. Most private nursing homes at the time were funded largely by Medicare and Medicaid prospective payment formulae with insured and fee-for-service patients

making up the shortfall in case-mix based reimbursement. In the early to mid 90s, a plethora of corporate for-profit Long-Term Care, skilled nursing and assisted living facilities were created which had the immediate effect of siphoning off the revenues from traditional nursing homes that subsidized the other patients. Based on 1997 data from the FAC report, it cost the VHA $2.014 billion to care for 63,081 veterans; or $87.47 per day per veteran. Whether these veterans were cared for in skilled nursing, nursing home care, home health care, adult day care, community residential and specialized rehabilitation, psychogeriatric services care, domiciliary care, assisted living, hospice, palliative or respite care is not stated. Compare these statewide Long-Term Care costs to VA's $87.47 per day.

In comparison, Medicare provides about 12 percent payments to nursing homes and is a major funding source of home care. Medicare is primarily rehabilitative and is provided on a short-term basis. Chronic long-term care that extends beyond three or four months is not covered by Medicare. Medicaid is a program that pays about 44 percent of nursing home costs, as well as substantial amounts of home care and assisted living costs. There are income and asset tests to qualify for Medicaid.

STATEWIDE DAILY LONG-TERM CARE COSTS
Source: Urban Institute December 1998

Alabama	$99	Louisiana	$65	Ohio	$107
Alaska	330	Maine	105	Oklahoma	64
Arizona	98	Maryland	106	Oregon	89
Arkansas	64	Massachusetts	109	Pennsylvania	114
California	83	Michigan	95	Rhode Island	125
Colorado	98	Minnesota	102	South Carolina	84
Connecticut	130	Mississippi	80	South Dakota	80
Delaware	97	Missouri	86	Tennessee	78
Florida	95	Montana	88	Texas	75
Georgia	75	Nebraska	63	Utah	80
Hawaii	150	Nevada	110	Vermont	94
Idaho	94	New Hampshire	112	Virginia	78
Illinois	78	New Jersey	105	Washington	114
Indiana	86	New Mexico	92	Washington, DC	210
Iowa	69	New York	166	West Virginia	97
Kansas	78	North Carolina	95	Wisconsin	91
Kentucky	83	North Dakota	94	Wyoming	93

Given the wide disparity in the per diem costs of the states in operating nursing homes, The American Legion fails to see how outsourcing veterans would result in a "no growth budget" contracting with state nursing homes. This data does not distinguish between urban and rural facilities, nor Resource Utilization Groups (RUGS III) which assesses the case mix of patients for medical complexity, including fractional FTEs for skilled nursing or physician time.

Concurrently with the FAC's work, quality of care in private and public nursing homes had become a major issue with the repeal of "the Boren Amendment" as part of the Balanced Budget Act of 1997. The Boren Amendment required that Medicaid-funded nursing home rates be adequate and reasonable to meet the costs which must be incurred by efficiently and economically run facilities in order to provide care and services in conformity with state and federal law, regulations and quality and safety standards of Section 1902(a)(13) of the Social Security Act. State Medicaid officials overwhelmingly came to oppose the amendment, believing they were being forced to spend too much on nursing homes at the expense of other programs. If VHA is to place veterans in state-run nursing homes, new legislation will need to be enacted to restore the intent of the Boren Amendment.

The FAC report that seems so overwhelmingly budget driven does not account for the statistics and costs it cites. For example, the numbers provided for nursing home care for 1997 show an average daily census of 13,289 at a cost of $1.1 billion. This does not translate into meaningful data since there is no way to extrapolate what were the daily costs or what was the yearly census.

The FAC stated that by outsourcing most new demand, VA would be able to maintain, invigorate and re-engineer the core of VA operated services. The recommendation goes on to suggest that the new demand for Long-Term Care would be met primarily through non-institutional services, contracts, and available veterans' state homes. Veterans, who seek to enter VA's Long-Term Care facilities, do so because they are veterans and eligible to seek health care services from VA. Many of these veterans are single, elderly men and women who would rather die at home with extended family or among comrades with whom they can share experiences, strengths, sorrows and hopes.

The Veterans Millennium Health Care and Benefits Act of 1999

In response to the FAC's recommendations, Congress passed the Veterans Millennium Health Care and Benefits Act. This Public Law established VA health care priorities for VA nursing home care, in particular, and Long-Term Care (nursing home, home care, community-based care, etc.) more generally. It established criteria for eligibility for nursing home care to any veteran in need of such care for a service-connected medical condition and to any veteran who is in need of such care and who has a service-connected medical condition rated as 70 percent or more. Once the veteran is placed in a VA nursing home, he or she may not be transferred to a non-VA facility without his or her consent. This effectively precludes access to VA nursing facilities to the vast majority of today's elderly veterans.

Section (b) of the Act requires that, the term "medical services" includes non-institutional extended care services. This provision is due to expire on December 31, 2003 and should be re-authorized. Under the Act, extended care services include geriatric evaluation, nursing home care (either in VA facilities or contract community based facilities), domiciliary services, adult day health care services and "such other alternatives to institutional alternatives to nursing home care as the Secretary may furnish as medical services under § 1701(10) of this title."

That is, VA is required to plan Long-Term Care services for eligible veterans, to estimate and project veterans' sub-populations at risk of use or need for Long-Term Care services, and to

estimate and project potential use of VA's Long-Term Care services. The Act further sets up a series of pilot programs and establishes a Treasury account known as "the Department of Veterans Affairs Extended Care Fund." There appears to be no Treasury offset to this fund, but monies collected may be used solely for the operation of extended care programs. The American Legion recently testified that VHA's Medical Care Collection Fund (MCCF) should also be excluded from Treasury offset as is collections from the Indian Health Service. Even though it is technically not considered an offset, the funds projected to be generated by MCCF are deducted from VHA's annual budget.

The Government Accounting Office, in a letter to the ranking Democratic member of the Committee on Veterans' Affairs, stated that in FY 2001 VA spent approximately $3.12 billion on a roughly equivalent veterans' Long-Term Care census as in FY 1997. Of that amount less than 10 percent was spent on non-institutional care, a clear disregard for the mandates in the law. More than two years after the passage of the Veterans Millennium Health Care and Benefits Act, VA still has not completely implemented its response to the Act's requirements. Availability to these core services is uneven nationally with the share of VHA's Long-Term Care costs increasing a mere 4 percent between FY 1991 and FY 2001.

End-of-Life Issues

Some non-institutional alternatives to Long-Term Care are to be found in the family and community settings at far lower costs than traditional nursing home residency. Many of the 600,000 aging veterans with dementia and Alzheimer's can be maintained at home for substantial periods of time. There comes a point, however, at which the individual must be committed to Long-Term Care for end-of-life care and services beyond the capabilities of the family or community. The American Legion recognizes that comfort and dignity at the end-of-life for veterans is a priority issue. The need to improve the care of the dying in VHA facilities is well established, however, some 58 percent of VAMCs do not have hospice beds, 27 percent do not refer to community hospice providers, and 59 percent of VAMCs have no palliative care staff. Hospital deaths occurred in intensive care units at twice the rate in VAMCs as in Medicare hospitals.

Counting State Veterans' Homes Beds as Department of Veterans Affairs (VA) Assets

The American Legion believes that VA's practice of counting State Veterans' Homes beds as their own should cease immediately. Certainly, the Federal government contributes to the construction of these facilities, but their upkeep is strictly a State fiscal responsibility. VA should be embarrassed to take credit for some of these facilities; a case in point is the Rocky Hill State Veterans Home and hospital in Connecticut. This 130 plus year old facility was recently toured by The American Legion's National Commander, Ronald F. Conley, as part of his commitment to improving veterans' health care. *The Hartford Courant* in several editorials referred to the home variously as a "pit", and a "hellhole" with "health and safety code violations that would make your stomach churn." The American Legion adamantly opposes this practice.

In the President's budget request for FY 2004, there is an initiative to limit institutional Long-Term Care benefits to Priority Group 1a veterans. The Veterans Millennium Health Care and

Benefits Act of 1999 (Public Law 106-117) directs VA to provide nursing home care service to any veteran whose service-connected disability necessitates nursing home care and to any veteran needing nursing home care who is rated 70 percent or more service-connected disabled. Currently, this mandatory group of veterans (Priority Group 1a) is estimated to comprise 34 percent of the total Nursing Home (VA, Contract Community and State Home) census and Nursing Home Budget in 2002. The vast majority of Priority Group 1a veterans are cared for in either VA Nursing Home Care Units or in contract community nursing homes at VA expense, with an estimated 4-5 percent of veterans in State home nursing homes being in this category. This policy would significantly reduce nursing home care in a VA Nursing Home Care Unit or community nursing home to other than Priority 1a veterans, unless the care is needed for post-acute rehabilitation or specialized care, respite, hospice, or geriatric evaluation and management in the nursing home setting. Enrolled veterans with a spinal cord injury/disease who require nursing home care and are enrolled in Priority Group 1b-7 would also be a priority.

The American Legion adamantly opposes this initiative and does not believe this was the intent of Congress or former President Clinton when this bill was written, passed, and enacted.

Another Long-Term Care initiative in the President's budget request seeks authority to allow all institutional and non-institutional Long-Term Care services to be counted towards meeting the capacity requirements for extended care services. Currently, P.L. 106-117 requires the Secretary to ensure that the staffing and level of extended care services provided by VA nationally in VA facilities during any fiscal year is not less than the staffing and level of such services provided in VA facilities in 1998. The American Legion believes the congressional intent of this provision was very clear and appropriate – to sustain, not decrease VA's Long-Term Care services in VA facilities.

The American Legion applauds VA's effort in non-institutional Long-Term Care services in addition to its institutional care, but is extremely concerned VA has failed to comply with the clear instructions of Congress and the President in sustaining its 1998 level of staffing and services.

Capital Assets Realignment for Enhanced Services (CARES) and VA's Long-Term Care

In the near future, there appears to be a golden opportunity for VA to take positive actions towards addressing VA's Long-Term Care mandates. Through the rehabilitation of VA's current capital assets of vacant buildings and construction of new facilities on VA property, VA's Long-Term Care could meet current demands. Many proposals have already been published in the Federal Register that would lease VA property to commercial assisted living facilities and skilled nursing facilities. Many of these vacant buildings could be brought up to code for a relative pittance and used by VA in compliance with PL 106-117 mandates for the core services of geriatric evaluation, adult day medical care and care-giver respite. The entire Long-Term Care issue has been removed from the CARES process because of CARES model inadequacies. While the model is being revised and the new demand projections analyzed. The American Legion remains concerned over the omission of VA's future Long Term Care plans during the first iteration of CARES.

The CARES Commission is currently reviewing the "planning initiatives" and developing "market plans" for each Veterans Integrated Services Network (VISN) addressing effective and efficient utilization of its capital assets. Since Long-Term Care and mental health care will be "added" later, The American Legion is deeply concerned opportunities to meet the mandates of the Veterans Millennium Health Care and Benefits Act will not receive the appropriate attention, except as an after-thought.

Conclusion

Mr. Chairman and Members of the Subcommittee, as a nation at war; we are reminded of the hardships and sacrifices of a small portion of America – veterans. On Monday, across the nation, we will praise veterans – past, present, and future. The thanks of a grateful nation will echo in national veterans' cemeteries and in the halls of VA medical facilities. But regrettably, there are over 200,000 veterans waiting 6 months or longer for access to VA's quality health care and even worse, hundreds of thousands of Priority Group 8 veterans will not even be allowed to enroll – regardless of their medical conditions. However, if these veterans can become financially destitute, they can enroll and join their colleagues on the waiting list.

The American Legion believes there are better alternatives in meeting the health care needs of America's veterans:

- VA medical care should be funded as mandatory, rather than discretionary appropriations;
- VA should be recognized as a Medicare provider and be authorized to collect and retain third-party reimbursements for the treatment of allowable nonservice-connected medical conditions of enrolled Medicare-eligible veterans; and
- VA should be authorized to offer a premium-based health benefit packages (to include specialized services) to veterans with no private or public health insurance to meet their individual health care needs.

For many of the veterans enrolled in the VA health care system, it is their best health care option. They are attracted to VA for many reasons, but the quality of health care delivery throughout the VA health care system is the most prominent reason. Veterans in need of Long-Term Care are well aware of the quality of care provided by VA extended care services. Currently, the vast majority of veterans seeking Long-Term Care are those of the "Greatest Generation" and the "Forgotten War." What better way to thank the "Greatest Generation" – those that saved the World -- than meeting their Long-Term Care needs? What better way to prove to the veterans of the "Forgotten War" that they are not a footnote in history books, but rather the "true defenders of democracy"?

On June 15, 1999, Representative Stearns (FL) addressed his colleagues on the House floor and said, "What this legislation does is offer a blueprint to help position VA for the future, and I think it is appropriately entitled the Veterans' Millennium Health Care Act. Foremost among the VA's challenges are the Long-Term Care of our aging veterans' population. For many of the World War II population, Long-Term Care has become just as important as acute care. However, the Long-Term Care challenge has gone unanswered for too long." The American Legion agreed with Representative Stearns and supported the Veterans Millennium Health Care

Act of 1999. His insight as to VA's Long-Term Care problems was well documented and his solution was very proactive.

Thank you for the opportunity to present testimony on this critical issue. This concludes The American Legion's testimony.

BLINDED VETERANS ASSOCIATION
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STATEMENT OF

THOMAS H. MILLER, EXECUTIVE DIRECTOR

BLINDED VETERANS ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ON

DEPARTMENT OF VETERANS AFFAIRS LONG-TERM CARE PROGRAMS

May 22, 2003

Chairman Simmons, Ranking Member Rodriguez, and members of this Subcommittee, thank you for this opportunity to present the views of the Blinded Veterans Association regarding Department of Veterans Affairs (VA) long-term care programs. BVA feels there are many parallels in VA's attitudes toward long-term care and blind rehabilitation. There is a need for a fully operational continuum of care in both services. The need for both long-term care and blind rehabilitation is projected to increase in the coming years as the veteran population rapidly increases.

The Millennium Health Care Act directs the Secretary of Veterans Affairs to increase and expand VA's ability to provide long-term care to its aging veteran population. The Secretary's proposal to close 5,000 long-term beds concerns BVA. VA claims that the money saved by closing these beds will be used to provide non-institutional alternatives as well as state and community nursing home beds. As often happens with VA, the numbers do not add up; the money "saved" from closing the VA nursing home beds is not equal to the money set aside for these non-VA alternatives. BVA has a hard time understanding why, in this time of an aging population, any type of long-term care options would be diminished. We agree that non-institutional and local opportunities need to be explored and supported, but also strongly encourage VA to maintain the capacity, as the law requires, of VA nursing home beds. Not everyone desires or is able to receive home health care.

Congress, and this Committee in particular, need to hold VA for accountable for its failure to maintain capacity. As with other laws setting capacity requirements, such as PL 104-262, VA continues to enjoy liberal interpretation and little, if any accountability, for repeatedly failing to meet Congressionally mandated standards.

BVA is extremely disturbed that VA fails to address long-term care in Phase II of the Capital Asset Realignment for Enhanced Services (CARES). Projections for the need for long-term care were estimated, but the numbers were too high, it was decided that this issue would not be addressed. According to the General Accounting Office report "Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs" (GAO-03-756T) when asked

about the omission of long-term care from the CARES process, VA said that "the projections did not reflect its long-term care policy."[1] The projections did not reflect their budget either.

BVA would be remiss in not taking this opportunity to discuss the need for expanding the continuum of care of blind rehabilitation services as preventing, or at least delaying, the need for long-term care. Currently, VA offers comprehensive blind rehabilitation only in a residential setting. Over 2,600 blinded veterans are awaiting entrances into one of the 10 Blind Rehabilitation Centers (BRCs) across the country. Many wait up to year. Very few of the 92 Visual Impairment Service Team (VIST) Coordinators, essentially case managers for blinded veterans, are allowed to contract locally for much needed services.

If a veteran cannot or will not travel away from home for blind rehabilitation, they are out of luck. Comprehensive blind rehabilitation allows blinded veterans to live a more independent life. BVA is concerned about the physical and mental health of those blinded veterans who cannot or will not attend a BRC. These veterans are more likely to injure themselves or others, and are more dependent on a caregiver. If a blinded veteran's caregiver dies or is no longer able to assist him or her, long-term care will most often be the only option. This does not have to be the case.

VA is known worldwide for excellence in its comprehensive blind rehabilitation services. A veteran receives adaptive skills to maximize independent function in activities of daily living such as cooking, financial management, and communication and medication management. The skills taught also include orientation and mobility instruction, comprehensive low vision evaluation (including prescription of and training with low vision aids and devices), psychosocial adjustment counseling, and the option of computer access training. Blinded veterans who attend a BRC develop more wholesome and healthier attitudes about blindness and achieve more successful reintegration into their families and communities.

As the veteran population ages, it is becoming increasingly more difficult for those veterans who desire blind rehabilitation to leave their local community for a long period of time to receive much needed blind rehabilitation services. All of these factors keep a veteran happier, healthier, and safer than if they had received no blind rehabilitation.

Unlike the larger health care system, VA Blind Rehabilitations Service (BRS) did not embrace the transition from hospital-based rehabilitative care to outpatient care, but has steadfastly maintained the inpatient approach to the provision of blind rehabilitation services. As a consequence of failing to develop and implement outpatient models of blind rehabilitation, many of the residential or inpatient BRCs have lost capacity because essential professional staff positions have been taken to support other outpatient priorities in their respective Networks.

In our view, while VA struggles to achieve a more appropriate balance between tertiary and outpatient care, VA BRS must, for the first time, establish an appropriate balance between inpatient and outpatient service delivery by expanding its capacity to provide outpatient services at the local level. This shift is imperative if the unique and special needs of an aging veteran population with severe visual impairment and blindness are to be served.

We are all aware of the aging veteran population and the increasing need and demand for health care services associated with aging. Mr. Chairman, aging is the single best predictor for blindness or severe visual impairment. As the overall population of veterans ages, more and more veterans are losing their vision, requiring rehabilitative services. Because of all the other chronic medical problems associated with aging, more and more members of our blinded veteran population are either unable or unwilling to leave home to attend a comprehensive residential

BRC as this often necessitates traveling hundreds of miles to the nearest BRC. Also preventing many of these veterans from leaving home is the change in roles within their families. Spouses of these veterans have developed serious health problems and are often disabled themselves, relying on the veteran for their care. Consequently, the blinded veteran who has been the recipient of care has been forced into becoming the caregiver.

Unfortunately, the current reimbursement model for resource allocation fails to provide incentives for facilities for the provision of local services. With respect to the allocation model, if the local VAMC refers a veteran to the BRC, the local VAMC will not have to pay for any services delivered or the prosthetics prescribed. Should the VAMC provide service locally, however, the VAMC must for pay for the care.

Mr. Chairman, given access to appropriate blind rehabilitation services, no veteran need be placed into a nursing home care bed solely because of blindness; other medical complications should be the only reason for such a placement. VA BRS needs to develop an aggressive strategic plan to address the needs of older veterans, especially those who are unable to attend the BRC program.

Thank you very much for this opportunity to share the views of the Blinded Veterans Association regarding long-term care and specifically how it relates to blinded veterans. We look forward to working with this Committee to ensure that all blinded veterans receive the services they need. BVA also hopes that this Committee will assure that VA continues to expand, and not diminish, its ability to provide a wide variety of long-term care options, including VA nursing home beds. Both VA blind rehabilitation services and long-term care are needed now more than ever to meet the needs of those who sacrificed so much for our freedom.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
MAY 22, 2003

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) on long-term care programs conducted by the Department of Veterans Affairs (VA). As an organization of more than one million service-connected disabled veterans, DAV is concerned about VA's commitment to meet the needs of an aging veteran population and availability of specialized long-term care services.

As the veteran population ages, the need for VA extended care services is expected to significantly increase. According to the Government Accounting Office (GAO) report issued May 8, 2003, the veterans population most in need of nursing home care—veterans 85 years old or older—is expected to increase from almost 640,000 to over 1 million by 2012 and remain at that level through 2023. Veterans age 85 or older are especially likely to require either institutional long-term care or other types of home-based geriatric services. Because the rate of disability tends to increase progressively with age, the issue of long-term care continues to be an important one—especially for severely disabled veterans.

Public Law 106-117, the Veterans Millennium Health Care and Benefits Act, commonly known as the Millennium Act, enhances VA's medical benefits package and extends long-term care benefits to provide a full range of services. The Act requires VA to provide enrolled veterans access to a continuum of noninstitutional extended care services including geriatric evaluation, adult day health care, and respite care. VA also provides, as part of its extended care services, home based primary care, skilled home health care, and homemaker/home health aide services. As part of the Act, VA is also required to comply with the long-term care capacity provisions by ensuring that the staffing and level of extended care services provided nationally in VA facilities during any fiscal year is not less than the staffing and level for such services provided nationally in facilities during 1998.

As a result of the Millennium Act, VA must provide nursing home care to veterans with a service-connected disability rated 70 percent or more or veterans in need of such care for a service-connected disability. Care may be provided in a VA nursing home, or a nursing home where VA contracts for care, or in a home health setting. Nursing home care may be also be provided on a discretionary basis to other enrolled veterans. VA may also provide domiciliary care, which emphasizes rehabilitation and return to the community, to veterans that are determined to have no adequate means of support. Noninstitutional extended care services are part of the benefits package and should be available to all enrolled veterans.

Long-term care is a crucial component of VA's health care system providing a continuum of health care that is patient focused. VA reports that expects to meet patients' needs through not only in-house institutional care and contract care but also alternative health care delivery options such as adult day health care, home health care, respite and home-maker/home health aide services. VA states its goal is to help veterans maintain optimal health in the least restrictive environment and that it is committed to providing a variety of extended health care services so that veterans with long term care needs have access to different types of treatment depending on their specific needs. As a world class leader in health care VA's experience in delivering health care to the aging veteran population potentially will be of great importance to the entire nation.

Although VA is required to comply with the 1998 capacity levels for extended care services, the VA's fiscal year 2004 budget submission includes a proposal to allow VA to include all institutional and noninstitutional long-term care services to be counted toward meeting the capacity requirements of extended care services. VA believes the requirement that only VA-operated and VA-staffed extended care programs can be included to meet capacity levels is too restrictive and proposes all types of care including noninstitutional and contracted care be included to meet capacity requirements. VA argues that its emphasis on noninstitutional long-term care services is the optimal method of providing extended care services to veterans and therefore the law should be aligned with that policy.

DAV, as part of *The Independent Budget* (IB), is opposed to this proposal. While demand for long-term care services has been increasing, VA has been reducing its inpatient long-term care capacity and has failed to meet its statutory obligation to maintain capacity at the 1998 levels for extended care services. According to VA the average daily census in VA nursing home beds decreased from 13,426 in 1998 to 11,766 in fiscal year 2002. Although we support increasing a variety of alternative noninstitutional extended care services in VA, we believe VA also needs to maintain institutional beds and staffing levels at the 1998 levels as required by law. Although we agree that most elderly veterans would prefer to remain in the home setting with a variety of options to meet their long-term care needs, this is not always possible. Some veterans will undoubtedly require care in an institutional setting.

The President's fiscal year 2004 budget proposed increasing noninstitutional long-term care for VA by $77 million but proposed a cut in nursing home care by $198 million, eliminating 5,000 nursing home beds and cutting nearly 900 nursing home staff. We are concerned that this represents a dismantling of the inpatient long-term care program at a time when there is a projected increase in the need for such care. Significant reductions in the program may result in limited access for some veterans in need of VA's specialized inpatient long-term care services. VA seems decidedly intent on having as few inpatient nursing home beds available as possible. This may result in VA having to contract out for long-term care services for veterans who require this type of inpatient care, or veterans may have to seek care in the private sector. We continue to have concern about VA's oversight of contracted nursing home facilities and the quality of long-term care provided to veterans in the private sector. VA generally provides a more comprehensive level of care than in the private sector and has a vested interest in providing quality care to our nation's veterans. Few systems offer the comprehensive level of care VA is able to provide—ranging from acute care to home-based health care. For these reasons we

believe VA should ensure availability of inpatient nursing home beds for veterans who require such care.

VA's fiscal year 2004 budget submission also includes a proposal that would limit institutional long-term care benefits to Priority Group 1a veterans, veterans rated 70% or greater, and veterans whose service-connected disability necessitates nursing home care. VA believes that the current policy on long-term care significantly reduces nursing home care to other than Priority Group 1a veterans, unless the care is needed for post-acute rehabilitation or specialized care, respite, hospice, or geriatric evaluation and management in the nursing home setting. Enrolled veterans with a spinal cord injury/disease who require nursing home care would also be a priority.

We are opposed to limiting institutional long-term care benefits to Priority Group 1a veterans. Given the clearly stated language in the Millennium Act related to capacity, we believe VA can and should provide institutionalized long-term care services to other service-connected disabled veterans in need of such care.

VA continues to struggle with the issue of long-term care. With a constrained budget, VA must weigh the needs of an aging veteran population against the high cost of providing inpatient long-term nursing home care. VA attempted to address the issue of long-term care needs in its Capitol Asset Realignment for Enhanced Services (CARES) initiative. Unfortunately, this important but complex issue has been currently put aside during this critical phase of CARES. According to GAO, the initial data and projections for nursing home needs exceeded VA's current nursing home capacity and were not consistent with VA's policy on long-term care. VA has indicated it is currently rethinking its policy on long-term care and plans to develop a separate process to provide projections for nursing home and community-based services. Additionally, it has plans to include long-term care needs in its strategic planning initiatives.

VA must develop a policy that is equitable across the system and meets the needs of aging veterans. As GAO pointed out in its May 8, 2003 report, "Until VA develops a long-term care projection model consistent with its policy, VA will not be able to determine if its nursing home care units in 131 locations and other nursing home care services it pays for provide equitable access to veterans now or in the future."

We are eagerly awaiting GAO's new report on long-term care due to be released as of this hearing date. It is unclear at this time if VA is providing all six noninstitutional extended care services evenly across its Networks. A May 16 article in the *Gainesville Sun* refers to a new GAO report on long-term care. According to the article, GAO investigators found that VA has failed to clarify that all hospital systems must offer home health services and that VA has not emphasized the importance in providing these services or encouraged Networks to make them a priority. The article indicated that out of 139 VA hospital systems, 126 do not offer all six available categories of outpatient long-term care services.

Although we must wait for the official GAO document before we can comment on these findings, we do have concerns that VA is not meeting the needs of veterans requiring extended

care services. Network Directors and local facility managers are ultimately responsible for understanding and complying with the law and making such services available to all eligible veterans. However, it is our experience that often times the field interprets statutes or directives from VA Headquarters incorrectly or differently across the Networks. Budget pressures also play a key role in determining what services become "priorities" in the field. Availability of services and limitation of the number of veterans who are allowed to participate in certain specialized programs often depends on the resources available at the local level to offer such services. We have also found that local facility directors are sometimes forced to ration certain types of specialized care depending on competing priorities within the Network. We hope that the new GAO report will discuss these and other important factors relating to the delivery of long-term care services in the VA health care system. We also hope the report confirms the unmet needs for specialized extended care services throughout the Networks and identifies the number of veterans waiting to receive such care.

We are also awaiting VA's report on the outcome of the pilot projects established under the Millennium Act to provide assisted living services through contract arrangements and to determine the effectiveness of different models of all-inclusive care to reduce the need for institutionalizing patients.

In closing, VA's challenge will be to meet the anticipated needs of aging veterans who require extended care services during a period of budget constraints. VA must assess patients' future long-term care needs and develop a sound strategy for meeting those needs. VA must live up to its statutory obligation to maintain its capacity to provide extended care services in VA facilities while exploring more community and home-based solutions as required by law. Congress must provide sufficient resources necessary to stop the downward trend of VA's inpatient long-term care program and meet the increasing demand for long-term care services. In our eyes, the issue of long-term care reinforces the need for mandatory funding for VA health care to ensure veterans access to a full continuum of care. VA must ensure that long-term care programs are fully integrated into the health care system and that services are universally available and not restricted. As VA develops its strategic planning model for long-term care programs, it must be designed to effectively deliver services equitably throughout the Networks. But most important, VA must be responsive to patient care needs.

Finally, we thank the Subcommittee for holding this hearing today and providing DAV the opportunity to express our views on this important issue.

STATEMENT BY

RICHARD B. FULLER

NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

REGARDING

LONG TERM CARE PROGRAMS OF THE DEPARTMENT OF VETERANS AFFAIRS AND IMPLEMENTATION OF PUBLIC LAW 106-117, THE VETERANS MILLENNIUM HEALTH CARE AND BENEFITS ACT

BEFORE THE

HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH

May 22, 2003

Mr. Chairman, thank you for inviting me to represent the members of Paralyzed Veterans of America (PVA) to present our views on the status of the Department of Veterans Affairs' (VA) long term care programs with particular emphasis of the VA's implementation, or lack there of, of the long term care provisions of Public Law 106-117.

PVA works closely with the disability community and those groups representing seniors to advocate for a national policy for long term care protection. The United States is one of the few nations in the industrialized world that does not have a comprehensive program to cover the debilitating cost for its citizens facing extended care as a result of catastrophic injury, disease or age. Long term care programs in the United States are a patchwork of State and Federal Programs constantly under threat from deficit pressures and budget cutting, or stop gap proposals calling for tax deductions for extremely high cost long term care insurance premiums most Americans cannot utilized or afford. The crisis in American health care, the record numbers of the uninsured, the spiraling cost of health care, the drive to provide insurance coverage for prohibitively expensive prescription drugs, have driven long term care off the radar screen of most politicians. And yet, this problem facing millions of Americans and their families every day does not go away. In fact, the demand for long term care in whatever setting is going to increase

dramatically, while the national response to this problem remains obscured.

I raise this national perspective to make the point that the same pressures facing federal and state governments in their response to long term care protection facing all Americans are also afflicting the VA and veterans. Ironically, assistive living and long term care were the primary mission of the series of veterans homes established following the War with Mexico and the Civil War in the mid-nineteenth century. Health care had been an incidental service in these facilities. One Hundred and fifty years later, VA provides a good quality health care service, but rising health care demand, soaring costs for services, prescription drugs, and chronic budget pressures have placed VA long term care services on the back burner of priorities for its health care professionals, managers and budgeteers. With major gaps widening in coverage for health care services in the private and public sector across the United States, veterans could always look to VA as a safety net if they faced long term disability or illness. That is no longer the case.

In an attempt to shore up VA long term care services, the Congress, in 1998, approved P.L. 106-117 the Veterans Millennium Health Care and Benefits Act. The Act required VA to maintain its capacity of inpatient long term care beds at a level as of the date of enactment. The capacity legislation was designed to maintain bed levels. Its intent was to see that VA maintain the level of care provided in those beds. By VA's own admission it has failed to maintain that level of care. Average daily census, once 13,426 in 1998, dropped to 11,766 in 2003. The Administration's FY 2004 budget proposal would cut an additional $198 million from this program, in effect, according to House Veterans' Committee Reports, cutting 900 FTEE from inpatient long term care programs, effectively eliminating an additional 5000 beds. From these statistics it is obvious VA has no intention of maintaining its nursing home capacity.

The public law gave a distinct eligibility for inpatient long term care services for veterans with service connected disabilities rated 70 percent or higher. PVA was

concerned at the time that VA would construe this distinction for veterans with higher service connected ratings as meaning that all other veterans, not within that category, were not covered for VA nursing home care and effectively eliminated from eligibility for these services. Indeed, that has become the case in many locations. In reality, the impact of the law, requiring VA to maintain its inpatient long term care capacity, singularly implies that all categories of veterans are still eligible for long term care in nursing homes within that mandated capacity for VA to provide them. If there is confusion on this matter within the VA, the Subcommittee should take steps to restate its original intent with additional legislation.

The Act also authorized eligibility for a wide range of services, alternatives to inpatient nursing home care, for all enrolled veterans. For many veterans and non-veterans with catastrophic disabilities, alternatives to being confined in nursing homes can be a true blessing. With the proper case management, home and community based care can provide a more humane and often less costly alternative to inpatient long term care. PVA welcomed this provision when it was enacted. However, VA has begun to implement this program, not as an alternative to inpatient long term care, but as an offset to required inpatient nursing home capacity levels. Worse, VA has been reducing inpatient levels saying that home and community programs would pick up that slack of that demand, and then totally failing to implement the alternative programs at required levels. We understand the GAO report presented at this hearing will document that fact.

PVA knows a lot about service capacity levels. With the help of this Subcommittee we were able to have a capacity requirement placed in statute mandating levels of beds and staff in VA spinal cord injury (SCI) centers. Prior to that time, SCI centers were under the same threat as nursing homes, subject to unilateral reductions in beds and staffing at the determination of local VA managers. The capacity requirement was written in much the same way the one for VA extended care beds and staff was written. However, only through constant pressure and vigilance were we able to have VA agree to those capacity requirements and maintain those levels.

Although it has come close, VA has never maintained the full staffing and bed levels agreed to in a directive sent from VA Central Office to the Field. One of the largest discrepancies has been in area of SCI long term care. Of 180 beds listed in the long term care area under our agreement, up until recently, VA still had to identify 60 of those beds. We have testified before this Subcommittee many times on this program. We are encouraged to say that after negotiations with VA, progress has been made to designate those outstanding inpatient long term care beds at specific locations across the country. These beds are to be designated either at existing SCI centers or at nursing homes affiliated with VA hospitals that also have SCI centers.

Long term care is a serious problem for PVA. Unlike an 80 year old who suffers a debilitating stroke and requires nursing home care, a 20 year old high level quadriplegic on a ventilator could be facing decades of extended care services. Where and how that person receives that care is always a difficult decision. Fortunately, VA has established the specialized services in VA SCI centers that can be found nowhere else in the United States. VA nursing homes can provide a level of care for such a complex patient, with the appropriate training and monitoring of VA care givers, that can never be purchased or found in the private sector. Also, at stake are the wishes of the veteran patient and his or her family. Careful determination needs to be made whether this person can be cared for properly at home, or closer to home. In that sense, assessments need to be made as to the consequence of the veteran's well-being and the veteran's family's well-being. The entire array of VA long term care services must be put into play, including respite care, home and community based care for this individual. But above all, VA needs to ensure that the veteran is receiving the appropriate care, by appropriately trained individuals, in the most appropriate setting.

VA must maintain all these options, whether for a veteran with a spinal cord injury or any other debilitating condition. The Department has developed and earned an excellent reputation in the quality and scope of its long term care services. Hopefully, this

Subcommittee and the Congress will see to it that it does not abandon this unique and so essential mission.

I will be happy to respond to any questions you may have.

VETERANS OF FOREIGN WARS

OF THE UNITED STATES

STATEMENT OF

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS' LONG TERM CARE PROGRAMS

WASHINGTON, DC MAY 22, 2003

On behalf of the 2.6 million members of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I would like to thank you for the opportunity to participate in today's hearing on Department of Veterans Affairs' (VA) long term health care programs, to include institutional care such as nursing home care and non-institutional care such as adult day care.

The Veterans' Health Care Eligibility Reform Act of 1996 provides all veterans enrolled in Categories 1-8 full access to all of the health services described in VA's Medical Benefits Package. Further, the Veterans Millennium Health Care and Benefits Act required VA to provide extended care services to veterans with service-connected disabilities of 70 percent or more and those who need such care because of a service-connected disability. Specifically "the Secretary shall operate and maintain a program to provide extended care services to eligible veterans... such services shall include the following: (1) geriatric evaluations (2) nursing home care (3) domiciliary services (4) adult day health care (5) other non-institutional alternatives, and

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(5) respite care." The staffing and level of these extended care services must be maintained at the fiscal year (FY) 1998 levels.

Unfortunately, VA has failed to meet its statutory obligation to maintain capacity to provide extended care services. The nursing home average daily census (ADC) provided by VA in FY 1998 was 13,426 compared to 11,974 in FY 2002. This shortfall is of particular concern because according to the General Accounting Office (GAO) the "veterans population most in need of nursing home care - veterans 85 years old and older – is expected to increase from almost 640,000 to over 1 million by 2012 and remain at that level through 2023." Clearly, nursing home care demand is about to be at an all time high.

Possessing this knowledge and an unmistakable mandate from Congress, VA, in its FY 2004 budget, still proposed closing 5,000 VA nursing home care beds. According to this full Committee's interpretation of VA's proposal, with which the VFW concurs, " VA would substitute non-institutional alternatives, as well as state and community nursing home beds for these VA nursing home beds, [while] not requesting sufficient resources to match the level of capability eliminated by removing these beds from service." The VFW is opposed to this substitution policy. We do, on the other hand, recognize and support the full committee's effort to provide VA with the resources necessary to maintain the nursing home bed level at the 1998 level and we will continue to advocate for full Congressional support and funding.

While we are opposed to VA shifting its statutory obligations, we certainly support expanding more non-institutional solutions to long-term health care. The Millennium Act required VA to carry out three pilot programs relating to long-term care (VISN 8, 10, and 19) and one program relating to assisted living (VISN 20). While it took some time to get the programs up and running, it is our understanding that each one of these programs is proving successful. In speaking with veteran participants we have heard only positive comments and VA

staff report increased cost savings and patient satisfaction. One of the pilot programs, however, consists strictly of contracted care and we would caution that VA should ensure that any contracted care is at the same level and quality as VA care. With that in mind, the VFW believes that these non-institutional programs must be expanded and made available nationwide in order to ensure equitable access for eligible veterans.

Regarding equitable access, we find ourselves concerned with information contained in the May 8, 2003, GAO testimony on key management challenges in VA health and disability programs that state, "VA policy provides networks broad discretion in deciding what nursing home care to offer those patients that VA is not required to provide nursing home care to under the provisions of the [Millennium Act]." As a result "... veterans who need long-term nursing home care may have access to that care in some networks but not in others. This is significant because about two-thirds of VA's current nursing home users are recipients of discretionary nursing home care." The VFW would be adamantly opposed to turning away these users or denying access to them by downsizing capacity. We believe this inequity can only be corrected when every enrolled veteran, regardless of his disability rating, is guaranteed timely access to the full continuum of health-care services, to include long-term care.

Mr. Chairman, this concludes my testimony and I will be happy to answer any questions you or members of the subcommittee may have.

Statement of
THE ALZHEIMER'S ASSOCIATION

for the record

To
COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES

May 22, 2003

"Oversight Hearing on Long-Term Care Programs in VA"

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION
Washington Office: 1319 F St., NW, Suite 710 • Washington, DC 20004 • Phone: (202) 393-7737 • Fax: (202) 393-2109

Mr. Chairman and members of the Committee:

The Alzheimer's Association appreciates the opportunity to submit the following statement to the Committee on Veterans Affairs for the Oversight Hearing on Long-Term Care Programs in VA.

The Alzheimer's Association, a national network of chapters, is the largest national voluntary health organization dedicated to advancing Alzheimer's research and helping those affected by the disease. Having awarded $136 million in research grants, the Association ranks as the top private funder of research into the causes, treatments, and prevention of Alzheimer's disease. The Association also provides education and support for people diagnosed with the condition, their families, and caregivers.

The purpose of our comments is to describe a successful, ongoing collaboration of the VA and the Alzheimer's Association. This collaboration began in 1997, when the Veterans Integrated Service Network in upstate New York (VISN 2) and four Alzheimer's Association chapters in the same geographic area applied and were selected to participate in Chronic Care Networks for Alzheimer's Disease (CCN/AD), a national demonstration project to improve care for people with Alzheimer's disease and other dementias. For more than five years now, VISN 2 and Alzheimer's Association chapter staff have worked together to create and implement the CCN/AD model of dementia care, with a particular focus on coordinating the medical and long-term care services available to veterans through the VA and supportive community services available to them through the chapters. Preliminary findings from an extensive evaluation show positive outcomes for the veterans and their family caregivers and enthusiastic responses from VA staff members who have been involved in the project.

Data collection for evaluation of the CCN/AD demonstration project ended in November 2002, but the close working relationship between the VA and the Alzheimer's Association continues in VISN 2. In addition, we are now finalizing a proposal for a project to implement the same model of care in other VA sites across the country. In this replication project, we will be using a more rigorous research design that will allow us to compare use of VA services, cost of care, and other outcomes for veterans with Alzheimer's disease and other dementias who are served through this model versus usual care. We will be seeking funding from the VA, other government agencies, and private foundations for the replication project.

Profile of VISN 2

VISN 2 is an integrated health care delivery system composed of inpatient facilities, nursing homes, community clinics, and non-institutional long-term care programs and services provided through contracts and community agency referrals. VISN 2 provides acute inpatient and nursing home care services at five locations: Albany, Western New York, Syracuse, Bath, and Canandaigua. It also provides primary care at twenty-nine community-based outpatient clinics located throughout the region. The VISN serves an area of 42,925 square miles, encompassing 47 counties in New York State as well as two counties in northern Pennsylvania, with an estimated population of 573,546 veterans (17.7% of whom were treated in FY 2000).[1]

[1] "Veteran Demographics". Department of Veterans Affairs Web site. Available at: www.va.gov/visns/visn02/. Accessed December 6, 2001.

Nationally, the rate at which the veteran population is aging surpasses the rate for the non-veteran population, and VISN 2 is serving large numbers of elderly veterans. In FY 2001, 52% of veterans who received VA services through VISN 2 were age 65 years and over, and nearly one-quarter were age 75 and over. Nationally and in VISN 2, the number of veterans age 85 and over is expected to nearly double in the next five years.

Historically, veterans age 65 and over have used health care services at a higher rate than younger veterans, but health care service use is much higher among those age 85 and over in all major care settings-acute inpatient, nursing home, and ambulatory care. While the overall veteran population is expected to decline by 20% in the next ten years, significant growth in the number of very old veterans will result in substantial ongoing demand for health care services.[2]

Prevalence of Alzheimer's disease increases rapidly with age, from about 3% of people age 65 to 74, to 19% of those age 75-84, and 47% of those age 85 and older.[3] Age-specific prevalence rates are not available for other diseases and conditions that can cause dementia, but rates are known to increase with age for most of these diseases and conditions. As a result, the total number of veterans with Alzheimer's disease and other dementias will grow significantly in coming years. Awareness of these demographic data and a desire to improve the care provided for veterans with Alzheimer's disease and other dementias were the primary reasons that VISN 2 leadership chose to participate in the CCN/AD demonstration project.

Overview of the CCN/AD Demonstration Project

CCN/AD is a joint project of the Alzheimer's Association and the National Chronic Care Consortium (NCCC). In late 1996, these organizations sent out a request for proposals to all organizations that were members of NCCC and the Alzheimer's Association chapters in the same geographic areas, inviting them to apply jointly to participate in a national demonstration project to improve care for people with Alzheimer's disease and other dementias.

The VA is a member of NCCC, and VISN 2 is the designated VA representative to NCCC. When the request for proposals to participate in the national demonstration project was sent out, VISN 2 leadership decided to apply and was selected along with the four Alzheimer's Association chapters in its geographic area. Other organizations that participated in the demonstration project include non-VA health care systems and Alzheimer's Association chapters in San Francisco, Denver, Minneapolis, Philadelphia, and Albany, NY.

Once the project sites were selected, health care professionals and chapter staff from these sites worked together to develop detailed objectives and a model of care to be implemented and evaluated in the demonstration. The model they created consists of protocols and instruments to achieve four objectives: 1) identification of people with possible dementia; 2) diagnostic assessment; 3) ongoing medical and nonmedical care management; and 4) support for family caregivers.

Beginning in 1999, this model of care was put in place in all the demonstration sites. Training about Alzheimer's disease and dementia was provided for many health care

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[2] Ibid.

[3] Evans, D.A., Funkenstein, H.H., Albert, M.S., et al., "Prevalence of Alzheimer's Disease in a Community Population of Older Persons: Higher Than Previously Reported," Journal of the American Medical Association, 262(18):2551-2556, 1989.

professionals and other service providers. The project enrolled and provided services for more than 1,450 people with Alzheimer's disease and other dementias and 1,300 family caregivers. An extensive evaluation was conducted, and analysis of the resulting data is now underway. Preliminary findings are available about the characteristics and needs of the enrollees and their family caregivers, their responses to a telephone survey about the services they received, and the responses of health care professionals and chapter staff to a mailed survey about their observations and attitudes about the project model and the working partnership between the health care organization and the Alzheimer's Association chapter at their site.

The Upstate New York CCN/AD Site: Partners in Dementia Care

Once selected to participate in the CCN/AD demonstration project, VISN 2 and its four Alzheimer's Association chapter partners began cross-training procedures to teach and learn about each other's organizational structure, programs, and services. At the same time, they participated in meetings and conference calls with other CCN/AD sites to develop the project model. Initial training about the model and about Alzheimer's and dementia care was provided for VISN 2 and chapter staff, and enrollment of veterans began in 1999. Over the next 3 years, more than 500 veterans were enrolled and served through the project, called "Partners in Dementia Care" in the Upstate New York site.

Dementia Care Managers

For the demonstration project, VISN 2 created a new position, "Dementia Care Manager." In each of the five main locations in VISN 2, a nurse or social worker was hired for this new position. The Dementia Care Managers perform diverse functions, all intended to improve the care available for veterans with Alzheimer's disease and other dementias. They arrange and assist with training; help with the identification and assessment of the veterans and their family caregivers; respond to questions about the project model and tools; and work with VA primary care providers and chapter staff to coordinate care for the veteran and family and establish the necessary support system in the community. They serve as a portal of entry into the VA system and continuum of services and as a direct point of contact for chapter staff and project enrollees and their families

Training

Training about Alzheimer's and dementia care was a major component of the project. Primary care providers were targeted for initial and ongoing training, and other VA and chapter staff were also trained in sessions specifically designed to meet their needs. A site-wide curriculum was developed that outlined a basic introductory presentation that was delivered (with CME credit) at each of the five main centers in VISN 2 and later at many of the community-based outpatient clinics. The purpose was to assure that each location started with the same basic information. Dementia Care Managers and chapter staff then identified ongoing educational needs for health care professionals and other providers at their locations. Faculty was recruited from within the VA, local universities, Alzheimer's Disease Centers, and Alzheimer's Disease Assistance Centers. In addition to dementia topics, VA and chapter staff were educated about the project objectives, protocols, and tools and about their roles in implementation. A milestone occurred when demands for training came from numerous VA staff themselves after hearing about or experiencing the quality of Alzheimer's Association chapter training sessions for direct care providers. Eventually, this led to use of Alzheimer's Association chapters for train-the-trainer programs and development of a plan to use those newly

trained as instructors and dementia resource individuals in their unit. The implementation of that plan was the culmination of efforts to reach our goal to train the full range of staff at VA facilities

Preliminary Findings

- More than 500 veterans with Alzheimer's disease and other dementias were identified and enrolled in the project; these individuals were primarily male (94%) and married (79%); 64% had a diagnosis of Alzheimer's disease, and their mean age was 77.

- 500 family caregivers were also enrolled; these individuals were primarily female (89%); 78% were wives of the veteran; their mean age was 67, and 16% were employed full-time.

- More than 1,000 VA and chapter staff members received training about Alzheimer's and dementia care through the project. This training included formal group presentations as described above, formal and informal one-on-one meetings and case-based discussions, grand rounds, conference presentations, and written materials. Project data indicate that training was most effective when it was ongoing over the course of the project, when it was endorsed by a local "physician champion," and when it was supported and encouraged by VA supervisors.

- The CCN/AD protocols and instruments for identification of people with possible dementia were well received by VA staff. Training about these protocols and tools was used to raise awareness about dementia, and the tools were eventually incorporated into the VISN 2 computerized medical record.

- VA primary care providers used the CCN/AD protocols and instruments for diagnostic assessment despite concerns about the time required for their use. Providers who used the protocols and instruments most often also reported the most positive attitudes about their value for the veterans.

- The working relationship between the VA and the Alzheimer's Association chapters was effective in connecting veterans and their families to the chapters; 72% of veterans enrolled in the project received at least one chapter service.

- The working relationship between the VA and the Alzheimer's Association chapters was also effective in bringing chapter services into the VA; at each of the five main locations, a "resource room" was established with informational materials about Alzheimer's disease and dementia for veterans and their families; Alzheimer's support groups were also begun at the five main centers.

- In response to a 3-wave mailed survey, VA health care professionals and other providers reported positive attitudes about the partnership with the chapters; they agreed that the partnership improved outcomes for their patients and improved the quality of care they were able to provide.

- In response to a 3-wave telephone survey, family caregivers of veterans enrolled in the project (n = 270) reported that they had received extensive information about many important topics, including how to manage daily care for the veteran and how to access needed community services.

- In response to a 3-wave telephone survey, veterans enrolled in the project who were able to participate in a telephone interview (n = 85) reported that they had also received extensive information about topics important to them, including available treatments for Alzheimer's disease and other dementias, how to manage daily tasks, and how to coordinate help from family and friends.

- Veterans and their family caregivers generally reported high satisfaction with the care and services they received through the project.

Next Steps in the VA/Alzheimer's Association Collaboration

In VISN 2, each of the five main centers has now signed a memorandum of understanding with the local Alzheimer's Association chapter, defining their agreement about details of their ongoing cooperation in the care of veterans with Alzheimer's disease and other dementias. Thus, the project functions will continue even though data collection and other aspects of the national demonstration have ended.

Using the evaluation findings and clinical knowledge obtained through the project, VA and Alzheimer's Association staff from the Upstate New York site, VA headquarters, and the Alzheimer's Association national office are now working together to develop a proposal to replicate the project in other VA medical centers across the country. A one-year planning grant to develop the proposal was provided by the Robert Wood Johnson Foundation, which also funded much of the work in VISN 2 over the past five years. We are currently refining the project model to incorporate findings from the Upstate New York site that would make it most appropriate for other VA sites. We are also investigating possible sources of funding for the replication.

Conclusion

In upstate NY, the collaboration of the VA and the Alzheimer's Association in the CCN/AD project has been successful in demonstrating a model of care that can improve care for veterans with Alzheimer's disease and other dementias. This collaboration was based on the organizations' understanding that they have a common goal; that they serve a common population--individuals with dementia; and that neither organization has sufficient expertise and services to provide all the care needed by these individuals and their family caregivers. This understanding promoted pooling of experience, expertise and resources. The Alzheimer's Association chapters have extensive experience providing support and education for people with dementia and their families. VISN 2 brought to the partnership the clinical experience and expertise of its staff and an enviable array of medical and institutional and non-institutional long-term care services. The partnership worked, allowing both organizations to provide better care for their clients. The Alzheimer's Association is pleased and proud of the accomplishments of the CCN/AD project in VISN 2 and hopeful that these accomplishments can be sustained in VISN 2 and replicated in other VA medical centers across the country.

STATEMENT OF

THE EASTERN PARALYZED VETERANS ASSOCIATION

TO THE HOUSE OF REPRESENTATIVES VETERANS

AFFAIRS SUBCOMMITTEE ON HEALTH

CONCERNING LONG-TERM CARE PROGRAMS IN THE

DEPARTMENT OF VETERANS AFFAIRS

Submitted by:

Jeremy Chwat
Director of Legislation

May 22, 2003

The Eastern Paralyzed Veterans Association appreciates this opportunity to present our views on the issue of long-term care in the Department of Veterans Affairs. As a National Veterans Service Organization that is dedicated to enhancing the lives of veterans and all Americans with spinal cord injuries (SCI), we are extremely concerned about an apparent shift in Department of Veterans Affairs (VA) policy with regard to the VA's placement of Spinal Cord Injury Long Term Care beds. VA, through its Capital Asset Realignment for Enhanced Services (CARES) process, is disbursing SCI designated LTC beds onto Geriatric and Extended Care units (G&E) rather than maintaining these beds in a separate and distinct setting.

VHA Directive 2000- 022 mandates that VA maintain at least 260 SCI extended care beds throughout the system. The placement of 180 of these SCI LTC beds were not identified, yet VA, through the CARES process, asserts that beds randomly situated throughout G&E Units will be deemed as SCI designated beds for the purposes of fulfilling this mandate. While VA intends to count a certain number of LTC beds per VISN toward satisfying this mandate, these beds will not physically exist until they are occupied by SCI patients.

According to 38 U.S.C. §1706 (b) (3) VA must maintain separate and distinct specialized programs and therefore, we believe, VA cannot legally offer mandated SCI services in a non- SCI specific program and still satisfy the statutory requirements. Additionally, in order to maintain an adequate level of

SCI care and specialized training, a constant SCI patient concentration is necessary. We therefore oppose the disbursement of SCI LTC beds onto the Geriatric and Extended Care wards.

It is the position of the Eastern Paralyzed Veterans Association that, first and foremost, Spinal Cord Injury LTC services be provided on an SCI designated ward consisting of a minimum of 20 contiguous extended care beds. These SCI LTC Units should be co-located with a tertiary care facility and no SCI designated extended care bed should exist outside of an SCI LTC unit. As mandated by VHA Directive 2000-022, all 260 SCI extended care beds must comply with all staffing requirements in this directive. There should be no difference in the quality of care provided at extended care units co-located with an SCI Center of Excellence and those units co-located at a non-SCI specific tertiary care facility

We strongly believe that there is a major difference in the quality and range of services that can be provided in an SCI LTC unit and that these differences are borne out by the existence of two specialized SCI extended care centers. Just as with separate and distinct SCI acute care centers, these LTC centers have mandated staffing levels and a concentrated patient population with special health care needs that allow for the expertise necessary to offer high quality SCI care. From acute injury through the end of life, an SCI patient always requires specialized services.

When Congress created 38 U.S.C. §1706 (b) (3), it clearly saw the need for separate and distinct specialized programs throughout the continuum of care. VA's new disbursement policy runs counter to your mandate.

In conclusion, we ask that you reinforce the need to VA Secretary Anthony Principi for separate and distinct specialized programs to care for our most seriously injured veterans throughout their entire lifespan.

Eastern Paralyzed Veterans Association commends the committee for their actions and leadership on this, and all veterans' issues and we appreciate the opportunity to discuss these important concerns. We look forward to working collaboratively on finding a solution that would ensure quality long-term care for our nation's veterans.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts. Eastern Paralyzed Veterans Association received no relevant federal grants or contracts relevant to the subject matter of this testimony over the past two fiscal years

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN SIMMONS TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Rob Simmons, Chairman
Committee on Veterans' Affairs

Subcommittee on Health
Oversight Hearing on May 22, 2003
Post-Hearing Questions regarding Long-Term Care Programs in the Department of Veterans Affairs

Question 1: The VA recently reported to this Committee that it would make no effort during FY 2003 to reach the Millennium Act requirement for long-term care census, even given the Secretary's commitment to do so in a letter to Chairman Smith dated May 8, 2002 [letter enclosed]. Simply put, VA is not requiring your network directors and facilities to maintain a daily census of 13,246 veterans in VA-operated nursing home beds. That census is down to just over 11,000 according to GAO's report. The apparent justification is that VA is proposing in its FY 2004 budget to reduce its number of long-term care beds by nearly 5,000.

(a) Who is responsible for this contravention of the law?

Response: VA established aggregate and VISN-specific targets to restore to the 1998 baseline the average daily census (ADC) in VA Nursing Home Care Units, in conformance with the Millennium Act requirement and the Secretary's commitment to Chairman Smith. The aggregate ADC rose to 11,766 at the end of FY 2002 (94% of the target for that year) and stood at 12,198 at the end of the second quarter of FY 2003 (97% of target). VA continues to monitor each VISN's progress toward meeting these targets through the quarterly performance review process. For FY 2004, the target established is full restoration of the baseline ADC. VA did propose a reduction in nursing home ADC in the FY 2004 budget submission now before the Congress, but will not implement the revised targets unless and until the Congress approves the budget proposal.

VA seeks to provide long-term care in the least restrictive setting that is compatible with a veteran's medical condition and personal circumstances, reserving nursing home care for those situations in which the veteran can no longer be safely cared for in home and community-based settings. This approach honors veterans' preferences for home and community-based care, preserves spousal bonds and personal friendships, maintains or improves medical outcomes, and enables VA to serve more veterans with the same resources. VA requests that Congress endorse this approach by approving the proposed modification of the workload requirement to include the census of all of VA's institutional and non-institutional long-term care programs.

(b) Is the Secretary aware that the Department has directly contradicted his written promise to Chairman Smith?

Response: As noted above, the Department is in the process of fulfilling the Secretary's promise to Chairman Smith.

Question 2: Since Congress has made it clear that it will take no action on the VA proposal to reduce the statutory long-term care bed floor, when will the Department issue revised long-term care goals?

Response: As noted above, VA has already established targets to restore the VA nursing home care ADC to the 1998 baseline directed by Congress. The revised targets proposed in the FY 2004 budget submission have not been implemented, and will not be implemented without Congressional approval. Ambitious targets have also been established to expand the non-institutional long-term care services authorized by the Millennium Act.

Question 3: You stated in your testimony that VA is making progress in expanding home and community based care, as recommended in 1998 by the VA's Federal Advisory Committee on Long-term Care. Dr. Kizer, then-Under Secretary for Health, testified before this Committee in 1999 that VA spending for home and community based care amounted to 7% of VA's total long-term care spending. According to VA's latest data, for FY 2002, these programs accounted for only about 10.8% of total spending. Does this small increase account for the progress you mentioned in your statement?

Response: VA believes that long-term care (LTC) should focus on the patient and his or her needs, not on an institution. Such a patient-centered approach supports the wishes of most patients to live at home and in their own communities for as long as possible. Therefore, newer models of long-term care, both in VA and outside of VA, include a continuum of home and community-based extended care (H&CBC) services in addition to nursing home care. VA's increase in H&CBC programs follows these models.

As stated in our testimony, VA has substantially expanded its H&CBC Programs over the past few years. For example, between FY 1999 and FY 2002, patient census in H&CBC grew by more than 30%. Expenditures for H&CBC grew by 53% during the same period, increasing from $171.2 million to $261.3 million. All this reflects VA's greater emphasis on placing veterans in such programs in lieu of more costly institutional programs.

Question 4: One of your FY 2004 budget performance measures calls for a 22% increase in the number of veterans receiving home and community based care. Given your past rate of change in expanding home and community based care alternatives, is this goal attainable by the end of FY 2004?

Response: The average yearly increase in Home and Community Based Care workload was 10.6% over the past 4 years. The FY 2004 President's Budget proposes a 21.4% increase in 2004, following a 22% increase in 2003. This plan is optimistic. However, VA believes it has established sufficient monitors and incentives to assure that improved veteran access to home care and adult day health services is achieved in this time frame.

Question 5: How does VA provide VISN directors incentives to improve long-term care services within the VISNs, including expansion of alternatives to bed care, as recommended by the 1998 Advisory Committee?

Response: VA established VISN-specific targets for average daily census (ADC) in VA nursing home care units and compliance is tracked during the quarterly performance reviews between the Deputy Under Secretary for Health for Operations and Management (DUSHOM) and the Network Directors. Issues surrounding compliance with the targets and proposed actions are discussed.

In 2001, VA initiated a performance measure that is included in the budget with outcomes reported to the Deputy Secretary. In addition, in FY 2002, the DUSHOM also initiated a quarterly monitor to track on home and community based care (H&CBC). VHA is currently considering development of a performance measure for access to H&CBC.

Question 6: What proportion of the veteran population in need of long-term care does VA expect to receive their care from programs paid for by other sources such as Medicaid?

Response: VA has no specific projections regarding the proportion of the veteran population that will receive care from programs paid for by other payers.

Question 7: You stated in your testimony that Philadelphia was the only VA Medical Center reporting a waiting time for VA Nursing Home care. Does VA have a formal process for maintaining a nationwide waiting list for VA Nursing Homes? If so, please provide the Committee with details about the process VA uses to determine whether there are veterans waiting to be placed in VA Nursing Homes, as well as the locations where this is occurring.

Response: VA does not have a formal nationwide waiting list for VA nursing home care. The Under Secretary's testimony was based on an informal survey of VISN Directors. The Geriatrics and Extended Care program office also monitors written correspondence and the Seniors Mailbox (an electronic mailbox for veterans and their families) for complaints of difficulty in obtaining nursing home care.

Question 8: You indicated in your testimony that VA expects to have 10,000 veterans enrolled in home tele-health programs by this time next year. Please provide the Committee with a report about your plans for accomplishing this goal, including a timetable and the allocation of resources.

Response: VA has developed a model of care coordination that uses home tele-health technologies to enhance the care of veteran patients with a range of chronic diseases, including diabetes, chronic heart failure, spinal cord injury, post-traumatic stress disorder, and wound care.

Following a successful implementation and evaluation of this model in VISN 8, VA has embarked on an implementation of this care coordination model in an additional 10 VISNs during FY 2004. It is anticipated that each VISN will enroll 1,000 patients into its care coordination program by the end of FY 2004. Funding will be made available for the equipment costs of this expansion.

A total of $6 million is being provided for VISNs to implement these programs. Care managers will use tele-health technologies to enable them to handle larger caseloads and become care coordinators. This can be accomplished within existing staffing requirements. An additional $1 million will be provided to establish a training center to undertake the training of care coordinators.

To facilitate implementation, an Office of Care Coordination is being created as a program office in VA Central Office (VACO). The Office of Care Coordination will be created from the existing VACO Telemedicine Strategic Healthcare Group and will require no additional VACO staff. The clinical implementation of the care coordination program will involve recruiting field-based staff and cost $169,845 in FY 2003, and $451,477 in FY 2004.

The timetable for the program is as follows:

January 2003	Announcement of program
June 2003	Establishment of VA Office of Care Coordination
July 2003	Solicitation for requests for proposals from VISNs to establish programs/training center
October 2003	Awards to VISNs to establish Care Coordination Programs and Training Center
January 2004	Care Coordination programs operational in 11 VISNs

Question 9: What role does home tele-health play in caring for aged veterans with diminished capacities, such as those suffering from a variety of brain disorders?

Response: VA is in the process of establishing models of care using home tele-health for aged veterans with diminished capacities due to dementia. In VISN 8 there are three programs established to care for this category of patients and provide support to care givers. VISN 11 is establishing a dementia care program using home tele-health. Consideration is being given to establishing similar programs for veterans suffering from Parkinson's Disease or Multiple Sclerosis.

Question 10: You stated during the hearing that "socialization" was a key component of a successful long-term care policy. What impact would VA's stated goal to provide more long-term health care in the home have on the need for "socialization"? Are adult day care programs important to providing social support for those veterans receiving care in their home? What needs to be done to increase the availability and accessibility of adult day care?

Response: Allowing a veteran in need of long-term care (LTC) to remain at home maintains the social network of family and friends, as well as interaction with the community in which the veteran lives. Adult day care programs offer many important benefits, including support for caregivers and an environment that stimulates social interaction in a supervised setting. The VA emphasis on expanding non-institutional LTC is increasing the access to adult day care, as evidenced by the increase in average attendance by 28% since FY 2000, and 9% in the first half of FY 2003.

Question 11: The Veterans Millennium Health Care and Benefits Act authorized a number of non-institutional long-term care programs. These authorities expire on December 31, 2003. Should these authorities be extended and should the Committee consider altering any of them?

Response: VA recommends at least a one-year extension for the non-institutional services authorized in the Veterans Millennium Health Care and Benefits Act. This extension would provide additional time for data gathering and analysis, which in turn would allow for a more informed decision on the long-range future of these services.

Question 12: In an exchange with Chairman Simmons, Dr. Burris stated that his office was in the process of identifying geographically the location of different non-institutional long-term care services relative to the concentration of older veterans. As requested during the hearing, please provide the Committee with this map when it is completed.

Response: Geriatrics and Extended care, Strategic Healthcare Group (GECSHG), is working to identify geographical locations of different non-institutional Long Term Care Services relative to the concentration of veterans. Mapping software has been installed for the GECSHG staff and the following maps of non-institutional care programs are being developed: Respite, Home Based Primary Care, Adult Day Health Care, Homemaker Home Health Aide, Contracted Skilled Home Care, Non-institutional GEM and Geriatrics Primary Care. A set of maps should be available by September 30, 2003, and will be shared committee staff when complete.

These maps will be updated and used to determine where additional services are required. Once accomplished, VISN Directors and VACO officials will work in partnership to develop an action plan to provide these additional services.

Budget Formulation, Network Strategic Planning and Joint Operational Planning all must be considered when planning to increase non-institutional care. Non-institutional care continues to be a priority in the President's budget.

CONGRESSMAN EVANS TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Ranking Democratic Member Lane Evans
House Committee on Veterans Affairs
Subcommittee on Health
May 22, 2003

Oversight Hearing on the Long-Term Care Services in the Department of Veterans Affairs

Question 1: The January 2003 Report to Congress of VA's Experience Under the Millennium Act concludes "there was only a small increase in numbers of veterans 70 percent service-connected or greater who were estimated to need nursing home care but who actually received that care from VA". How do you interpret this finding? If we assume that need has not diminished, is there any chance that these veterans are being discouraged from seeking admission to VA long-term care programs?

Response: Several factors contribute to the small increase. The Millennium Act was enacted late in calendar year 1999. The January 2003 Report to Congress includes data only through FY 2001; thus there was only a relatively short period of time in which the Act was in effect before the reported data were collected. In addition, we believe that some veterans are choosing to use other options for obtaining care (e.g. Medicare/Medicaid, private pay) for reasons of personal preference or convenience, but this is hard to quantify because VA does not see those patients. Perhaps most importantly, the need for nursing home care has diminished as disability rates have declined among the elderly, nursing home utilization rates have fallen, and the availability of home and community-based long-term care alternatives to nursing home care has increased. An informal survey of VISN leaders indicated that there were no waiting lists for nursing home care, and monitoring of a patient inquiry hotline shows no increase in complaints of unavailable nursing home services. Thus, we have no reason to believe that veterans are being discouraged from seeking admission. Certainly, VA has no policy to discourage nursing home admissions for patients who need that level of care.

Question 2: As you know, the Millennium Act requires VA to operate and maintain geriatric evaluation, adult day health care, and respite care programs as well as nursing home and domiciliary care. How does VA interpret that requirement? Does it mean that all enrolled veterans are eligible for those services?

Response: Geriatric evaluation, adult day health care, and respite care are part of the VA medical and extended care benefits package and are thus available to each enrolled veteran who meets the eligibility criteria and seeks to obtain them from VA. VA provides those services either directly or by purchasing them from its affiliates and community partners. It is VA's goal to provide equitable access

to these services to all similarly situated veterans, to the extent possible. However, as we stated in our May 22 testimony, completely equal access to non-institutional services is not possible for a number of reasons. Some services cannot be offered if appropriate providers are not available in the local community. Delivery of other services is cost-effective only if there is a sufficient population of eligible veterans in the geographic area. Still other services require the implementation of care coordination on a broader scale than currently exists.

Nursing home and domiciliary care are provided on a discretionary basis, except for those veterans for whom nursing home care is a mandatory benefit under the Millennium Act.

Question 3: In your view, should VA have a role in providing non-rehabilitative custodial care to elderly veterans? If so, what should that be?

Response: VA's role in providing non-rehabilitative custodial care is best served through the contract community nursing home program and VA's partnership with the State Veterans Homes. VA's own Nursing Home Care Units are (with only one exception) co-located with VA medical centers and thus more suitable for post-acute rehabilitative care, geriatric evaluation, hospice and palliative care, respite care, spinal cord injury, and other more intensive services that may draw on the resources of the affiliated acute care facility.

Question 4: The assumptions made in your long-term care planning model seem to be at the heart of dilemmas about how VA should be responding to veterans' needs for long-term care. At one time, Committee staff was told that the model identified a need for 17,000 new nursing home beds – a finding that was immediately rejected by VA. What assumptions are included in the long-term care planning model and what is the current plan for incorporating long-term care needs into the Capital Asset Realignment for Enhanced Services model?

Response: We agree that the outdated assumptions of the original Long-Term Care Planning Model contributed to conflicting views as to how VA should respond to veterans' needs for long-term care by projecting very high levels of need for nursing home beds. The discrepancy between the high demand for nursing home beds projected by the Long-Term Care Planning Model and VA's difficulty in achieving even the lower capacity requirements mandated by the Millennium Act (which was due to lack of demand) prompted the agency to undertake a re-evaluation of the Long-Term Care Planning Model. The revision takes into account several factors not considered in the current Model, including, among other factors, the trend to diminished disability among the elderly, diminishing nursing home utilization rates, gender differences in nursing home utilization, and marital status. A first iteration of the revised model is nearing completion, and further refinements will be made through March of 2004. As preliminary data from the revised Model become available, they will be incorporated into VA's strategic planning process. We believe that projections

from the revised Long-Term Care Planning Model will support VA's policy of meeting most new demand for long-term care through non-institutional home and community-based services (including Care Coordination), reserving nursing home care for situations in which veterans can no longer be safely cared for at home.

Question 5: The Federal Advisory Committee on the Future of VA Long-Term Care recommended that VA maintain its nursing home program and deal with the expected growth in veterans' demand with growth in the state home program and in non-institutional long-term care services. This was a decision that we understood was made with conscious recognition of VA's budget situation. Is the decision to reject that recommendation now – 5 years down the road – based primarily on budget considerations? If not, what is the reason for the VA's recent recommendation to close many of its nursing home beds?

Response: The recommendation to reduce the average daily census (ADC) in VA nursing home beds was based primarily on VA's policy of providing care in the least restrictive setting that is compatible with the veteran's medical condition and personal circumstances, and preferably in the veteran's own home in order to maintain ties to spouse, family, friends, and community. As noted earlier, VA believes that nursing home care should be reserved for situations in which the veteran can no longer be safely cared for in home or community-based settings. VA has continued to expand its home and community-based long-term care services, as recommended by the Federal Advisory Committee, in order to provide a larger proportion of care in non-institutional settings. VA's new Care Coordination initiative will leverage telehealth technologies to further expand and enhance a broad range of long-term care services.

In addition, as stated above, we believe it is more appropriate to focus utilization of VA Nursing Home Care Unit beds on providing post-acute rehabilitative care, geriatric evaluation, hospice and palliative care, respite care, spinal cord injury, and other more intensive services. The recommended reduction in census would essentially eliminate provision of custodial care in VA nursing homes. However, that care would continue to be provided in contract community nursing homes and in State Veterans Homes.

Responses to Questions for the Record
Submitted to The Honorable Rob Simmons, Chairman
Subcommittee on Health
Committee on Veterans' Affairs
By
Thomas H. Miller, Executive Director
Blinded Veterans Association

Oversight Hearing on Long-Term Care Programs in the Department of Veterans Affairs

1. **The Department of Veterans Affairs has stated their intention to expand tele-health programs to provide more long-term care services in the home. Do you see a role for tele-health in caring for blinded veterans?**

Tele-health options are beginning to be explored by VA Blind Rehabilitation Services. Regarding tele-health, the *Blind Rehabilitation Gold Ribbon Panel Report* included the following in a section entitled "'Futures' Outlook for Blind Rehabilitation:"

> Implementation of tele-technologies supports the care management and staff education responsibilities of the VIST Coordinator and extends the geographical outreach of the BROS [Blind Rehabilitation Outpatient Specialist.] Appropriate FTE increases, coupled with tele-connection to Community Based Outpatient Clinics and VET Centers, dramatically strengthens cost-effective outpatient capacity.

The Visual Impairment Advisory Board is planning to explore this method of service delivery as well. This approach could be utilized for some rehabilitation teachers' interventions concerning activities of daily living. Currently, a blinded veteran must travel to a VA Blind Rehabilitation Center (BRC) and stay in an expensive BRC bed in order to receive Computer Access Training (CAT). VA may want to investigate utilizing tele-technology as an option for computer training, or at least tech support for blinded veteran computer users. This would free up these CAT beds for much needed comprehensive blind rehabilitation. Tele-health may also assist blinded veterans with co-morbidities such as diabetes. Such technology may help veterans manage their medical conditions to insure they are properly loading syringes or utilizing prosthetic devices appropriately and safely.

2. **Do you think GAO's conclusions that many VA medical centers are misinterpreting eligibility law is having a negative effect on your members (BVA members) gaining access to the alternative programs we authorized in the Millennium Act?**

BVA has not been contacted by veterans regarding their lack of access to long-term care. It must be noted that most veterans come to BVA with specific problems related to their blindness – whether it be compensation and pension, or to receive the appropriate training and equipment to cope with their sight loss.

RESPONSE TO FOLLOW-UP QUESTIONS FOR
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM THE HONORABLE ROB SIMMONS
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
MAY 22, 2003 HEARING

Question One: DAV has many severely disabled veterans, and is most affected by the "70% service-connected" nursing policy Congress enacted in Public Law in the Millennium Act. Assuming DAV is monitoring VA's implementation of this provision, are the needs of seriously disabled veterans now being met by VA in the long term care area?

Answer:

The Disabled American Veterans (DAV) does not have a formal way of monitoring the Department of Veterans Affairs' (VA's) implementation of the long-term care provision in Public Law 106-117 of the Millennium Act that requires VA to provide long-term care services to service-connected veterans rated 70 percent or greater or to any service-connected veteran in need of such care for a service-connected disability.

We do rely on feed back from our National Service Officers located around the country and encourage our members to contact the DAV National Service and Legislative Headquarters directly if they are unable to get the medical services they need at VA facilities. DAV believes there is rationing of VA health care, including extended care services, at many locations around the country. We received and confirmed one complaint from a 100 percent service-connected disabled veteran in his 80's, who, after being discharged from the Washington, D.C. VA Medical Center, was in need of home health care services. Unbelievably, this totally disabled veteran was told there was a waiting list for such care. When we contacted the facility, we were informed that the veteran had been placed on a waiting list for home health services, along with other service-connected veterans seeking such care, because the demand for such services exceeded the funding available for that program. We believe this type of rationing of specialized services is likely happening at other facilities throughout the VA health care system.

Clearly, the VA's insufficient health care budget affects health care managers' ability to deliver the specialized services veterans need. We were recently informed by one VA hospital director that he is continually forced to make difficult decisions about the programs and services he can offer to veterans as a result of the budget pressures he faces and the delay in funding that can and does occur because of the discretionary funding process. He indicated he feels pressured into keeping within his set budget and that a delay in getting funding, coupled with not knowing in advance what amount he will receive for the year, results in his being unable to timely hire needed staff, and ultimately affects delivery of care to veterans who need it. Similar findings were confirmed by the Government Accounting Office (GAO) May 2003 Report on long-term care.

Given our limited ability to monitor implementation of the VA's long-term care programs it is impossible to state unequivocally that service-connected disabled veterans are not getting the care they need. Although VA has stated it intends to ensure long-term care services are available to service-connected disabled veterans, as required by law, we are concerned that some veterans who are entitled to such care may be turned away or put on a waiting list due to the extreme budget pressures local hospital mangers face as a result of an inadequate health care budget. We believe better oversight and monitoring of this important program is needed.

The Millennium Act requires the VA Secretary to ensure that staffing and the level of extended care services provided nationally in facilities of the Department during any fiscal year are not less than the staffing and level of such services provided during fiscal year 1998. There is much debate over whether VA is actually complying with this statutory mandate. Therefore, we believe a thorough survey/investigation should be conducted to ensure that VA is providing long-term care services as required to severely disabled veterans and veterans who need such care for their service-connected conditions.

Question Two: Do you think GAO's conclusion that many VA medical centers are misinterpreting eligibility law is having a negative effect on your members (DAV members) gaining access to the alternative programs we authorized in the Millennium Act?

Answer: We believe the VA's failure to appropriately apply eligibility standards and to uniformly provide these important long-term care programs across the Networks negatively impacts all veterans, including service-connected disabled veterans.

GAO stated in its report that VA's lack of guidance to the field on the provision of these services have contributed to service gaps and individual facility restrictions on the use of extended care services. GAO identified that of VA's 139 facilities, 126 do not offer all six noninstitutional services authorized by law to all enrolled veterans. The findings included restrictions in providing services to only certain veterans, sometimes based on level of service disability, or limiting the number of veterans who can use a service at any one time. Based on GAO's survey, many hospital managers faced with a host of competing priorities have chosen to use available resources for priorities other than alternative extended care services.

We support the recommendations made by the GAO that VA must refine current performance measures to ensure that all its facilities appropriately apply eligibility standards when determining veterans' eligibility for extended care services and that mandated services are offered uniformly throughout VA.

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

RESPONSE TO

QUESTIONS FOR THE RECORD SUBMITTED BY
CHAIRMAN ROB SIMMONS
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

REGARDING THE OVERSIGHT HEARING ON
LONG-TERM CARE PROGRAMS IN THE DEPARTMENT OF VETERANS AFFAIRS
MAY 22, 2003

Question 1: What changes have you observed in the Department's long-term care services in the past 5 years, and what conclusions does your organization draw from these observations?

Response: The VA system has gone from a long-term care mission open to all veterans when beds were available, to a post acute, short-term, rehabilitative mission that refers non-service connected (NSC) veterans to community care on Medicaid or self pay. Now, due to the Millennium Bill, VA Medical Centers are trying to fill nursing home care beds with veterans who are service-connected 70% or higher but still restricting access to NSC veterans even though there is a co-payment reimbursement program available to recover a portion of VA's expense.

It is apparent that VA has been trying to get out of providing long-term care services to veterans, which is evident from their failure to maintain the long-term care beds at the 1998 level and their failure to fill vacant beds with NSC veterans using the $97 a day co-payment program.

Question 2: The 70% service-connected nursing home policy Congress enacted in Public Law 106-117 requires VA to furnish nursing home care to veterans in need of such care for a service-connected disability, or for any disability of 70% or more. Considering your view of VA's long-term care programs, is this a good policy and why?

Response: We consider the policy of providing nursing home care to veterans for their service-connected conditions and for those rated 70% or above as good policy, however, it just the beginning of what VA should be doing to meet their responsibility of providing a full continuum of care to all enrolled veterans. The VFW contends, and in fact has a National Resolution, urging Congress to mandate and provide funding for the provision of nursing home care for all veterans. Nursing home care represents a major gap in VA health care and is desperately needed to meet the needs of our aging veteran population in the latter years of their lives.

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