DEPARTMENT OF VETERANS AFFAIRS POLICIES AFFECTING THE MILLIONS OF VETERANS WHO WILL NEED LONG-TERM CARE IN THE NEXT TEN YEARS

HEARING

BEFORE THE

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DEPARTMENT OF VETERANS AFFAIRS POLICIES AFFECTING THE MILLIONS OF VETERANS WHO WILL NEED LONG-TERM CARE IN THE NEXT TEN YEARS

WEDNESDAY, JANUARY 28, 2004

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The committee met, pursuant to notice, at 12 p.m., in room 334, Cannon House Office Building, Hon. Chris Smith (chairman of the committee) presiding.

Present: Representatives Smith, Stearns, Moran, Baker, Simmons, Miller, Bradley, Beauprez, Renzi, Murphy, Evans, Michaud, Hooley, Strickland, Berkley, Udall, Davis, and Ryan.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. The committee will come to order, and I want to wish everyone a good afternoon.

Our hearing today is focused on a very important part of the VA's mission, caring for older veterans. There is little dispute about the significant growth in the number of aging veterans who will need some sort of medical assistance over the next 10 to 15 years. Despite these clear projections, however, it is not clear whether or how the VA will meet this challenge.

Last year, planners in the Veterans Health Administration compiled a national assessment of veterans' future demand for VA health care services and the facilities needed to deliver those services. To the dismay of many of us, the VHA CARES plan contains not a single proposal to deal with veterans' long-term care needs. VA planners justified this outcome on the basis that VA lacked a reliable planning model. They promised to come up with a plan to meet veterans' long-term care needs at a later date. However, VA prepared and adopted a long-term care planning model in 1997 to help a prestigious federal advisory committee conclude its work on this very topic. Congress and veteran advocates believe it is absolutely critical for the CARES Commission to address this glaring gap in VA's mission planning. And we look forward to reviewing its report next month.

In 1999, following the issuance of the Final Report of the Federal Advisory Committee on Long Term Care, Congress enacted legislation consistent with its recommendations to give impetus to VA's efforts to meet the health care needs of older Americans—veterans.

The Millennium Health Care and Benefits Act (Public Law 106–117) requires the Veterans Administration to: maintain its own long-term care programs; sustain a defined number of nursing home beds; and enhance other long-term care such as geriatric evaluation, domiciliary, adult day health care, respite, palliative and hospice programs in both institutional and non-institutional settings. All these authorities were recently extended in Public Law 108–170, our 2003 veterans health bill, reconfirming Congress' clear intent that VA fully implement these programs.

I believe that VA's single biggest challenge in health care today, and for the next decade or more, is how to best address the growing number of elderly veterans who need care for chronic and complicated health problems.

Although Dr. Roswell has testified repeatedly that VA should provide more care in settings other than nursing home beds, VA has struggled to expand alternatives to institutional care in recent years and has not kept pace with the rising demand for such services. In an effort to learn more about what is driving VA's long-term care decisions, we asked GAO to undertake a thorough review of the number of veterans receiving VA services and the cost to VA.

When GAO began its work, it was confronted by a dearth of reliable information on VA's long-term care programs. it was many months before the VA could compile data useful to GAO. GAO's testimony illuminates some fundamental issues: VA cannot verify its actual capacity to deliver long-term care, and some of the indicators VA uses are misleading. Moreover, VA is unable to accurately report on the cost of services provided to veterans. These findings raise fundamental questions, who is actually managing VA's provision of long-term care, and how is it being done without basic performance and cost data?

The testimony of the VA and the VA inspector general led to a conclusion that stronger guidance and direction is sorely needed if VA is to fulfill its long-term care mission. Although VA has a series of policies in place covering different aspects and initiatives in long-term care, it seems that there are few consequences if managers ignore these policies.

As I mentioned, the VA's inspector general for health care inspections will testify about recent oversight and review of VA management of long-term care. For many years, the IG has been critical of the management programs VA uses to contract for veterans long-term care needs. In a report issued last month, the IG found an all-too familiar lack of policy guidance and overspending in these programs. In addition, the IG documented disturbing and inexplicable placement decisions that resulted in some veterans receiving homemaker and home-health aide services who did not need them, while large numbers of veterans who needed such services could not obtain them. VA has identified homemaker and home health aides as an important non-institutional service for homebound chronically-ill veterans. There is certainly a great demand for these services, and VA needs to examine the administration of this program far more closely.

I look forward to the witnesses and the statements they will make. And we are especially grateful that Under Secretary Roswell is here and will provide testimony to the committee.

I would like to at this point yield to my good friend, Mr. Evans, the ranking Democrat, for any opening comments he might have.

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

Mr. EVANS. Thank you, Mr. Chairman. And thank you for choosing this topic of long-term health care as the first hearing of this year. The committee has had a long history of passing beneficial long-term care legislation for veterans, such as the Millennium bill. We don't want to see it undermined by policy changes which do not comport with congressional intent. The bill requires the VA to maintain the capacity of its in-house, long-term care health programs. We also ask the VA to completely consider innovative pilots of assisted living and case management. It requires the VA to offer lifetime care to highly service-connected veterans. In many ways this is a monumental bill.

So what other changes have we seen in the VA's programming since this monumental legislation was enacted? According to a report VA sent to this committee just a few weeks ago, very few. Mr. Chairman, we have some serious questions to raise regarding VA's implementation of this bill and other policies that are seriously affecting the provision of long-term care for our veterans.

I look forward to working with you to continue to address these concerns and thank you for holding this hearing. I appreciate it.

[The prepared statement of Congressman Evans appears on p. 45.]

The CHAIRMAN. Thank you very much, Mr. Evans. Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you very much. I have no opening statement but do appreciate the opportunity to listen and learn about this particular issue and the challenge the VA faces in meeting the needs of our aging veteran population. Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from Kansas, Mr. Michaud?

Mr. MICHAUD. Thank you, Mr. Chairman. I have no opening statement. I do want to thank you, Mr. Chairman, and Ranking Member Evans for having this hearing. It is timely and it is an issue that I am really concerned about. Thank you very much.

The CHAIRMAN. Thank you very much. Mr. Beauprez?

Mr. BEAUPREZ. Thank you, Mr. Chairman. I, too, find this to be a very timely topic. We have got an issue very much on the front burner in Colorado right now with the state veterans nursing home and long-term care for all our veterans is very much of interest to me. So thank you for the timeliness and the selection of this topic for a hearing.

The CHAIRMAN. Thank you very much. Mr. Renzi? Mr. Miller? Chairman Simmons?

OPENING STATEMENT OF HON. ROB SIMMONS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Mr. SIMMONS. Thank you, Mr. Chairman, for holding this hearing. It is a follow-on of hearings that we have had in the Health Subcommittee last year. And, as we know from the statistics, it is an incredibly important issue. In I believe 1998, 387,000 veterans were 85 years or older. In fiscal year 2002, 640,000 veterans were

85 years or older. And this year it is 870,000. And so these are dramatic increases. And this is essentially the population that I see that would be seeking long-term health care. So in anticipation of the growth of this population, I think this hearing is very appropriate.

I also want to make a brief comment about the fact that in Connecticut in 1864 we founded the first state home for veterans, 1864. It was originally started by a wealthy businessman who promised to care for all soldiers who were wounded in the Civil War and all widows and orphans whose husband or father was killed. And that was the first time I think in the history of the country that a state stepped up to the plate and established a state home.

We still have that state home. It is currently at Rocky Hill. It has been at that location for over 100 years. And we have a developing partnership with the VA where Linda Schwartz, who is our state commissioner of veterans' affairs, working with Roger Johnson, who heads the VA in Connecticut, are actually partnering so that the VA focuses on primary care and a high-quality of health care, surgeries, this sort of thing.

And then the Connecticut DVA focuses on taking some of the long-term or chronic care patients. And it works extremely well because the citizens of Connecticut are able to step up to the plate and support these long-term care patients in a home environment, a home environment. Meanwhile, the VA can focus on its resources on having one of the best hospitals, the West Haven VA Hospital and a system of CBOCs to deal with the more acute or more critical health care needs of our veterans.

So I would simply say that in the State of Connecticut that works as a very fine model. It may not work elsewhere in the country, but I would be interested to hear what the witnesses have to say about this issue, and I thank the Chair.

The CHAIRMAN. Thank you, Chairman Simmons. Mr. Strickland, the gentleman from Ohio?

Mr. STRICKLAND. No opening statement.

The CHAIRMAN. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman, but I don't have an opening statement. Thank you very much.

The CHAIRMAN. Ms. Hooley.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chairman. In very recent years——

The CHAIRMAN. Could you put on your microphone, please?

Ms. HOOLEY. Thank you. I thought I had a loud voice, okay?

In very recent years we have seen an increase in the number of veterans age 85 and older—mostly our World War II veterans—requiring some type of long-term care. The number of veterans in this age group is expected to rise dramatically in the next decade. I am pleased the VA has expanded upon its non-institutional focus as a means of reaching more veterans in need of care. Through home-based primary care, homemaker/home health aides, adult day care, skilled home care, and home respite and hospice care, the VA, hopefully where appropriate, has shifted the focus of care to a more cost-effective and to a generally more welcome setting in the minds of our veterans and their families.

In all types of non-institutional long-term care we see approximately a 75 percent increase in the average daily census workload over the last 6 years. We are reaching more veterans but is the level of care adequate? Does one three hour visit from a homemaker each week adequately support an 85-year-old veteran at home with an ailing spouse? The program has advantages, but it must be robust enough to be meaningful. How would this once a week visit count during the average daily census count? Are increasing numbers an indication of meaningful support and care or do they indicate that we are just reaching more veterans? As cost-effective and welcome as non-institutional options may be for all concerned, there are times when this option is not the best option and institutional care is warranted.

This institutional option does not diminish as the population of 85-year-olds grows. With the number of those likely requiring long-term care in a nursing home setting growing, why did this administration in its 2004 budget request propose closing some 5,000 beds? Why does VA propose limiting access by veterans it is required to treat?

Mr. Chairman, in our oversight role, this committee must consistently look over the horizon and help VA identify potential problems they may have missed in their planning and budgeting process. Thank you for calling this hearing. I believe it is important to have a VA plan for adequate care for our veterans.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Hooley. I would like to welcome our first panel of witnesses to the table. I am sorry, I would like to recognize Congressman Stearns, who is the author of the Millennium Health Care Act, for any comments he would like to make.

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Thank you, Mr. Chairman. I got in in the nick of time here. I appreciate that. And, again, I want to thank you for holding this hearing on VA long-term care programs. As you mentioned, I was very proud to author the Millennium Health Care Benefits Act, Public Law 106–117. And important components in it were to expand long-term care options for veterans and their care givers. I see that the 2000 census-based veteran population 2001 shows there were 25.6 million veterans in 2002. I think a lot of them obviously live in Florida. In fact, actually, Florida has the second-largest veterans population and the number one, Mr. Chairman, oldest. So long-term care needs are of tremendous interest to our state.

The VA points out that the most new demand for LTC is being met through non-institutional services. And there is also a rise in home and community health care-based care. As the author of a provision in the new Medicare law that conducts a demonstration project for consumer-directed care, which is currently done in the Medicaid program, with great emphasis in home care services, I am intrigued to hear what might be some options for veterans here today.

So, again, I thank you, Mr. Chairman, for holding this hearing, and I look forward to hearing from our panelists.

The CHAIRMAN. Thank you very much, Mr. Stearns. I would like to welcome Ms. Cynthia Bascetta, who is the director of the Veterans' Health and Benefits Issues at the General Accounting Office. For the past 4 years, she has led reviews of VA budget and planning process and evaluations of specific programs in the Veterans Health Administration and the Veterans Benefits Administration. Before that, she directed GAO's work on the Social Security Administration's disability programs. Her work resulted in billions of dollars in savings and supported bipartisan legislation to improve the disability insurance and Supplemental Security Income programs.

Ms. Bascetta joined GAO in 1983 after beginning her career at the U.S. Department of Labor's Occupational Safety and Health Administration where she prepared regulatory impact analyses of major workplace health standards. She has been a frequent and very valuable witness before this committee, and we welcome her today.

She is joined by Dr. John Daigh, who is the Assistant Inspector General for Health Care Inspections in the Office of the Inspector General at the VA. Dr. Daigh has a distinguished career as a colonel with the United States Army. He attended the United States Military Academy in West Point, New York and graduated with a Bachelor of Science degree in 1974. He obtained his medical degree from the University of Texas Medical School in Dallas, Texas in 1978. He also has a degree in accounting and a master's degree in taxation.

Dr. Daigh held various positions from 1983 to 1998 at Walter Reed Army Medical Center. Most recently he was the chief of the Department of Neurology. He has also spent time at the Uniformed Services University of Health Sciences in Bethesda, MD as assistant professor of neurology and assistant professor of pediatrics from 1984 to 2002. He retired from active duty in 2002. And Dr. Daigh, you are welcome, as well.

Ms. Bascetta, if you could begin and introduce the remainder of your panel, if you would.

STATEMENTS OF CYNTHIA A. BASCETTA, DIRECTOR, HEALTHCARE, VETERANS' HEALTH AND BENEFITS ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JIM MUSSELWHITE, ASSISTANT DIRECTOR, HEALTHCARE, VETERANS' HEALTH AND BENEFITS ISSUES, GENERAL ACCOUNTING OFFICE; AND JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTH CARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY VICTORIA COATES, DIRECTOR, ATLANTA REGIONAL OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF CYNTHIA A. BASCETTA

Ms. BASCETTA. Thank you, Mr. Chairman. I am accompanied today by Jim Musselwhite, who led this work. We appreciate the invitation to testify today about VA's long-term care services. I won't repeat the projections we know so well, but I would like to point out that for the last 6 years the aging veteran population has

already posed a pressing demographic challenge for VA. During this time, the ranks of these elderly veterans rose dramatically by about 100 percent. As you know, these are the veterans most in need of long-term care services. And now and for the foreseeable future we can expect many of them to seek a range of long-term care services from VA.

Our current findings provide a clear picture of changes in workload for both nursing home care and non-institutional services. But they also raise important questions yet to be answered. In a nutshell, has access to VA services been sufficient to meet the needs of elderly veterans so far and will it be sufficient in the future? Answering this fundamental question will require better analysis and data from VA than we have seen so far.

My testimony today is based on our ongoing review for this committee of VA's nursing home care and non-institutional services workload, measured in terms of average daily census. Our work required extensive data verification efforts because VA could not provide reasonable assurance that its data were complete and accurate. In particular, information from headquarters was often delayed and inconsistent with network data. Workload numbers for some services took VA over 6 months to provide with sufficient documentation, and we are still waiting for complete documentation of VA's non-institutional services workload. Although we are confident in the findings we are reporting to you today, we continue to be concerned about VA's ability to provide basic management information about long-term care in a timely and reliable manner.

Let's look first at what happened to nursing home workload over the last 6 years. In 2003, nursing home workload was 33,214, 1 percent below its fiscal year 1998 workload, with a dip in fiscal year 2000 of 8 percent below the 1998 level. Dis-aggregating the data by network reveals much greater increases and decreases in this workload. The sharpest decline was 19 percent in one network and the steepest increase was 42 percent in another. VA needs to explain what this variation might mean for meeting veterans' needs in different parts of the country.

Where veterans receive nursing home care also changed during this period. The average daily census in VA's own nursing homes and in community nursing homes combined dropped by more than 2,400. In contrast, average daily census in state veterans homes rose steadily, almost offsetting the declines in the other settings. By 2003, fully half of all nursing home care was provided in state homes, up from 43 percent in 1998.

To evaluate this change, we need to better understand the implications for access, quality, and cost of this shift to using state veterans homes. And we need to know if the slice of the nursing home pie going to state veterans homes is going to grow even larger.

VA's own homes now account for about 37 percent of the workload, down from 40 percent in 1998. This is largely explained by our analysis of length of stay trends, which shows that fewer veterans with stays of 90 days or longer were in VA's own homes. Short stay patients increased but not enough to offset the decline in long-stay patients. Again, a network level analysis shows variation in this trend. While most networks showed declines, long stay patients in VA's own homes did increase in five networks.

VA officials attribute the overall decline in long stay patients to the priority given to post-acute care, the type of skilled nursing home care financed by Medicare. We need a better understanding of the effect of this priority on VA's ability to provide long-term nursing home care. VA can help by making transparent its strategy for providing the full continuum of long-term care services to eligible veterans.

The workload in community nursing homes paralleled the decline in VA's own homes, dropping from 17 to 13 percent of workload by 2003. Many fewer veterans received care in this setting. VA officials told us that compared to the past, they used shorter-term contracts, often 30 days or less, to transition to veterans to nursing home care financed by other payers, such as Medicaid.

Turning to non-institutional services, we found that average daily census increased by 75 percent over the last 6 years, although these services still constitute a much smaller proportion of the total long-term care workload. Much of the growth was in skilled home health care and homemaker home health aide services, which are key to preventing or delaying nursing home care.

As in our prior work, once again the prominent theme of variation, this time among facilities, was a key finding for us. Some facilities did not offer some of the non-institutional services at all or offered them only in certain parts of the geographic area they served. But, as I mentioned in my initial remarks, we have not been able to analyze the potential variation in this workload because of significant delays in obtaining data from VA.

Mr. Chairman, I would also like to point out that the workload numbers we present for home-based primary care are substantially lower than those reported by VA in the budget and in previous testimony. This is because we re-calculated them for comparability with the measures of all other non-institutional services and to better reflect utilization. As you can see, our estimate of this workload is 944, much less than the 8,370 figure reported by VA for 2003.

To summarize, because of the striking demographic changes that have already occurred, and the further aging of the population expected over the next decade, it seems clear that you and other stakeholders need answers to several important questions. We believe such information is necessary for more effective oversight of both VA's performance so far and its plans to meet the long-term care challenge in the future.

We look forward to continuing our work for you on these very important matters.

[The prepared statement of Ms. Bascetta appears on p. 51.]

The CHAIRMAN. Ms. Bascetta, thank you very much for your testimony. Dr. Daigh.

STATEMENT OF JOHN D. DAIGH, JR.

Dr. DAIGH. Mr. Chairman, I am pleased to have Ms. Victoria Coates here beside me. She is the regional director from Atlanta from our office.

Mr. Chairman and members of the committee, I am pleased to be here today to discuss programs that directly impact the quality of life of millions of veterans who need long-term care services. Today, I will present you with the results of our evaluation of the

Department of Veteran's Affairs Veterans Health Administration Community Nursing Home Program and the Homemaker and Home Health Aide Program. The Department of Veterans Affairs Office of Inspector General, Office of Healthcare Inspections conducted an evaluation of the community nursing home program to follow up on the Veteran's Health Administration's efforts to strengthen their monitoring of the program and to ensure that veterans receive appropriate care in a safe environment.

We visited eight VA medical facilities nationwide that contracted with 302 community nursing homes in their jurisdiction. We visited 25 of these nursing homes where we selected a sample of 111 veterans who were residents in these facilities, and we visited these veterans at these nursing homes. We reviewed their medical records at the nursing home and at the referring VA medical facility. At each VA medical facility, we interviewed the community nursing home program directors and staff, the relevant contract officials, and VA facility managers.

We also reviewed data from the Department of Health and Human Services, Center for Medicaid and Medicare Services. We found that while veterans we visited in the community nursing homes were generally well cared for, 8.1 percent of the veterans in our sample had been the subject of reported cases of abuse, neglect, or financial exploitation. Twenty-seven percent of the veterans in our sample were placed in nursing homes where CMS data showed that the nursing home had placed residents in harm's way or in immediate jeopardy. Quality assurance data from community nursing homes was often not incorporated into the VA medical facility's decision-making process. Contract procedures and inspection practices varied among VA facilities. Community nursing home review teams do not meet annually with Veterans Benefit Administration fiduciary and field examination examiners to discuss veterans of mutual concern.

We made 11 recommendations to the VHA and one to VBA in this report. The under secretary for health concurred with all recommendations except one affecting community nursing homes more than 50 miles away from parent facilities. The under secretary for benefits concurred with the recommendation to improve the information exchange between VBA and VHA personnel.

Let me now move on to our evaluation to determine whether the homemaker and home health aide programs at VHA medical facilities were in compliance with VHA policy and whether homemaker and home health aide services provided to patients were clinically appropriate, cost-effective, and met customer expectations.

As part of the Office of the Inspector General's combined assessment program reviews, we inspected homemaker and home health aide programs at 17 VA facilities. We selected 142 patients as a sample population. Our reviews showed that 20 of these 142 patients had medical records that indicated that the patients did not meet clinical eligibility requirements to receive homemaker and home health aide services. Twelve the 142 patients did not have any activities of daily living dependencies documented in their initial assessments for homemaker and home health aidee services. Fifty-nine percent of the VA medical facilities we visited had wait-

ing lists for placements in their homemaker and home health aide programs.

Only 18 percent of the community health agencies we visited provided quarterly documentation of performance improvement activities back to the VA program managers. And 24 percent of the veterans receiving homemaker and home health aide services also received basic special monthly compensation or pension benefits from VBA due to their need for agent attendance.

We recommended that the under secretary for health issue a policy replacing the expired VHA Directive 96–031 and provide additional guidance requiring that patients receive thorough initial inter-disciplinary assessments prior to homemaker and home health aide program placement. We also recommended that patients receiving homemaker and home health aide services meet clinical eligibility requirements and that benchmark rates for these services be established. We further recommended that the under secretary seek general counsel opinion on whether veterans basic monthly compensation from the Veterans Benefit Administration, due to their need for aid in attendance, status be considered when prioritizing these services and determining the frequency visits. The under secretary of health concurred with the findings and recommendations. VHA subsequently published guidance for benchmark rates to be used for this program.

This concludes my testimony. I would be pleased to answer any questions that you and the members of this committee may have.

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

The CHAIRMAN. Thank you very much, Dr. Daigh. Let me just begin the Federal Advisory Committee Report in 1998 made this comment in their conclusion section, "Without changes to the system, VA is at risk of eventually dismantling its long-term care system. Despite high quality and continued need, long-term care is perceived to be an adjunct entity unevenly funded and under valued. Continued neglect of the long-term care system will lead to further marginalization and disintegration and have costly unintended consequences throughout the VA health care system."

And I was wondering as you have made your recommendations and as I have read your reports, you paint, I think, a very disturbing picture of the unanswered questions about whether or not the shift to the state homes has indeed has led to any demise in the area of access or quality, not to mention the fact that we have, as you pointed out in your testimony, Dr. Daigh, a significant rise in those who will be eligible peaking in the year 2013. The numbers are staggering when you look at need. And yet we seem to be ebbing if not in decline. Mention was made earlier about the 5,000 beds that might have been idle had the recommendation for funding gone through for 2004.

In a bipartisan way, this committee, working very, very hard in a tortuous legislative process that only within days concluded, upped the amount of money available for health care, medical care by $2.9 billion year over year for a big increase. So the hope is that at minimum those 5,000 beds not only will not be idle, they will remain robust and available, but that we will also add to them.

If you could comment on that question: have we made any progress? There was a very dire observation made back in 1998

about the corrosive effect of neglect, the idea of being undervalued. And then we look at VISN–2 where there is the Partners for Dementia and they are working side by side with the Alzheimer's Association, and we will hear about that later on. There is a recognition that much could be done where there is the will, if you might want to comment on that, Ms. Bascetta?

Ms. BASCETTA. Well, I think we are definitely making progress, particularly in the non-institutional area, but the burning question is what is the need, what is the range of services that veterans need and in what parts of the country and how are the services matching up with the need. That is what has been lacking for a long time. And without that fundamental information, I don't know how we will ever be able to decide how much progress we have made and whether the steps that we are taking are ones that we agree are appropriate.

The CHAIRMAN. Are there reasons why you have been unable to get that basic data?

Ms. BASCETTA. Well, that basic data that we are talking about now as opposed to the information on program review that we have been trying to get is their long-term planning model, which is separate from the data problems that I was discussing in my testimony. We have been asking about the status of the long-term planning model probably for about a year now. And, as you mentioned in your opening statement, part of that is linked to CARES.

The CHAIRMAN. We will have, and this committee will do its rigorous oversight on any recommendation by CARES, but I find it still to be astonishing and unconscionable that left out of the process is a meaningful discussion, or any discussion at all, about long-term health care and what assets are needed to accommodate this exponential growth in need.

Let me just mention Dr. Joel Streim, who will not be testifying—he can't make it today—but he has submitted testimony from the American Association for Geriatric Psychiatry. He makes a very interesting point which we all kind of know, but he quantifies it I think in a way that bears raising, especially if we are going to marry up need—or resources with need. He points out that: "The prevalence rate of diagnosable psychiatry disorders among residents of community nursing homes is between 80 to 90 percent. We call them nursing homes but the numbers indicate that these facilities are defacto institutions for the care of patients with mental illnesses."

Dr. Daigh, you may want to comment on this as well. He points in his testimony that there is a lack of the type of skill base, especially psychiatrists and people who could handle people suffering from dementia, so that the provision of care may not be meeting the actual day to day needs of those who are in, as he points out, what are really homes for mental patients, particularly with dementia.

Dr. DAIGH. Mr. Chairman, I was a little surprised when we did our review of nursing homes and we went in and looked at the patients, to what extent psychiatric illness was a major factor in these patients care. A number of the veterans of World War II age in our sample turned out to be gentlemen who had actually been under government care for many years and were in long-term care

because they had schizophrenia or other chronic illnesses. A tremendous number of patients had Alzheimer or Parkinson's Disease or other disabilities of age.

So it is a very difficult problem for this patient population and it is an extremely prevalent problem, which complicates the care greatly.

The CHAIRMAN. Ms. Bascetta, did you want to comment on that?

Ms. BASCETTA. The scope of our work was really limited to the elderly. We didn't look specifically at other chronic conditions that would require long-term care services.

The CHAIRMAN. But as he points out, these are the people already being cared for in at least the institutional settings?

Ms. BASCETTA. That is right.

The CHAIRMAN. Okay, I see my time is up. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman. What is the status of recommendations you have made regarding contract nursing homes, do you consider these problems to be resolved?

Dr. DAIGH. Sir, we have not yet had the policy adjustments, we had asked VHA to come out with some policy and make some adjustments and those policy adjustments have been worked on over a number of years. And we are not yet satisfied that the adjustments they have proposed meet the standards that we would like to see for that program. It has been one of the problems that we have had with this program is getting a timely cycle between the creation of policy, the implementation of policy, and then the revision of policy.

Mr. EVANS. What is your time line? How long can we expect the committee to——

Dr. DAIGH. I believe that we will receive the next draft imminently. I believe that they are shortly to get us that draft, but we have heard this for some time now so we would like them to move a little quicker.

The CHAIRMAN. Thank you. Mr. Moran has left. Mr. Beauprez? He has left. Mr. Renzi?

Mr. RENZI. Thank you, Mr. Chairman. Dr. Daigh, when you were providing us with a statement, you mentioned the abuse of our veterans. And I think you used a figure of 8 percent. When you define abuse, what kind of abuses are we seeing?

Dr. DAIGH. We used standard definitions of abuse, the Federal Register had a definition of abuse and that is what we used.

Mr. RENZI. What are they? What type of abuse? Bed sores? What?

Dr. DAIGH. Oh, I see what you are talking about. We basically looked for neglect, abuse, and financial abuse.

Mr. RENZI. When the abuse is found, what types of penalties, what corrective measures are immediately put into place?

Dr. DAIGH. It depended on the level of abuse. If it was significant abuse and brought to the attention of VHA employees, we found that they generally acted responsibly. VHA would offer the veterans an opportunity to obtain care at another nursing home or they would seek proper resolution of the problem. It is hour hope that by more aggressively monitoring these homes, we could prevent instances of abuse. So a stronger program we think might lead to less abuse.

Mr. RENZI. Thank you. When we are dealing the majority of time with contract labor, not government employees, correct?

Dr. DAIGH. That is correct, sir.

Mr. RENZI. So you have the ability to fire them or relieve them much quicker or you have the oversight over the contractor itself?

Dr. DAIGH. I am uncertain of the answer to that question, sir. These are veterans in contract nursing homes, off the premises of the VHA facility so I don't know the answer to that question.

Mr. RENZI. Okay, maybe I can follow up later with Dr. Roswell. Thank you, sir. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Michaud?

Mr. MICHAUD. Thank you, Mr. Chairman. This one is for Mr. Bascetta. You are finding that increasing amounts of long-term care are being provided by state veterans home. I am very concerned that efforts to treat VA funding as a third party liability for Medicaid purposes may result in bankruptcy or closure of some of these homes. What impact would the loss of state home beds have on veterans, especially veterans with mental impairments who may need long-term institutional care?

Ms. BASCETTA. Well, clearly with the growing tendency to place more and more veterans in the state homes, if there are financial difficulties and there is some contraction in the number of beds there, without going back to community homes, those veterans would be hard-pressed to have access to care. We didn't look at the cost implications of any of these shifts in our work so far, but we do intend to look much more closely at both VA's expenditures and the rest of the financial implications of the changes in these settings.

Mr. MICHAUD. This question is for Dr. Daigh. You had mentioned about abuse in homes. What happens to some of these homes, is there a penalty for some of the abuse that you had found or find?

Dr. DAIGH. In the course of our inspection, the cases of serious abuse that we found, that would typically make the newspapers or everyone would agree is blatant abuse, they didn't occur to any of the patients in our sample. But they did occur to other residents in the nursing home in which veterans were resident while we were doing our study. And we thought that when it came to light, the individuals from VHA acted very responsibly in trying to ameliorate the situation the best they could in terms of treating the veterans appropriately. With respect to penalties to the nursing home, that was not the purview of our review. Most of these incidences would be reported to the state ombudsman and would also be investigated through local and state agencies.

Mr. MICHAUD. Do you think, talking about abuse and there are certain types of abuse, some are more severe than others, that veterans should have the right to sue individually the Federal Government and administrators of the government for the abuse they have given veterans for not adequately providing the care that they are supposed to give our veterans in this country? That is a different type of abuse but definitely we are not taking care of the veterans. There are homeless veterans out there. There are hospitals who are refusing to deal with any more veterans because of the waiting list. Do you think that is a different type of abuse that we should hold the Federal Government accountable?

Dr. DAIGH. Sir, I have not adequately considered that proposition and I don't feel qualified to answer that right now. I could respond in writing if you like but I haven't thought about that enough.

Mr. MICHAUD. Yes, if you could respond in writing. Thank you, Mr. Chairman.

The CHAIRMAN. Chairman Simmons?

Mr. SIMMONS. Thank you, Mr. Chairman. To Ms. Bascetta, I am intrigued by how the VA provides per diem for people in long-term care that are in state hospitals or in other types of environments. And you mentioned that you have not perhaps studied the funding system thoroughly, that you may be doing that in the future, so if you can't answer the question, I would be intrigued in having you pursue it a little bit. But the question essentially is how do we pay? The VA, as I understand it, will pay a per diem for a veteran in long-term care in a state hospital. In some cases, I have heard that that is offset by Medicare payments.

And so my first question is is that per diem in addition to state Medicare payments or is there an offset so essentially the VA is subsidizing the state in its obligation under Medicaid? And then, secondly, it is my understanding that the per diem payment is really a fraction, in some cases 10 percent of what the cost would be if the long-term care was provided in a veterans facility, that the VA offsets the cost in private nursing homes to about 70 percent of the cost.

So in this regard, and I know Dr. Roswell will probably respond to this question as well. In this regard, it does seem that the state option is a bargain. Have you had any opportunity to study that kind of reimbursement and have any recommendations to make on that subject?

Ms. BASCETTA. As you pointed out, we haven't looked in depth at this yet. We have a general awareness of the relative cost. And the state homes do appear to be much less expensive in terms of the per diem. I believe it is a little bit over $50 a month, the payment that the VA makes to the state homes. But they also share in the construction costs. So I guess the bottom line for us is that we hesitate to say anything at this point because what we do know is that the financing is very complicated, not only between the VA and the state homes but with all the other payers who are potentially involved.

Mr. SIMMONS. One other question you may not be able to answer as well, sorry about that. Dr. Roswell is taking notes. When these payments are made, are they made directly to the state home or are they made to the state general fund out of which then the dollars are allocated? Do you have any idea for that?

Ms. BASCETTA. Another good question that I will find out the answer for you hopefully in our continuing work.

Mr. SIMMONS. The bottom line I guess from my perspective is I am looking for a good deal for the veterans, not necessarily a good deal for the states.

Ms. BASCETTA. We agree and we think that one of the fundamental questions is the cost-effectiveness of the care. You need to know about the needs piece but you need to know about the efficiency with which the care is being provided, not only for the vet-

erans but to assure that the taxpayers are getting the best value for their money.

Mr. SIMMONS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. The question is for Ms. Bascetta. My understanding is that the VA is now providing long-term care and I will define that by being 90 days or longer to only about 19 percent of the nursing home patients. First of all, is that consistent with your conclusions? And that being the case, especially for the older and the sicker veterans, is this leaving a gap in the continuity of care? Are there patients greater than 19 percent that may be in need of extended care beyond the 90 day period of time?

Ms. BASCETTA. That is a good question that I don't have the answer to. These are some of the issues that we would like to pose for VA about what the basic need is out there and how well it is being met or not being met. Clearly, the kinds of continuity gaps that you are talking about are really problematic for filling the continuum of services that veterans in these situations need. And we know that the best health care outcomes are achieved when the transitions are smoothest between different care settings and different types of services.

Mr. STRICKLAND. The second question, your analysis did not differentiate between the VA and contract settings and examining capacity. As you know, this committee has required the VA to maintain the capacity of its in-house programs. This is my question. Are the settings in VA, contract settings equivalent in your view? Do they tend to provide the same kind of care or the same quality of care?

Ms. BASCETTA. We have not looked at quality of care. Perhaps the IG has a comment about that. We did note, particularly in the non-institutional area, that especially with our adjustment in the calculation of the home-based primary care, which is roughly equivalent to the skilled home health care that Medicare provides, those non-institutional services are overwhelmingly provided under contracts, not by VA's own employees. But as far as quality of care, we don't have any observations at this point.

Mr. STRICKLAND. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Strickland. Mr. Stearns?

Mr. STEARNS. Thank you, Mr. Chairman. Ms. Bascetta, how many years have you been an analyst on VA matters?

Ms. BASCETTA. A little over 5 years now.

Mr. STEARNS. Okay. What did you do before that?

Ms. BASCETTA. I worked on Medicare and Medicaid issues for a while, and I spent about 6 or 7 years on social security disability issues.

Mr. STEARNS. You are an expert as far as I am concerned. So you have had an understanding of the VA health and you have also studied Medicaid, I assume, you have a pretty good feel for that. The staff was kind enough to give me some statistics here. Bear with me. VHA is about a $30 billion program in operation. And they spend about $3 billion on long-term care.

But, as I understand, Ms. Gong is going to testify that Medicaid, a $200 billion agency, spends about $75 billion on long-term care.

So the VA is spending about 10 percent and Medicaid about 37 percent.

So the differences are pretty dramatic. Does that mean in your analysis that the VA is not spending enough or Medicaid is spending too much?

Ms. BASCETTA. Well, we are talking about pretty different populations.

Mr. STEARNS. This is long-term care. Isn't long-term care long-term care?

Ms. BASCETTA. Well, I don't know what is included in the Medicaid long-term care numbers compared to the VA long-term care numbers in the sense that there are a lot of——

Mr. STEARNS. Well, you know what the components are for the long-term care for veterans, don't you?

Ms. BASCETTA. Yes.

Mr. STEARNS. Okay.

Ms. BASCETTA. But in the Medicaid population there might be a significantly younger population with chronic disabilities who are included in the $75 billion.

Mr. STEARNS. I know but you and I both know populations, profiles of people who are in chronic need of long-term care is about similar, profile-wise, across the country. I think what you are trying to do is hedge because it is two different programs. I am just speaking in general here. We are not going to go down into the details of each patient here. We are just talking in general statistics. You have got 10 percent in the VA and 37 percent in Medicaid. Surely there has got to be something this tells you.

If you had to decide on which, would you think the VA is using the dollars wisely or Medicaid, I mean from your analysis just give me a broad answer here, just yes or no?

Ms. BASCETTA. Well, I wish I could. I am uncomfortable saying yes or no more on the VA side because I don't know how well they are meeting the need in terms of efficiency. I don't know whether the $3 billion is efficiently spent. I don't know the answer for that on the Medicaid side either for that matter.

Mr. STEARNS. Have you ever studied Medicaid?

Ms. BASCETTA. Quite a while ago. Most of my Medicaid background is on the public health side, not on the long-term care side.

Mr. STEARNS. Ms. Bascetta, in this whole room and probably in America, you are about as good an expert as anybody is going to be. There certainly is not going to be anybody with more experience than you. You have been an analyst 5 years on veterans. You have been on the Medicaid some time ago. I just call attention, Mr. Chairman, that the statistics here would show that the VA, at my first blush, that they should be spending more money on long-term care than 10 percent.

Is that a fair statement, Ms. Bascetta? Do you think I am wrong saying that?

Ms. BASCETTA. Well, I wouldn't say you were wrong.

Mr. STEARNS. That is okay, you can say I am wrong.

Ms. BASCETTA. I would go back to my original concern about my own knowledge of what is in that Medicaid number. For example, one of the younger populations that are high utilizers on the Medicaid side are children and adults with mental retardation.

Mr. STEARNS. That is a good point.

Ms. BASCETTA. That is not in the VA population.

Mr. STEARNS. That is a good point.

Ms. BASCETTA. And I wish I knew, I wish I could tell you, maybe I could find out for the record what percentage of the $75 billion is spent on services like that.

Mr. STEARNS. Well, let me move on. I have another question. This is a little bit of what Chairman Simmons has mentioned, that the state option is a bargain. He said, "The 1998 Long-Term Care Advisory Committee recommended VA hold steady on in-house nursing home beds and dramatically expand non-bed and home-based programs." In fact, I put these recommendations in the Millennium Health Care Bill. The GAO reports the 85-plus age group has grown by 100 percent but the VA's overall long-term growth was 11 percent. Why has VA's non-bed programs not grown more since 1998? Do you understand the question?

Ms. BASCETTA. Yes, and I think that that is a very important question to pose to VA because there does appear to be much less growth in the total combined workload of the institutional and non-institutional services compared to the dramatic growth in the elderly population, that proportion over 85 who would be most in need of those services.

A question for the future though, and something I also feel frustrated because I don't know enough about is the capacity in the future to meet that need because what is different in VA than in the general population is that the other users of long-term care elderly, not younger people with chronic illnesses, but the other elderly component is those between 65 and 84. That component in the general population is growing very fast. But in the VA it is going to decline very steeply.

So they may have sufficient capacity to meet the need of the 85's and over or of the entire elderly population. We don't know. These are the kinds of numbers we are trying to really press VA to produce for us so we can make some informed decisions about what they need to meet the needs in the future and whether they can do it with the resources they have now or whether we need to have a broader discussion about other funding streams.

Mr. STEARNS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. I am going to have to leave for a moment but before I go on to Ms. Hooley, just make a point if I could and perhaps you might want to answer this. When Cliff Stearns' bill became law, it set a minimum at the 1998 level for long-term health care capacity, not a maximum but a minimum, a floor. Many of us are concerned that that floor has been breached and would have been breached in a profound way had the previous budget become law.

Perhaps you might want to speak to the issue. We shouldn't be thinking in minimums when you talk about long-term health care. The $64 question that I had that I have not been able to get an answer to is what percentage of eligible veterans, who could utilize long-term health care, actually get it? Is it 5 percent? Is it 10 percent, who get it from the VA that is.

And the second question is not unlike the first, and maybe in part not an answer but my sense of what is happening. The VA

sees that Medicaid, especially with the spend down provisions, people spend their own money, and there is a spousal impoverishment provision so that the other spouse perhaps doesn't become a pauper, although many times they do, but about 50 percent of those in nursing homes are on Medicaid. So in the way the VA has shifted the burden and responsibility that ought to be borne to a greater extent, maybe not wholly, totally, but certainly more to Medicaid. So I think Mr. Stearns' question goes right to heart——

Mr. STEARNS. It is a good question.

The CHAIRMAN (continuing). Where does responsibility and duty come in or you have finger pointing. But do we have a number, how many veterans who are eligible and who could be getting long-term health care are actually getting it?

Ms. BASCETTA. I don't have those numbers. Those are precisely what we need from VA to have exactly the discussion that we are talking about now.

The CHAIRMAN. Ms. Hooley?

Ms. HOOLEY. Yes, thank you, Mr. Chairman. And thank you for asking that question and for holding this hearing because those are critical questions that we need to have answered.

Ms. Bascetta, I have a question for you. You stated VA's long-term health care policy was post-acute nursing home care as a priority and then long-term care as resources permit. In your view, do the resources seem to permit VA to make long-term care available to many veterans?

Ms. BASCETTA. Well, we know that the non-acute care is available to varying extents. What we don't know is the sufficiency question that I believe you asked in your opening statement.

Ms. HOOLEY. Right.

Ms. BASCETTA. Because again we don't have a good estimate of what is needed, and we are not able to match that need with services across different geographic locations.

Ms. HOOLEY. Do you think we will have, be able to get those answers?

Ms. BASCETTA. I certainly hope so. I don't see why not.

Ms. HOOLEY. Okay. Dr. Daigh, I have a quick question for you. I want to emphasize one point of your testimony. You say VA is contracting with providers that have significant violations, right? And those violations have been identified for Centers for Medicaid and Medicaid Services, CMS. Can you just check CMS' website and find out if there have been violations, can you do that? Is it that easy?

Dr. DAIGH. It is that easy and we are encouraging that people take that simple step and do that, yes.

Ms. HOOLEY. My question is is this being done?

Dr. DAIGH. It is not being done as routinely as we expected to see it being done. So the answer is some places did a nice job of it but many places did not take that simple step.

Ms. HOOLEY. Do they all know they can look at that and get that information?

Dr. DAIGH. Most of them did, yes.

Ms. HOOLEY. And they still didn't use it?

Dr. DAIGH. It varied again by facility but it was not uniformly used.

Ms. HOOLEY. Sometimes numbers are hard to predict things that are happening in the future, what the population is going to look like but it seems to me this is really an easy thing to do that we should absolutely be using when it is right there in front of us.

Dr. DAIGH. We agree and when we went to look at the contract files at VHA facilities, we would have expected to find data like that in those files to consider reappointment or renewing the contract. And we didn't see that as nearly as often we would have liked to have.

Ms. HOOLEY. Okay, thank you, Mr. Chair.

Mr. SIMMONS (presiding). Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

I might just follow up, I think that the questions that people are asking in part is why don't we have some of this information and how tough is it to get that? Do you think that—it sounds like the VA has really made greater use of its contract non-institutional care than perhaps developing its own resources. Is that a fair assessment? And if it is, do you think that—why do you think that is from your perspective?

Ms. BASCETTA. Well, that is a fact. Whether or not that is a wise use of their own resources is an open question because we haven't looked at what the relative costs would be of them trying to provide that service through their employees. It could very well be that the most efficient thing for them to do is to contract those services, particularly in markets where those services might be plentiful. Maybe they can get a very good deal.

Mrs. DAVIS. There hasn't really been an attempt to really analyze that, whether it is rural, whether it is more urban?

Ms. BASCETTA. We are continuing our work and certainly looking at the cost-effectiveness of the current delivery patterns is something we would want to look at.

Mrs. DAVIS. You also mentioned the mental health area, which is critical. And from your perspective again, we know that that is a great need. Is there a sense that this is really from a development point of view in terms of growing our own essentially, in terms of having the people available, the training, et cetera.

Do you see a growth in our ability to respond to that or has that been kind of on a flat plain, have we not really addressed those issues in a way that obviously the population would suggest?

Dr. DAIGH. That wasn't one of the questions we looked at in the study but the sample population clearly had significant psychiatric issues in terms of the incidence of psychiatric disease. And it makes it very difficult to provide care in any setting for those patients and was probably the most important complication of providing care to this population. I can't directly answer your question based on the questions we asked when we did our review.

Mrs. DAVIS. I guess going back in terms of the issues around Medicaid and again developing those resources, the percentage of resources that is put into that would also be helpful to know. Did I get a sense that you are having such difficulty getting this information? And why is that? Perhaps we will hear in the next panel but what is the problem?

Ms. BASCETTA. Would you like to comment?

Mr. MUSSELWHITE. We have had difficulty getting information. I am not sure what the problem is but there are inconsistencies in data that are provided sometimes between data from headquarters and data from a network prospective, for example. Just to give you an example, in the nursing home workload, we asked networks as well as the headquarters folks what the average daily census numbers were for the various years and there were discrepancies which we had to work out. And why all that happened, I can't exactly tell you. Some of the issues are just sort of normal data issues that occur but others, for example, one network thought that maybe they had not input all their data that would count all the people who had been in nursing homes over a given period.

So it is a question in many cases of looking for documentation to understand how the information is gathered. For example, in the home-based primary care side, we just asked for documentation as to how those numbers were calculated. And when we did, that is when we understood that they are based on enrolled days, not the number of visits that a patient receives. So we went through the process with all the non-institutional services and for all the other services, it is on the basis of visits.

So we really had to get behind the numbers to see how they were calculated. For example, on home-based primary care, you might want to ask VA why they have done it based on enrolled days. I can't answer that. But we tried to be consistent, once we understood how the data were calculated, we put them all in the table the same way and it is a different number total than the one VA reports. So it takes a bit of getting behind the numbers to figure out what is going on.

Mrs. DAVIS. Appreciate your work on this. Thank you.

Mr. SIMMONS. The gentleman from New Hampshire, Mr. Bradley, is recognized. Mr. Baker? It is a conspiracy against Republican members.

OPENING STATEMENT OF HON. RICHARD H. BAKER

Mr. BAKER. Yes, I am accustomed to this treatment, Mr. Chairman. In looking at the data provided in Network 17 relative to the increase in utilization, it is a rather staggering jump in relation to the performance of the network generally where by far and large most demonstrated in a decrease while Network 17 was up some 42 percent, twice it is close to second place finisher. I understand that Texas is engaged in significant new construction activities for several new facilities now on line with more company. Then looking at the VA's home workload declines, Network 17 had the most significant decrease in workload provided by VA-operated nursing homes. It appears that there has got to be some policy observation arrived at.

Well, in addition, the community nursing home load was also down in Network 17. In your conclusions, one of the questions posed is what are the implications for access, quality, and cost of VA significant shift using state veterans nursing homes to provide.

My point is that Texas is appearing to create a very interesting policy question for us. If there is nothing the Congress has done to initiate Texas' unilateral action, and it is merely a policy deter-

mination of the state legislature, we need to be more engaged in nursing home provision.

What does that say to us about the direction of long-term nursing facility care? Do we need to be concerned about the proliferation of state facilities at the expense of free enterprise community-based institutions? Does it have good implications for the VA-operated facilities? Out of all of this work, what conclusion can you draw or observation can you make about the advisability or inappropriateness of that step because it is going to get significantly more disparate because there are more facilities coming on line. Are you worried about that?

Ms. BASCETTA. Correct.

Mr. BAKER. Are you happy about that? Don't care about that?

Ms. BASCETTA. Well, we don't know enough about the implications across the board, cost, quality, and access, to know whether we are happy about it or not or whether we are happy in some places and not in others.

Mr. BAKER. Well, if you could maybe without getting overjoyed but reach a conclusion at some point because if we don't, with Texas doubling their capacity, they are dictating to us how the system is going to function. And there may be advisable directions or steps that we should take based on professional analysis of these implications. So I just request, Mr. Chairman, that some observations or recommendations be made about this implication. It clearly in the view of the overall network performance is an aberrant act. And I don't know whether it is good or bad either, but I would like to have somebody who knows more about it tell me. Thank you.

Ms. BASCETTA. We agree, thank you.

Mr. SIMMONS. I thank the gentleman. Before I excuse the first panel, and I believe everybody has had a chance at questions, I would like to address a question to Ms. Coates, who I understood flew up from Atlanta, in the heart of the storm. It is my understanding that in December 2003, your evaluation of the VA Homemaker and Home Health aide Programs noted that about $10 million could have been available to provide needed services to veterans if VHA had implemented previous IG recommendations. Is that a correct statement? How did you come up with that figure? And what comments would you like to make on that subject?

Ms. COATES. We had an audit division that assisted us in developing the financial figures. I have a general picture of how those numbers were developed, I would be happy to share those. But something specific, I would probably need to get back to you on.

Mr. SIMMONS. If you could do that for the record, we would appreciate it. And we also appreciate your coming up under these difficult conditions. Thank you very much. Unless there are any additional questions for panel one, I want to thank them for their testimony and participation. And in the case of the GAO, we look forward to a continuing relationship to answer some of the questions that we have posed.

At this point, I would like to welcome panel two, which is composed of the honorable Robert H. Roswell, Under Secretary for Health, Department of Veterans Affairs, accompanied by Dr. James F. Burris, who is the chief consultant for geriatrics and extended

care of the Strategic Healthcare Group, Veterans Health Administration, Department of Veterans Affairs. Welcome, gentlemen.

Dr. Roswell, you know the routine and I am sure you have a statement for the record. We would welcome that. If you want to summarize that or plunge into some of the issues that have already been raised, I leave that to your discretion.

STATEMENT OF ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JAMES F. BURRIS, M.D., CHIEF CONSULTANT FOR GERIATRICS AND EXTENDED CARE, STRATEGIC HEALTHCARE GROUP, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Dr. ROSWELL. Well, thank you, Mr. Chairman. I would like to make an opening statement, although it will be abbreviated. My full statement has been submitted for the record.

I am certainly pleased to be here to discuss some very important issues that have already surfaced and a topic that is very near and dear to my heart. With me is Dr. James Burris, our chief consultant for geriatrics and extended care. I would like to say that Jim joins us after a lengthy hiatus in leadership in the Office of Geriatrics and Extended Care. It has been over 18 months since the previous chief left. During that time, we functioned with an interim acting chief, a woman who dedicated her life to caring for the nation's veterans and particularly for long-term care. Sadly, she was struck with a terminal illness and has departed VA and is no longer with us. But I would like for the record to acknowledge the tremendous leadership that Marsha Goodwin-Beck provided as the acting director of geriatrics and extended care and someone who, as I said, devoted her life to improving the care for veterans.

Mr. Chairman, the need for accessible long-term care for services cannot be overstated. As has been mentioned, by the year 2010, the number of veterans over age 85 will triple to more than 1.3 million. And in comparison to the general population, VA patients are older, with lower income, lacking health insurance, and much more likely to be disabled and unable to work.

VA remains fully committed to providing institutional long-term care for eligible veterans who require this level of service. However, we must recognize that this type of care is costly and is likely to impair longstanding relationships with friends and family and reduce the overall quality of life. Accordingly, veterans have indicated a preference for care in non-institutional settings where possible. And when it becomes necessary, institutional care as close as possible to their homes.

VA has responded to the veterans' desires in several ways. First, we have emphasized rehabilitation care and functional restoration in VA nursing homes. This not only improves the cost efficiency of acute care services by shifting post-acute care to a lower cost environment but it has also led to sufficient patient improvement for those cared for in our VA nursing homes to allow over 70 percent of veterans treated in that setting to be returned and be discharged to their own residences. This emphasis on restoration of functional independence has resulted in shorter average lengths of stay in VA

nursing homes, allowing more patients to benefit from this approach.

From 1998 through 2003, the number of patients treated annually in VA staff nursing homes has actually risen from 47,000 to almost 56,000 patients, an 18 percent increase, despite the fact that the average daily census has fallen slightly from 13,391 to approximately 12,000.

When veterans eventually require maintenance care in an institutional setting, we have emphasized the availability of state veterans homes which allow veterans and their families greater choice in the location of care. From 1998 to 2003, the average daily census of veterans receiving care in state homes and domiciliaries has risen from 18,000 to over 20,000, a 13 percent increase.

Newer models of long-term care now include a full continuum of home and community-based extended care services in addition to home care. VA expects to meet most of the need for long-term care through CARE coordination, home health care, adult day health care, respite and homemaker and home health aide services. VA has made steady progress in expanding its own home and community-based extended care programs. From 1998 to 2003, the average daily census in these programs increased from 11,700 to 18,322, a 57 percent increase. VA plans to reach an average daily census of 22,000 in fiscal year 2004. And our new CARE coordination program will add to that number approximately 7,500 more veterans for a total of almost 30,000 veterans by the end of this fiscal year.

Last May, I announced plans to establish the Office of Care Coordination, and I am pleased to report that that office is now fully operational. Care Coordination uses best practices derived from scientific evidence to bring together health care resources in the most appropriate effective and efficient manner to care for the patient. CARE Coordination provides patients a continuous connection to clinical support services from the convenience of their place of residence and supports the family members and others who provide care in the home. Initial efforts in Care Coordination are focusing on high resource utilization patients with chronic diseases at great risk for nursing home placement.

On a needs basis performed last year, we anticipated that each VISN would have at least 1,000 to 1,500 patients who could benefit from such services. The emphasis on these programs to support non-institutional care of veterans and promote their independent living will result in an average daily census in our CARE Coordination which has grown from 2,000 in fiscal year 2002 to over 7,000 this year.

Mr. Chairman, we have had an opportunity to review GAO's draft statement for the hearing and discuss it briefly with them. We feel the GAO's findings emphasizes the need to capture data more accurately reflecting the services that we actually provide to veterans. While average daily census serves as a useful planning and budget tool, it does not truly reflect the great number of individuals who receive and benefit from the various services we are privileged to provide.

In conclusion, Mr. Chairman, VA has made great progress in increasing the number of veterans who receive needed long-term care

services. Today, veterans have more options in more locations which allow them to achieve their full functional independence potential and still maintain a satisfying quality of life.

Mr. Chairman, that completes my opening remarks. Dr. Burris and I would be happy to answer any questions you may have.

[The prepared statement of Dr. Roswell, with attachment, appears on p. 146.]

Mr. SIMMONS. Thank you for your testimony. I accept your statement that there are more options available for long-term or chronic care. We have moved from an institution-based system to I guess what you could call a patient-based system. You have options that are available through your state homes, which we have discussed a little bit. You have options through local nursing homes that would then receive payments from the VA to provide services. And you have home health care options, which involve I think distance communication so that patient health can actually be monitored at some distance from the home with the assistance I guess of a family member.

So I see a variety of options there that I think is important. The fundamental question I have is how is the VA monitoring these options to ensure quality across now a very broad and diverse spectrum of service providers? And how is the funding going so that we know that you are getting more bang for the buck? We know that if you were to provide this service in-house, it would cost almost 10 times as much as what it costs in a state home. And I guess there is a 30 percent saving if you out source to a private nurse care facility.

So I am interested in following the dollars, if you will, and interested in how you follow the dollars to ensure that these veterans get the long-term care that they need?

Dr. ROSWELL. Well, Mr. Chairman, as important as the dollars are, much more important are the veteran and the desires of his or her family members. Having said that, we are very scrupulous in monitoring the dollars. The VA staff nursing home beds that I spoke of on average cost about $400 a day. That higher cost reflects the rehabilitation services that are provided, which leads to the shortened stay.

But much more important than the shorter stay is the fact that we are actually able to return veterans seven out of 10 times back to their homes, where they are functionally independent for at least a period of time. The contract community nursing homes on average cost about $200 a day, roughly half that, a substantial savings.

Let me point out, though, in response to one of the earlier questions, that the reality of the contract community nursing home is that it is a transition program towards Medicaid-provided long-term care. Medicaid, as was discussed, devotes a large percentage of their budget, 37 percent, to long-term care in institutional settings. VA devotes less than that.

But let me point out that we don't even count veterans who choose (or their families choose) to receive care through that venue. We do assist them, though, in ascertaining Medicaid benefits if that is their desire to move to a Medicaid provider in their community. When we place a veteran on a contract, we will do so only with homes who pass a very rigorous inspection. When they fail to

pass that inspection, when they fail to meet CMS certification, we withdraw patients from that contract. We are more efficient than we once were in ascertaining those Medicaid benefits on behalf of our patients and therefore the average length of the contract is shorter. But it doesn't mean fewer patients are receiving care.

With regard to the state home, as Ms. Bascetta indicated, VA provides 65 percent of the cost of construction and in exchange provides for veterans a discounted per diem of a little over $50 a day, a substantial savings. So we have gone from $400 to $200 to zero cost for Medicare beneficiaries to $50 for those who seek care in state homes. Again, state homes often are a preference for veterans seeking care in their community. State homes are in many locations that VA nursing homes aren't, and we try to honor the desires of the veteran. We work with the state homes to make them more efficient, to achieve discounts on pharmaceutical services.

One of the things that we have considered in the past is paying the full per diem cost, not the discounted per diem cost for veterans who are 70 percent service-connected or greater who desire care in a state home. I might point out that that is the only veteran group that this Congress has seen fit to offer full access to long-term care. The eligibility reform legislation, which became effective in 1998, makes institutional long-term care services a discretionary benefit. It is not part of the uniform benefit.

The Millennium bill that Mr. Stearns co-authored and spoke about adds non-institutional long-term care services to that uniform benefit, but institutional long-term care is still mandated only for those 70 percent service-connected. By extending that benefit to the service-connected veterans, we might be able to further improve the budgetary issues that the state homes are dealing that have been alluded to.

And then I haven't any mentioned long-term care which is provided in a non-institutional setting. There we are literally providing care at a cost of only a few dollars a day. So there is a substantial savings. Obviously, though, it is not the dollars that drive that; veterans repeatedly tell us they would much rather be at home than in an institutional setting.

Mr. SIMMONS. Thank you. I see the red light. I have some additional questions, but I thank you for that response. Mr. Strickland, the acting ranking member? Oh, Mr. Michaud, I apologize.

Mr. MICHAUD. I switched seats here.

Mr. SIMMONS. He is moving on me, okay, I apologize.

Mr. MICHAUD. I am moving on you. I am moving further to the center.

Mr. SIMMONS. That is good.

Mr. MICHAUD. The question is, a couple actually, Congress recently received a final report from VA on implementation of the Millennium bill and it says, and I quote, "To date, there is evidence of at most only small changes in VA long-term care services occurring immediately after enactment of Public Law 106–117 compared to what has been expected in absence of the law." What this says to me is that VA had decided to create policy regardless of what the law says or what the intent of the law says.

And I guess I have a concern, particularly being a public official for 22 years in the State of Maine where bureaucrats tend to do

whatever they want to do regardless of whatever the intent or what the law actually says. I would like to have you comment.

Dr. ROSWELL. Well, I think VA is being responsive to the Millennium bill. I apologize that we can't be more timely in our response, but I think good care and honoring the choice of veterans and their families requires time for implementation. Let me ask, if I may, though, Dr. Burris to provide some specific comments on that.

Dr. BURRIS. Thank you, Dr. Roswell. Prior to the passage of the Millennium Act, we had a series of recommendations from the Federal Advisory Committee on the future of VA Long-Term Care. VA began to take action on a number of those recommendations even before the passage of the Millennium Act so that from my point of view you would expect the outcomes not to be too different because VA and Congress were thinking very much in the same way about what the future of long-term care in VA should be.

In particular, the Crossroads Report, the Report on the Future of VA Long-Term Care, recommended that VA sustain its own nursing home infrastructure and the community nursing home program but that most growth in nursing home care should be in the state home program. And that is exactly what we have done. The Crossroads Report also recommended that we shift much of the care from institutional to non-institutional home and community-based settings. And, as you have heard, that is exactly what VA has done.

So the fact that we were just thinking alike explains in part that there wasn't a lot of difference between the direction VA was going before and after the passage of the Millennium Act. And in part what Dr. Roswell said just a moment ago that it takes time to develop the infrastructure and hire the staff and build the facilities to make the care available.

Mr. MICHAUD. I think it talked about maintaining but also to expand. I guess, Dr. Roswell, this committee recommended an additional $297 million for long-term care in our views and estimates for the fiscal year 2004 budget. Ironically, VA returned about $270 million to the U.S. Treasury for fiscal year 2003 and left many of Congress' long-term care capacity concern still unaddressed. Can you explain?

Dr. ROSWELL. I am not sure which money you are referring to that was returned to the Treasury. But let me point out that we are expanding both institutional and non-institutional long-term care. When we look at the number of veterans who receive and benefit from those services, the expansion of institutional care is fairly significant even though the average daily census in the highest cost level of care that the chairman asked about has been relatively static or actually declined ever so slightly. But the number of veterans who received those services in institutional settings either provided directly by or administered through VA has increased.

Mr. MICHAUD. I have several questions I would like to submit in writing but my last question is the American Legion says, "The key to fulfilling VA's obligation to provide long-term care to veterans is to obtain mandatory funding for veterans' health care." Do you agree with that? And, if not, why not?

Dr. ROSWELL. I believe that the congressional process of oversight applies equally well to the formulation of budgets. I am not sure that a formula can substitute for the judgment of this Congress in determining what the budgetary needs of the Department are. So the Department has examined the interest in mandatory funding carefully, but we still believe that health care is not predictable by a formula and value the oversight that this Congress provides.

Mr. SIMMONS. I thank the gentleman from Maine. As I hear that response, I think it means that they value our background and experience in dealing with these issues on a year to year basis.

The Chair recognizes the gentle lady from Nevada, Ms. Berkley.

Ms. BERKLEY. Thank you, Mr. Chairman. When it comes to veterans' issues, I would rather be called the "not-so-gentle lady from Nevada." Dr. Roswell, it is a pleasure to see you again. I am sorry that I am a little late to the hearing. It seems that everyone that lives in Nevada is in our nation's capital today in my office. So I had to attend to my responsibilities to the folks back home.

If I could, would you mind if I entered some remarks into the record, since I wasn't here for opening statements?

Mr. SIMMONS. Without objection, so ordered.

Ms. BERKLEY. Thank you for that. Dr. Roswell, you know these statistics probably better than I do at this point, and I don't mean to sound like a broken record but I would like to include them in the record if that is all right with you. For the last 17 consecutive years, Nevada has been the fastest-growing State in the nation, and the majority of the growth, of course, has been concentrated in southern Nevada, which is Las Vegas, NV, the community that I represent. Few communities face a greater need for veterans' care facilities than Las Vegas, home to one of the fastest growing senior populations and the fastest growing veteran population in the United States. A large number of my Las Vegas seniors have served their Nation in uniform, and they are turning to the VA in even greater numbers for outpatient treatment, hospital visits, nursing home care, a need that is growing particularly acute, as you know.

To help meet the demand for long-term care, the Nevada Veterans Nursing Home in Boulder City opened in August of 2002 with 180 beds. Those beds are long since filled. We are at capacity there already, of course. It is the only one of its kind in the entire state of Nevada. It is 30 miles away from metropolitan Las Vegas. And it is difficult—if there were beds available, it is still difficult for my seniors to access it without a burden to those that have family in Las Vegas, which are few. Two years after opening the doors, the facility is filled, and we estimate that this trend will continue over the long term.

I am concerned for a whole host of reasons. One is that the existing lack of nursing home beds in Las Vegas and the expected demand for long-term care in the future will continue to strain the available resources for veterans in southern Nevada. We have a crisis in our private nursing facilities so whenever the VA is able to get a veteran into a private nursing facility, it is at the expense of other people, other seniors that are on a very long waiting list. That is not a viable option. Home, non-institutional settings often-

times in the State of Nevada, in Las Vegas is not an option either because so many of our veterans move to Las Vegas after they retire and there is no family member there to help them. So they need institutional care.

The CARES plan recognized the needs of the aging veterans population and proposed a long-term care facility with 120 beds in Las Vegas as part of a full service medical complex and you know we are anxiously awaiting that. This proposal is a major breakthrough in health care services for southern Nevada's veterans and will make long-term care more accessible to our aging veterans and their spouses. It will not only provide Nevada with desperately needed nursing home care beds but will address current and future demands for nursing home specialized care and expand necessary services, such as Alzheimer care, rehabilitative and sub-acute care.

I am concerned—as you know, this is an issue that I spend a great deal of time on and it is a tremendous passion for me. Under the Veterans Millennium Health Care and Benefits Act, I think Congress mandated that the VA have 13,500 nursing beds available. But from what I understand, there are less now available than before. How does that impact on a community like mine that is so growth-oriented? I have 5,000 new residents a month coming into town; many of them are seniors, many of them are veterans. This is not going to stop. And if the VA is cutting back on the mandate, and I hate to use that word, but if it is in the bill, it is in the bill, the 13,500, if we are cutting back, what does that do for a growing community like Las Vegas with absolutely no veteran long-term care facility?

Dr. ROSWELL. Well, I certainly agree with the proposal that I crafted into the National CARES plan, which is now in the final stages of review by the independent CARES Commission. The bottom line is that the 13,391 in the Millennium bill is actually an average daily census in the existing VA nursing homes.

Part of the premise of CARES, part of the premise of the way we are looking at the growth and changes in the veteran demography nationwide is that our facilities aren't where there is the greatest need. And some of the facilities as they currently exist are woefully outdated. There is no question that in southern Nevada the population growth and the veteran growth is so great that we will need to place additional nursing home beds in that location.

In addition to all that you have stated, it will also improve the efficiency of the hospital care that we will provide in that location. And it will allow us to provide respite care for veterans who are able to be cared for in the home even though that may be a smaller percentage than the national average. It will allow us to provide geriatric assessment to help us identify ways that we can maximize the quality of life for veterans who need geriatric care but may not yet be ready for institutional care.

So in addition to all the benefits you provided, those long-term care beds will be a part of a full-service medical center, which is what is truly needed to serve the population of southern Nevada.

Ms. BERKLEY. Can I ask a follow-up question?

Mr. SIMMONS. Of course.

Ms. BERKLEY. Thank you. Let me ask, I am a little bit concerned about the direction that the CARES Commission is going in, be-

cause they are talking about shared facilities at Nellis Air Force Base. You and I envision, not only you and I, but we envision an entire campus where we have got the outpatient clinic, a full-service hospital, and a long-term care facility on a 50-acre parcel. If the CARES Commission decides to go with this idea of sharing facilities at Nellis Air Force Base, what does that do to the whole campus environment and what does that do to the potential for our long-term care facility for our veterans? Am I going to have that in one location and the hospital in another location and my veterans going to 10 different locations to get outpatient care? Where are we going with this?

Dr. ROSWELL. I could only speculate. Let me tell you that there is interest in maintaining the excellent collaboration VA currently enjoys with the Air Force at the Michael O'Callaghan Federal Hospital——

Ms. BERKLEY. Whose definition of "excellent?" It is not my veterans' definition.

Dr. ROSWELL. "Excellent" was my word. We recognize, though, that our needs are for a full-service medical center, which includes an outpatient clinic to replace the one that was so seriously damaged due to structural flaws. We need additional inpatient beds. The beds at the Michael O'Callaghan, even if all were made available to VA, would be inadequate to our needs. And we need long-term care beds. We also need a VA regional office for benefits administration to allow us to enhance the processing of disability claims in that area.

So we have a significant need. Yes, we probably need 50 or 55 acres to provide those full services. We are currently working closely with the Air Force. Secretary Principi has written Secretary Roche asking him for his assistance in identifying an adequate 55-acre parcel of land that would still allow joint operations but would meet our full needs. We are anxiously awaiting the reply to that letter from the Secretary of the Air Force.

Ms. BERKLEY. I would suggest Yucca Mountain—instead of nuclear waste, we put the VA facility on that.

Mr. SIMMONS. I thank the lady. My recollection is Yucca Mountain is a former nuclear test site, so I am not sure the veterans would appreciate that.

Ms. BERKLEY. No, actually it is not exactly at the Nevada test site, but I am sure they would not appreciate that.

Mr. SIMMONS. The gentleman from Ohio, Mr. Ryan, is recognized. No questions. Okay, if I could begin the second round, I have two questions. As a follow-on to my previous questions about funding, and my interest in this is not to reduce funding or to look for efficiencies necessarily but simply to see if there are areas where the funding goes astray. When the VA makes a payment to a state home or to a nursing home in a state, does that payment go either to the general fund or to let's say a Department of Health Services fund where it is then re-allocated to the provider? Or does it go directly from VA to the provider? That is the first point. And secondly is there any situation that occurs where the state veterans home or the providers might have excess funds which they then return back to a general fund in a particular state?

Dr. ROSWELL. We are not entirely sure. We will submit a more complete answer for the record. But I believe the money is provided to the state on behalf of the nursing home. It is not realistic in my mind that there would ever be any excess funds from the administration of a state home to turn back into the general fund of the state. I certainly don't think states see this as a revenue source. We recognize that the per diem payments we do make constitute only a small portion, roughly a third of the total per diem cost. And that is exactly why we are trying to enhance our partnership with state home directors and state directors of veterans' affairs to look at collaborative ways we can improve the efficiency of the operation through sharing agreements such as provision of pharmaceutical services.

I also think there is another innovative model of care that the committee might want to look at. Albeit it is a substantially lower per diem payment, state domiciliary could be a source of care that would allow concurrent enrollment in VA outpatient care programs, which would allow veterans to receive outpatient care and pharmaceutical benefits concurrently with the domiciliary per diem payment. This is not permissible when a veteran is in the skilled state nursing facility. I think that venue of care could then be coupled with the care coordination technologies that we are currently using that I spoke of to monitor care in that location.

We have actually administered such a model at one state domiciliary in Florida and found it to be a very, very successful way to monitor patients in an even lower cost, less-skilled facility but still provide very high quality care and monitor medication complications.

Mr. SIMMONS. I would like that follow-up on the funding. I think other programs from time to time grants are made to states that they may have charged some sort of an administrative fee as the dollars move forward. So I would be interested to know how it works with VA.

Moving to a more general question, we have already said for the record that there has been 100 percent increase of the veteran population most in need of long-term care over the last few years. That is those veterans 85 and older. It is my understanding that the funding to deal with those veterans has only increased by about 11 percent. That figure may not be correct. And the total number of beds available in the VA itself have actually gone down. Now that may be explained by finding other venues. But with 100 percent increase in the population and looking to almost double that over the next 10 years, do you feel the dollars are increasing adequately to meet those costs?

Dr. ROSWELL. It is certainly something that is a very great concern of mine and it is a high priority within the Department. Let me point out though that age alone is not a determinant of institutional nursing home care. That is why we are working so diligently as we speak to develop this long-term care projection model that as yet has not been developed. But it is clear in the medical literature that as more and more Americans reach older age, the level of disabilities are not as great as what we anticipated based on earlier literature.

Said differently, veterans who are age 85 in fact in many cases, because they have been beneficiaries of better care, better management through their earlier years, may not have the level of disability that requires skilled nursing home care. And that has to be a factor in how we project long-term care needs. Clearly, budget, though, is a major driver and it is something that we will continue to follow very closely.

Mr. SIMMONS. Thank you. The gentleman from Maine, Mr. Michaud.

Mr. MICHAUD. Thank you, Mr. Chairman. It seems to me that Congress has expressed its will pretty clearly that Congress wants VA nursing home beds that were operating in 1998 to remain available for long-term care. The administration has asked us to consider counting state and community nursing home beds in addition to the workload in non-institutional settings in its calculation of maintenance of capacity and Congress has refused that.

Will the administration request this permission again? And what specific steps will you take as a VHA leader to ensure that VA restores its bed levels in the event Congress continues to refuse to allow states and contract beds, among other services, to be counted?

Dr. ROSWELL. Well, of course, I am not at liberty to speak about the President's 2005 budget request. We anticipate that, though, and would be happy to respond at the appropriate time.

With regard to our historical request, I feel very strongly that my role is to advocate for veterans. And veterans tell me time and again that they want to be cared for as close to their family members as possible. Veterans don't want care in an institutional setting if it can be avoided. We have listened to that. We have tried to respond to that. When institutional care is unavoidable, then veterans and their family members want it to be as close to their homes as possible. We have a finite number and will always have a finite number of VA staff nursing home locations.

By working with contract community providers and working with state homes where we have had a significant number of new locations over the past several years, we have actually created and enhanced the choices for veterans. And I believe that is a good thing. And I believe that combining the 1998 aggregated census between those three levels of CARES, and looking to make sure that we maintain at least that level of institutional care, allows us to offer veterans a greater choice in how and where they receive long-term care.

Mr. MICHAUD. It is clear that in some of the recommendations in National CARES draft plan could have implications on VA's requirement to maintain bed levels at the 1998 levels. What step will you take to ensure proposed closures do not further erode the long-term care bed availability in the VA setting?

Dr. ROSWELL. We have been adamant in the formulation of the individual VISN market plans, which were aggregated to form the National CARES plan, to preserve the current level of long-term care beds. There is no question in my mind that we will need additional long-term care beds. But CARES is about capital assets. It is not about long-term care.

And time and again experience has shown us that taking a 50 year old hospital and attempting to convert it to provide long-term care winds up costing a lot more than new construction, and the end result is a renovated 50 year old hospital that is still not properly designed to meet today's standards for long-term care.

So an over-arching principle in the formulation of the CARES plan is maintain our current long-term care bed capacity but recognize that if we have additional needs, we will meet those with new construction because it is less costly. It gives us greater flexibility. It is more timely. And it affords a higher quality of life for veterans who would receive institutional long-term care.

Mr. MICHAUD. You had mentioned in your earlier comments that you view your role as advocating for veterans. In that role, when you deal with the budget, have you adequately requested the appropriate funding level to take care of veterans? And, if so, has the administration granted your request that you have requested? And, if not, how much have they cut it by?

Dr. ROSWELL. I believe that the budget requested by the administration has been adequate to meet the——

Mr. MICHAUD. No, my question was in your request for funding, since you advocate for veterans, has your Department granted your request for the funding that you asked or did they cut it back? I am talking about your request.

Dr. ROSWELL. My personal request?

Mr. MICHAUD. Yes.

Dr. ROSWELL. Yes, I think it has been met. It is——

Mr. MICHAUD. So they granted everything you have asked for?

Dr. ROSWELL. We have had discussions about how best to formulate the budget but let me point out that Secretary Principi doesn't formulate the budget personally. He draws upon my counsel as he crafts that. And I think he has been very receptive to the input I provided on long-term care. He has become a true believer, I would say I am reluctant to speak for him—but I think he really has become a true believer in the benefits of non-institutional care. And we believe that the budget we have crafted for the Department will meet those needs.

Mr. MICHAUD. So I take by your jumping around a simple yes or no answer that they have not granted your full funding request that you have asked?

Dr. ROSWELL. If I had to say yes or no, I would say yes, they have granted it.

Mr. SIMMONS. The gentleman from Ohio, Mr. Ryan.

Mr. RYAN. Thank you very much. I apologize for not being here. It has been a busy day. Some of the discussions, as we were just talking about, had to do with your long-term care model. For those of us who are new to the committee, can you explain to us a little bit about other than nursing home beds, what is the process in determining what the needs are for this long-term care model?

Dr. ROSWELL. One of the biggest advances to our geriatrics program has been what we call the GEM Program. It is a gem. But it actually is Geriatrics Evaluation and Management that allows a full inter-disciplinary assessment. Let me ask Dr. Burris how that process works and how it determines a wide range of needs that can be met through our geriatric services.

Dr. BURRIS. Let me just clarify. Were you asking about how we structure the long-term care planning model or were you asking about how we refer individual patients to the level of care that they require?

Mr. RYAN. I would like to know how you gather the information, how you determine what your long-term needs are as with the nursing home beds.

Dr. BURRIS. The process is modeled after the utilization of nursing home care and other long-term care services (the home and community-based services) in the Medicare/Medicaid population adjusted for the characteristics of the veteran population.

And included in the long-term care planning model that is now under development, in addition to that basic data, there will be trending of the changes in disability among elderly people that Dr. Roswell referred to, that is that older people are less disabled now and the rate of disability has been declining at about 1 to 2 percent per year over the last decade.

So that will be taken into account. The marital status of the veteran will be taken into account, again trended over time because veterans who have a spouse are less likely to require institutional long-term care than those who are living alone in the community. We will also be looking at the gender differences. As women are composing a greater part of the veteran population, they have different utilization rates for long-term care services than male veterans do.

So all of those factors will be taken into consideration in the development of the long-term care planning model.

Mr. RYAN. When would we get this information? When is the time frame for us to have all this information?

Dr. ROSWELL. That model is still under development. We would anticipate that shortly after the CARES plan is communicated, we will then be able to focus on the specific aspects of that model and bring it to completion.

Mr. RYAN. When is that?

Dr. ROSWELL. We anticipate that the Secretary's recommendations on the CARES Commission Report would be available some time in mid-March.

Mr. RYAN. So we can expect this information in mid-March?

Dr. ROSWELL. No, that information would be coming after that time but certainly I would think no more than 30 to 60 days after that time, we should have pretty much the fundamentals in place of what that model will look like.

Mr. RYAN. Thank you very much.

Mr. SIMMONS. If there are no more questions for this panel, I want to thank Dr. Roswell for his testimony. And thank Dr. Burris for his testimony.

And now I would like to call the third panel. The third panel is composed of Ms. Jade Gong, who is principal of Health Strategy Associates, where she advises national associations and health care providers on the need for both institutional and community-based long-term care for seniors to include veterans at the state veterans homes. We also have Ms. Linda Sabo, who is executive director of the Alzheimer's Association of Western New York since 1998. And I understand that New York's VISN has an excellent program for

dealing with Alzheimer's patients. So I look forward to hearing about that. We also have Philip Jean. And I will ask my colleague, Mr. Michaud, if he would introduce Mr. Jean.

Mr. MICHAUD. Thank you, Mr. Chairman. It is with great pride that I have an opportunity to introduce Philip Jean. He is president of the National Association of State Veterans Homes. Mr. Jean was elected by the membership of the National Association of State Veterans Homes and will serve as the 2003 and 2004 president. Philip has dedicated himself to improving the quality of care available to Mainers. From 1995 to 1999, he worked for North Country Associates as an administrator of a number of health care service facilities throughout the State of Maine. Since 1999, Mr. Jean has been the administrator of Scarborough Maine Veterans Home. This is 150-bed facility, provides some of the best possible skilled long-term Alzheimer, respite, residential, and end of life care in Maine.

I would like to particularly note the work that Mr. Jean has done that led to the addition of a 30-bed dementia assisted living unit. It is my honor to introduce to the committee someone who is working so hard for the veterans and their families. I look forward to working with Phil to improve the level of care available to our veterans and look forward to hearing his testimony, along with the testimony of all of our witnesses here today.

Thank you, Mr. Chairman.

Mr. SIMMONS. I thank you. The witnesses were introduced beginning with Ms. Gong and then Ms. Sabo and then Mr. Jean. If you want to follow that sequence, that would be fine. As you know, we will take your written or prepared statement and insert it in the record and that might give you the opportunity to be a little more creative in your presentation and perhaps even to discuss some of the issues that have been raised already on the record. I leave that to your discretion. You may begin.

STATEMENTS OF JADE GONG, MEMBER, VA GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE, HEALTH STRATEGY ASSOCIATES; LINDA SABO, EXECUTIVE DIRECTOR, ALZHEIMER'S ASSOCIATION, WESTERN NEW YORK CHAPTER; AND PHILIP JEAN, PRESIDENT, NATIONAL ASSOCIATION OF STATE VETERANS HOMES, MAINE VETERANS HOME

STATEMENT OF JADE GONG

Ms. GONG. First, I would like to thank the committee for its role in amending the Service Contract Act as part of the Veterans Health Care Capital Asset and Business Improvement Act of 2003. Prior to the passage of this law, I represented many long-term care providers and the Service Contract Act was often mentioned as a burden, creating an unwillingness to contract with the VA. Under this new law, providers that serve veterans can now enter into agreements with the VA and they are no longer subject to these detailed reporting requirements.

I would like to note that I did serve on the Federal Advisory Panel on Long-Term Care, the report which was mentioned many times today, as well as on the Geriatrics and Gerontology Advisory

Committee and on the Assisted Living Selection Committee for the pilot that was authorized in the Millennium bill.

I would say that a very important recommendation of our committee was to see that the VA indeed shift to actually providing these home and community-based services when they are appropriate. And we set as a target in our report that the VA essentially double its spending. We talked a lot about people and visits and episodes, all very confusing. Let's get down to the money that is spent. And we set a simplistic target that the VA double its spending in light of everything else that is going on on home and community-based options. And, as I looked at the last GAO report, as I looked at other GAO reports, recognizing also that, and comparing to state Medicaid programs, I found that the VA did not actually meet that target in terms of doubling their spending on non-institutional care despite the development of new programs.

Just to make a broad comparison to Medicaid programs, as was mentioned earlier today, no, they are not entirely comparable, but I would say that over the past decade Medicaid programs have focused on waiver programs. These combine a variety of services into particular programs to try to meet the needs of individual who are specifically eligible for the nursing facility level of care, as well as other kinds of programs. State Medicaid programs have shifted considerable dollars into non-institutional programs by comparison.

I also want to mention, again in the private sector, that assisted living, I am sure you have all heard, has grown tremendously. There are lots of discussions about its regulation and its quality, but I would say that in my opinion that it offers a very important level of care that is much closer to the community, that is home-like. Many, many private residents, as well as I think VA residents, would want to have their care in something that is closer to an assisted living facility. I believe for the most part now most veterans do not receive that level of care, assisted living care.

With all of that context, I have four suggestions or recommendations that I at least want to put on the table for discussion. The first is a little radical. It concerns the 1998 base year, around 13,000 to 14,000 days for VA-provided nursing home care. I don't know the details about the total level of spending associated with this number of days. But I do believe that buying VA into institutional care as opposed to non-institutional care, and I would like to see the VA have more flexibility to look at the individual and to spend that money for an eligible person with a package of services that that individual would need, be it institutional, the VA's own stay home contract or a combination of home care services.

So I would actually advocate for removing that number on VA's own provided nursing home care and look to a broader indicator, yet to be defined, about VA long-term care spending, whether or not it is quality services and holding the VA itself and the individual VISNs accountable for an appropriate level of long-term care spending in their population.

Secondly, as I mentioned, I did serve on the selection committee—no, the second recommendation I have is with regard to PACE, Programs of All-Inclusive Care for the Elderly. These are programs that operate all around the country now, serving Medicare and Medicaid beneficiaries. The VA through its pilot has set

up three of these programs in Columbia, South Carolina; Denver, Colorado; and Dayton, Ohio. It has been my understanding that the evaluation is not done yet and those programs would possibly terminate before the findings of those studies could possibly be applied across the country in the VISNs.

I would urge, I don't know if the VA can do it or if Congress would have to direct that, that those pilots be continued. They are excellent programs. They have been evaluated and studied for over 25 years in the Medicare/Medicaid programs. I would like to see those programs have a place somewhere within the VA but certainly that those programs be able to continue until the evaluations are complete and that could be looked at.

With regard to assisted living, I make the same recommendation with continuing that pilot.

And then finally, with regard to the state home construction and per diem program, we have talked about that a lot, I would like to see if some of that funding could be applied to assisted living rather than merely nursing home care and that a higher priority be given to that.

Thank you very much.

[The prepared statement of Ms. Gong appears on p. 150.]

Mr. SIMMONS. Thank you very much. Before we do questions, let's hear from Ms. Sabo.

STATEMENT OF LINDA SABO

Ms. SABO. Mr. Chairman and members of the committee, thank you for this opportunity. In light of some of the comments that have come up and some of the questions about CARE and resources and some very interesting propositions there, I am happy to tell you that I am here to talk a little bit about our experience with the Partners in Dementia Care Initiative.

Since 1997, my chapter—we serve Western New York, that is, the Buffalo Niagara region—and three other Alzheimer Association chapters in upstate New York have been working with the Veterans Integrated Services Network, you know that as VISN–2, to create a coordinated system of care for veterans with Alzheimer's disease.

The initiative is important for two reasons. First, the large number of veterans suffering from Alzheimer's disease and other dementia, and from here on when I say "Alzheimer," I mean people with Alzheimer and/or other dementia.

A new study using VA data found that more than 7 percent of veterans over 65 who received VA services between 1997 and 2001 had a documented diagnosis of dementia. In 2000, 13 percent of people 65 and over and 42 percent of those 85 and older had Alzheimer's disease. That is Alzheimer's alone for the latter, not all dementias. As we have already said many times here, we expect a huge increase in the number of veterans aged 85 and over. Therefore, we know that the numbers of those with dementia is going to be huge. We have to be prepared to meet the needs of those veterans.

A second reason the Partners in Dementia Care Initiative is important is that the VA must find innovative ways to ensure appropriate services and support are provided to veterans. This initiative

provides a best practice model for ensuring that. The Partners in Dementia Care Initiative is groundbreaking because of the extent of ongoing cooperation between the VA and the Alzheimer's Association chapters. VA physicians, nurses, and other VISN–2 staff worked with our chapters to identify the health care, long-term care and supportive services that each of our organizations can provide to veterans, particularly those with Alzheimer's Disease.

Coordination of care has been a problem, both within the VA and between VA and community agencies. Even if needed services are available, including the important, non-institutional services mandated by the Millennium Act, veterans with Alzheimer's Disease may not know about or receive those services. The Partners in Dementia Care Initiative is intended to ensure that these veterans and their families are connected to VA and non-VA services that will help.

Previous experience indicates that families who are referred to Alzheimer's Association from VA or other providers wait an average of 2 years before contacting us. We know from chapter experience that by that then, they frequently call because they are in a meltdown and are in trouble. In Partners in Dementia Care we developed a very effective manner for getting those families through outreach and direct contact to reach us much before those crises occurred.

Collaborating on the Partners in Dementia Care Project is important to the Alzheimer's Association because it helps us ensure veterans who are eligible for health care and long-term care services through the VA are quickly connected there. For the VA, the initiative creates a way to improve the care available by reaching our non-VA community services. Evaluation of Partners in Dementia Care Initiative indicates that this best practice model of care can increase early identification and diagnosis of Alzheimer's Disease and other dementia, improve quality of care, expand access to needed information and services, and increase satisfaction for veterans with dementia and their families.

For example, more than 500 veterans with Alzheimer's Disease were enrolled in Partners in Dementia Care. Most of these veterans had not been previously diagnosed. VA and Alzheimer's Association staff who were interviewed about the initiative had strongly positive attitudes about its impact on quality of care and outcomes for veterans. More than 80 percent of these care providers said the initiative had improved their own ability to care for persons with dementia.

A recent GAO study of Millennium Act services provided for veterans in all VISNs in 2001 found that VISN–2 provided non-institutional Alzheimer care for three times more veterans than the average for all the other VISNs. VISN–2 also provided non-institutional day services for nearly three times more veterans than the average for all the other VISNs.

The Alzheimer's Association and VA staff from VISN–2 and headquarters and some other researchers are currently working together on proposals to implement and evaluate this best practice model in other VISNs. We are aware that all of the non-institutional services mandated by the Millennium Act are not uniformly

available to all veterans and encourage the VA to increase that availability.

And, finally, while I have talked extensively about non-institutional services, I also want to stress the importance of having adequate nursing home beds for veterans with Alzheimer who need that level of care and don't have families to care for them.

Thank you.

[The prepared statement of Ms. Sabo appears on p. 157.]

Mr. SIMMONS. Thank you for that testimony.

And now Mr. Jean, from the great state of Maine.

STATEMENT OF PHILIP JEAN

Mr. JEAN. You can say Mr. Jean or Mr. Jean, either way.

Mr. SIMMONS. There you go. It is always confusing.

Mr. JEAN. Good afternoon, Mr. Chairman and members of the committee, and thank you for the opportunity to testify today on behalf of the National Association of State Veterans Homes on the issue of long-term care for veterans. I am pleased to serve as the 2003/2004 president of NASVH. I am joined today at this hearing by two of my colleagues. Bob Shaw is the administrator of the Colorado State Veterans Nursing Home and the legislative officer for NASVH. John King is the director of the Washington State Department of Veterans' Affairs and vice president of the National Association of State Directors of Veterans' Affairs.

Mr. SIMMONS. If they are here, could they stand so we could recognize them? Thank you for coming. Appreciate it. (Applause.)

Mr. JEAN. State veterans homes are the largest deliverers of long-term care to our nation's veterans. We operate under a program administered by the Federal Department of Veterans Affairs, which offers construction grants and per diem payments to support state veterans homes. Each state veterans home meets stringent VA-prescribed standards of care, which exceeds standards of care prescribed for other long-term care facilities.

With regard to the State Veterans Home Construction Program, six states have been identified by the VA as having either a great or significant need to build new state veterans homes immediately. These six states are Florida, Texas, California, Pennsylvania, Ohio, and New York. Under priorities set by the VA, 37 construction projects in 20 states will add needed new beds to the system. In addition, numerous other renovation projects within the system are either underway or planned in several other states. Most importantly, the state veterans home system can construct and operate these long-term care facilities at far less cost to taxpayers than can the Federal Government. This prompted the VA Office of Inspector General to conclude in a 1999 report that the State Veterans Home Program provides an economical alternative to contract nursing home placements and VA medical center nursing home care.

Unfortunately, there now exists an immediate threat to the state veterans home program that we hope the members of this committee will consider and address this year. The use of VA per diem payments by many states is threatened by interpretations of Medicaid rules by the Centers for Medicare and Medicaid Services. This threat applies to the growing number of states that have elected to fund their state veterans homes in part through Medicaid. There

are approximately 20 states where the state veterans homes are Medicaid certified. For those states, there is some ambiguity regarding the treatment of the VA per diem.

Under the interpretation of the Medicaid rules being advanced by CMS, VA per diem payments would be considered a third party payment in the Medicaid-certified states. This would require that the entire amount of the VA per diem be offset against Medicaid payments, thereby denying veterans who receive Medicaid in these states any benefit whatsoever of the VA per diem payments. This result obviously frustrates the intent of Congress in establishing the per diem payments in the first place. The CMS interpretation would treat veterans no differently than non-veterans. In my own state of Maine, this interpretation is also contrary to state law, which requires that the Maine Veterans' Homes retain any per diem funds they receive from the Federal VA.

The result of the CMS interpretation would be to force the state veterans homes that do not currently offset the VA per diem payment to look for alternative funding sources, reduce their standard of care, and possibly to close some state veterans homes. At the Maine Veterans' Homes, the VA per diem payments are the difference between our veterans home system operating in the black or operating in the red. We simply could not provide our current level of service if Medicaid funding were offset against the VA per diem amount. Our fear is that an insistence by CMS on their interpretation would jeopardize the funding balance for many Medicaid-certified state veterans homes across the country, particularly during a period when states face severe financial crises.

A clarification to the law to solve this problem would make clear that VA per diem payments would not be required to be treated as a third party payment under Medicaid. Federal law already includes exceptions for the similar payments, including those made under the Indian Health, Community Health, and Migrant Health programs. Clarifying that the VA per diem should similarly not be treated automatically as a third party payment would eliminate the threat to states that are Medicaid-certified. For the majority of states, which are not Medicaid-certified, there would be no effect. And because the proposed legislation would clarify the law as it is currently being implemented and applied, there would be no new cost to the Federal Government.

It is essential that Congress clarify the matter now and ensure that the long-term care promises we have made to our veterans are kept.

Mr. Chairman, we look forward to working with you and members of the committee on this important matter. And I thank you for the opportunity to testify.

[The prepared statement and supplement to testimony of Mr. Jean appear on pp. 161 and 172.]

Mr. SIMMONS. Thank you for that testimony. I have a couple of questions. The first question I have for Ms. Gong. Earlier today there was a brief discussion of what I guess we call tele-medicine. And a while ago I asked my local VA if they were doing anything in that regard and I was given a short briefing involving a very large piece of equipment that actually kind of looked like a battery

charger, as I recall it, big and heavy and wires in and out of it. And I wasn't terribly impressed.

Since that time, I have talked to some private providers who are either piloting in the private sector or developing tele-medicine systems that are quite sophisticated. And, as you probably know, Members of Congress run around with these little Blackberries, communicating with the world right off our belt.

So it seems to me that small and sophisticated systems might be available to our veterans, especially those who are receiving home health care. What is your experience with tele-medicine? Do you have any comments on that subject?

Ms. GONG. I don't know a lot about the details of the various technologies that are available. I do know that in rural areas and with rural long-term care we are trying to apply a similar strategy that Dr. Roswell mentioned, to use tele-medicine so that we can efficiently link with providers in urban centers to save on travel costs. We are thinking about that. There is a strategy for the Pace Program that I mentioned where we take very sick individuals and try to keep them at home. This is a new concept, a pretty new concept I think even outside of the VA. If that box is as big and bulky as you described, I think there are some sophisticated technologies that are out there that they could possibly explore.

Mr. SIMMONS. And are there certain patients, and maybe Ms. Sabo wants to come in on this, especially with regard to dementia, are there certain patients for whom this works well and others it doesn't. For example, dementia patients being cared for at home, does tele-medicine help, hurt, is it not applicable, is this a system that works better with other kinds of long-term care patients?

Ms. SABO. What I can tell you about persons with dementia is that a system like that might very well help their care givers, particularly if they live in rural areas. Upstate New York has a fairly large population of people we serve in rural areas. It does not help a person living alone with dementia because they are not going to remember what the box is for or understand how to use it.

So we find that many, many of our people who are cared for by families need those supports. It really depends on what other resources are available to the family.

Mr. SIMMONS. Thank you. Mr. Jean, I was intrigued by your experiences at the Maine state home and the threat you see presented by CMS or CMMS, however they want to call themselves, through Medicaid reimbursements. That is a very intriguing subject to me because Medicaid is essentially run through the state so if the state is offsetting their Medicaid payment, either with a per diem payment from the VA or in some cases garnishing retirement payments from the Veterans itself, how do we make sure that the veteran is getting maximum use of these dollars and that in fact the veterans program through the veterans home is not perhaps subsidizing some other health program within the particular state?

Mr. JEAN. Interestingly, one of the intriguing parts of the state veterans homes program is that the VA has prescribed standards that are more significant than those prescribed by CMS. The standards of care that are required by the VA certainly cost more. And the monies that we use in addition to the Medicaid reimbursement go to paying for round the clock nursing care and other things that

are not required and prescribed by CMS. It is just an example of things that we need to provide to ensure the quality of care, and it is certainly one of the things that makes the state veterans homes very unique as far as a long-term care provider for veterans.

Mr. SIMMONS. And you made mention of legislation that might address this issue. Are you familiar with the disposition of that legislation? That should be my question to answer but I was just curious since you raised it?

Mr. JEAN. Yes, very briefly, one thing I should also mention is back in 1986 there was legislation that was proposed at that time which was cosponsored by Mr. Evans on your committee. We are in the very early stages of working on that legislation but it is certainly something that is being worked on currently.

Mr. SIMMONS. I thank you for those comments. We are joined by Mr. Evans, the distinguished ranking member of the full committee and I would ask if he has any questions for the witnesses?

Mr. EVANS. I appreciate this compliment but I don't have anything at this time. So back to you.

Mr. SIMMONS. I thank the gentleman. And, Mr. Michaud, from Maine.

Mr. MICHAUD. Thank you, Mr. Chairman. I have a few questions for Mr. Jean. If the funding provided by the VA is considered a liability for the VA, what would the practical implication be for homes in the State of Maine and all across the country. And the second question is how would congressional clarification of the treatment of VA state home funding help state homes and why is it a timely issue now?

Mr. JEAN. In answer to your first question, the per diem that some states do use and have available to them—should that not be available to those state veterans homes in particular, the very simple answer and the effect of that would be that the facilities would have to close their doors. And there are many other states that are in the same position. The per diem basically is the difference, as I said in the testimony, between the state operating in the red and operating in the black. And so the per diem is certainly a very valuable source that we do have to ensure the care for the veterans.

In answer to your second question, if I understood it correctly, currently there is a threat, CMS is auditing different states and based on their interpretation, there may be threats to states that currently do not offset. They may need to either repay past payments that were not offset or begin offsetting immediately for Medicaid.

Mr. MICHAUD. A couple of follow-up questions. How does the cost of long-term care in state veterans homes compare to the same care in a VA facility? And the second question, in your experience, what are the benefits to the veteran patient and his or her family of receiving long-term care in the state veterans home?

Mr. JEAN. With regard to the state veterans homes, in terms of the cost of care, it is basically about half or less. The VA share for state veterans homes is just the per diem amount, so the cost is much, much less in the state veterans home program.

With regard to benefits for veterans in state veterans homes, there are certainly many, a few of which I mentioned a while back. One example is the differences in terms of VA-prescribed stand-

ards, higher standards of care that we provide to veterans in terms of round-the-clock nursing care. Many of the state veterans homes are considered teaching facilities for medical schools. They are all built to very stringent federal requirements, are very modern, and very clean. The standard of care and the quality of care is typically superb. And one of the other major benefits, especially in some states, is that the state veterans homes are spread throughout the state. They provide easier access to care.

Mr. MICHAUD. Thank you.

Mr. SIMMONS. I have a question for Mr. Jean. And, again, you have heard my remarks earlier about my enthusiasm for state veterans homes and how they complement the work of the VA, at least in my state, the VA hospitals in the CBOC system.

One of the issues that I have encountered in dealing with the senior population is the value of adult daycare where a veteran living at home has the opportunity to come into the veterans home for a portion of the day, which takes some of the burden off of the care provider, keeps that veteran active mentally, which I think is very important in dealing with issues like dementia, and contributes to their quality of life. A couple of years ago, this committee authorized adult daycare.

Have any of the three of you encountered the establishment of those programs in your area, and what is your assessment?

Mr. JEAN. I guess my initial answer would be in terms of the growth of the adult daycare program, certainly Dr. Burris from VA Geriatrics and Extended Care could probably speak much better to that than I could or Dr. Roswell as well. But the adult daycare program is a program that is part of the VA Geriatrics and Extended Care program and it is certainly one that I believe is available in some states.

Mr. SIMMONS. Do you have it in Maine?

Mr. JEAN. We do not.

Mr. SIMMONS. Is there any particular reason for that?

Mr. JEAN. The adult daycare program is one in which there has been very slow growth for a variety of reasons. And so within Maine particularly, there has been a focus on expanding upon the facilities in the last few years. Actually, four of the five homes have just added brand new domiciliary wings. So there has been growth in other ways, certainly among those programs which have been a priority in our areas.

Mr. SIMMONS. Thank you. Either of the other witnesses encounter these programs?

Ms. GONG. I believe in the work that I have done with state homes in doing some of the projections of need, I always recommend adult daycare. And I think there are several homes, I think three, I believe, that are in the process of becoming a reality, and hopefully, a few more. I think there are other kinds of programs the VA could implement that also uses that adult daycare model that benefit the veterans and their families in the way that you describe.

Ms. SABO. VISN–2 had provided day program services to three times as many persons as the other VISNs average. And I will say I know that program personally. It is a wonderful program and that is very well used, to the extent that there is quite a long wait-

ing list. Within the last year or so some funds were made available through the VA for people to benefit from adult day in community programs, for which they were reimbursed. That has been a heavily used program. And possibly through our Alzheimer Association chapter and possibly the other chapters in the state, (I can speak only to our chapter having direct experience,) that a very large number of veterans who have approached the chapter looking for services have been referred out for day programs and were able to reach their goal either through the program at the VA or through the funded programs. It has been a terrific resource.

Mr. SIMMONS. Thank you very much for that.

Mr. Evans? Mr. Michaud?

Hearing no more questions, I want to thank our panel for coming here today. I want to thank those in attendance for their attendance and patience. And wish you all the best.

This hearing is now adjourned.

[Whereupon, at 2:30 p.m., the committee was adjourned.]

APPENDIX

Statement of Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans Affairs
Hearing on Long-Term Care Policies of the
Department of Veterans Affairs
January 28, 2004

When President Clinton signed the Veterans Millennium Health Care and Benefits Act into law on November 30, 1999, some in Congress and in the Administration praised it as the most significant legislation to be enacted during that Congress. Looking back, it is a monumental bill. It guaranteed nursing home and non-institutional long-term care as part of a basic benefit package available to all veterans. It required the Department of Veterans Affairs (VA), at a minimum to offer life-time VA long-term care to those who had service-connected disabilities rated more than 70% or who required that care for those conditions. In fact, we just re-authorized these programs through P.L. 108-170.

In addition, we required VA to maintain the capacity of its "in-house" long-term care programs. We also asked VA to complete pilots to help Congress assess the benefit of adding different kinds of continuums of long-term care and assisted living to the services it provides for veterans.

So what changes have we seen in VA's programming since this monumental veterans' legislation was enacted? According to a report VA sent to the Committee just a couple of weeks ago, very few.

VA's report, also required by the Millennium Bill says, for the second year in a row, "To date, there is evidence of, at most, only small changes in VA long-term care services occurring immediately after enactment of Public Law 106-117 compared to what would have been expected in the absence of the law." In addition, both Chairman Smith and I have questioned VA's compliance with the law's clear intent of maintaining the capacity of its long-term care programs. For many of us, among the most unpleasant of the surprises in the Administration's budget request for fiscal year 2004 was the VA's proposal to close another 5000 VA nursing beds and by limiting care to only those veterans it is required to treat. Congress had intended this requirement as a floor, certainly not a ceiling!

It seems clear that, regardless of the Millennium Bill, VA is changing the mission of its long-term care programs. In 1998, the Average Daily Census in VA

Nursing Homes was 13,391, while at the end of FY 2003, it was 12,339 (a deficit in the census of 1,052). In addition, VA non-institutional long-term care census is well below 1998 levels. Domiciliary follow-up and outreach care has decreased dramatically. Census in Alzheimer's/Dementia outpatient programs has decreased by 39%. Even Adult Day Health Care—widely touted as a cost-effective alternative to long-term care has been reduced by almost 20%. VA attributes this to shorter stays, but can the Administration really expect us to believe that the need for more care isn't there given the significant aged population—close to 800,000 veterans now and which is projected to grow to 1.3 million veterans in 2010—it must support? VA will also say that its growth has come outside of its own programs, but I resolutely maintain that it was not Congress's intent to "substitute" contracted programs for its own long-term care programs.

We'll hear from the General Accounting Office that VA is now offering a benefit that is largely akin to that which is available through Medicare. My office regularly deals with individuals who want to use long-term care at VA, only to hear that they generally cannot be admitted for longer than 90 days and must be discharged after they have reached their maximal rehabilitation potential. So, for the majority of veterans using VA for long-term care services who have Medicare, VA long-term care no longer fills a hole in their health care coverage. Rather it now serves as an interim stop on a veteran's ultimate journey to welfare. Medicaid, not the VA, has become the veteran's long-term care financier in his or her final years. Is this what our veterans should expect of VA? How about the States? How are they faring since this significant, but covert shift in VA policy?

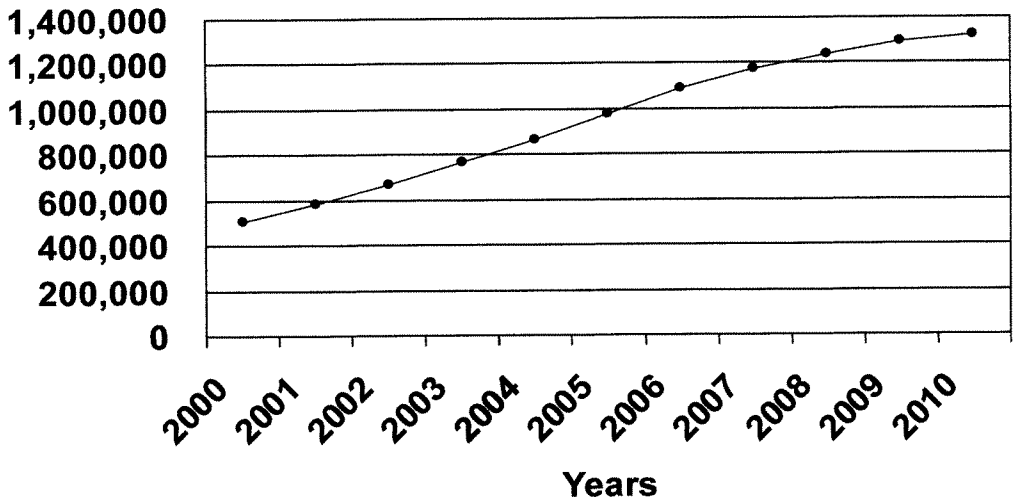
One of VA's long-term care successes in recent years has been the growth in the State Home nursing homes. This mutually beneficial agreement entails VA financing about 60% of state homes' construction costs and supporting, through an annually adjusted per diem, about a third of operating costs for each veteran using State Homes. Unfortunately, because of the severe shortfalls in many State budgets, states seeking to increase their revenues are treating or attempting to treat VA's per diem payments as a "third party liability" attributable to individual veterans rather than as a subsidy to assist State Homes in their operations. By treating the payments as third party liabilities, the states increase their revenues and the State Homes get no additional dollars to provide care to the veterans they are serving. This practice may jeopardize the continued existence of the State Home programs, forcing them into bankruptcy and veterans into private nursing homes paid by Medicaid. Mr. Chairman, I hope that you will work with me to address this problem.

What about the impact of the Capital Asset Realignment for Enhanced Services (CARES) process? Despite describing major changes for some VA facilities—many of which are long-term care facilities—VA has repeated its premise that CARES will not affect the provision of long-term care services. However, after the networks had submitted their plans, VA asked them to add 20 new facilities to be reconsidered for significant mission changes to its lists. Almost every one of these facilities primarily offers long-term and mental health care services.

It would be easy to blame this problem on money, save for the fact that VA left $270 million on the table last year—funds that surely could have been used to prop up the VA's ailing long-term care program. It is my view that VA is more likely looking to relieve its medical facilities of this costly chronic workload. Unfortunately, many of these veterans may have nowhere else to go. Out of necessity, VA has often become expert in managing the patients who are the hardest to treat—patients with wandering disorders, severe dementia, paralysis or those who are ventilator dependent. Private-sector providers and, oftentimes, state homes are loath to admit these high-need patients. This is why I have fought to maintain in-house capacity of VA's nursing home programs.

Mr. Chairman, this is one of those hearings which is likely to raise as many questions as it answers. It is clear that there are some significant policy issues for Congress to consider. In the final analysis, I do not believe that the policy VA is now carrying out is consistent with Congress's intent in passing the Millennium Act and other bills that have since passed extending its authorities. I hope to continue to work with you to consider steps for better matching VA's program with Congress's goals for veterans seeking long-term care.

Population of Veterans Age 85 and Older



Compiled by the Democratic Staff of the House Committee on Veterans' Affairs 1/28/2004

**Based on VetPop2001 Adj. Office of the Actuary, VA, December 2002*

OPENING STATEMENT OF
LUIS V. GUTIERREZ
Full Committee on Veterans' Affairs
"Hearing on Department of Veterans Affairs Long-term Care Policies"
January 28, 2004

Thank you, Mr. Chairman, for holding this very important hearing on the Department of Veterans Affairs long-term care policies. I would also like to extend my gratitude to the witnesses testifying before us today.

Our nation's veterans most in need of long-term care, specifically nursing homecare, are quickly growing in number. The number of veterans 85 years and older grew from 387,000 in 1998 to about 640,000 in 2002. This year, that number has climbed to 870,000, which represents an increase of more than 100% over the past seven years.

This committee foresaw the growth of this population and made long-term care a priority during the 106th Congress, when we passed the Millennium Health Care and Benefits Act, a bill I co-sponsored. Unfortunately, the VA has not fully realized the objectives we set forth in the Millennium Act. This became apparent in May of last year, when the Health Subcommittee received testimony from the GAO that reported serious shortcomings in providing long-term care.

I am pleased that we are making this issue the focus of our first full committee hearing this session of Congress, so that we can act quickly to correct the problems presented to us today. We must strive to ensure that those who have served our nation by putting themselves first are not forced to the back of the line when their needs are the greatest.

I again extend my thanks to the panelists for appearing before us today, and I look forward to hearing your recommendations so that we can better serve the needs of veterans who have defended our nation, at great personal sacrifice and often at the expense of their own well-being. Thank you.

Statement of Congressman Tom Udall (NM-3rd)
House Veterans' Affairs Committee
Hearing on Long-Term Care
1-28-04

Mr. Chairman,

Thank you for holding this hearing on a very important issue that seems only to be getting more dire as time goes by.

Long-term care is one of the basic promises we give those who serve our country. Judging by findings explained by the GAO, long-term care may not be reaching those who need it most. What is particularly disturbing to me is the lack of knowledge of how many veterans who need long-term care are actually being served by the VA, and I hope that will come to light today.

This issue is of great concern to many of the veterans who live in my district in New Mexico, and with an aging population, it is only becoming more important that we ensure that our veterans' needs are being met. In this hearing we are talking about the most vulnerable of our veterans. It is my hope that after hearing the testimony of those speaking today and having our many questions answered, we may have a clearer picture of what can be done in the Congress to better serve those who have so bravely served our country.

Thank you, Mr. Chairman.

United States General Accounting Office

GAO

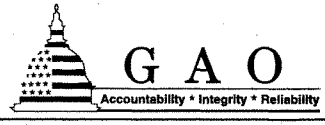
Testimony
Before the Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 12:00 noon EST
Wednesday, January 28, 2004

VA LONG-TERM CARE

Changes In Service Delivery Raise Important Questions

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



GAO-04-425T

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Highlights

Highlights of GAO-04-425T, a testimony before the Committee on Veterans' Affairs, House of Representatives

January 28, 2004

VA LONG-TERM CARE

Changes In Service Delivery Raise Important Questions

Why GAO Did This Study

The Department of Veterans Affairs (VA) is likely to see a significant increase in long-term care need over the next decade. The number of veterans most in need of long-term care services—those 85 years old and older—is expected to increase from about 870,000 to 1.3 million over this period. Many of these veterans will rely on VA to provide or pay for nursing home care or noninstitutional services that may help them remain at home and, for some, delay or prevent the need for nursing home care. VA operates its own nursing home care units in 132 locations. VA also pays for nursing home care under contract in non-VA nursing homes—referred to as community nursing homes. In addition, VA pays part of the cost of care for veterans at state veterans' nursing homes and also pays a portion of the construction costs for some state veterans' nursing homes.

This Committee has expressed concerns about recent trends in VA long-term care service delivery and how VA plans to meet the nursing home care needs and related long-term care needs of veterans as the elderly population most in need of long-term care increases. GAO was asked to determine for fiscal years 1998 through 2003 (1) how VA nursing home workload has changed and (2) how VA noninstitutional long-term care workload has changed.

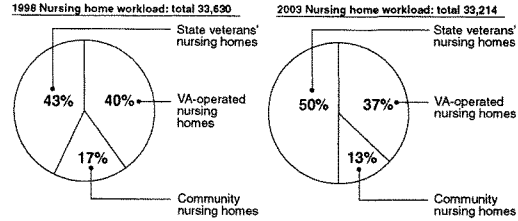
www.gao.gov/cgi-bin/getrpt?GAO-04-425T.

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

Recent trends in VA nursing home care and noninstitutional service delivery raise important questions, particularly whether access to services is sufficient to meet the needs of a rapidly growing elderly veteran population. VA's overall nursing home workload—average daily census—was 33,214 in fiscal year 2003, 1 percent below its fiscal year 1998 workload. The workload was below the fiscal year 1998 level each year, decreasing by as much as 8 percent below the fiscal year 1998 level in fiscal year 2000. VA's use of nursing home care by setting also changed over the 6-year period. First, the percentage of workload in state veterans' nursing homes increased as the number of state veterans' nursing homes receiving VA payments increased. Second, the percentage of workload in VA's own nursing homes declined, in part, because VA decreased the number of long-stay patients and increased the number of short-stay patients it treats in the nursing homes it operates. This is consistent with VA's increased emphasis on post-acute care. Third, the percentage of workload in community nursing homes declined from 17 to 13 percent. VA officials told us that now shorter-term contracts are often used to transition veterans to nursing home care, which is paid for by other payers such as Medicaid.

Percentage of Nursing Home Workload By Setting, Fiscal Years 1998 and 2003



Source: GAO analysis of VA data.

Note: The workload measure is average daily census, which represents the total number of days of nursing home care provided in a year divided by the number of days in the year.

VA's noninstitutional long-term care workload—average daily census—increased by approximately 75 percent from fiscal years 1998 through 2003. Workload increased by 4,655 during this period to 10,892, reflecting a change in VA's approach to care which includes meeting more long-term care need through noninstitutional services. Most of the growth in noninstitutional workload came from VA's greater use of contract skilled home health care, which includes medical services provided to veterans at home, and homemaker/home health aide such as grooming and meal preparation.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss veterans' use of long-term care services, which include nursing home care and noninstitutional services provided or paid for by the Department of Veterans Affairs (VA). Concern with meeting veterans' long-term care needs is increasing as the number of veterans most in need of these services—those 85 years old and older—is expected to increase from about 870,000 this year to 1.3 million over the next decade. Many of these veterans will seek assistance from VA to provide or pay for nursing home care or a range of noninstitutional services that may help them remain at home and, for some, delay or prevent the need for nursing home care.

To provide assistance to veterans with chronic illness or physical or mental disability, VA provides a continuum of institutional and noninstitutional long-term care services. VA provides care that its own employees deliver and contracts with other health care providers to deliver care. VA operates its own nursing home care units in 132 locations and also pays for nursing home care under contract in non-VA nursing homes—referred to as community nursing homes. In addition, VA pays part of the cost of care for veterans at state veterans' nursing homes and also pays a portion of the construction costs for some state veterans' nursing homes. VA also provides noninstitutional services to veterans in their own homes or in community settings using both its own employees and through contracts with other providers.

This Committee has expressed concerns about recent trends in VA long-term care service delivery and how VA plans to meet the nursing home care needs and related long-term care needs of veterans as the elderly population most in need of long-term care increases. To assist the Committee in its oversight responsibilities in this area, you asked us to determine for fiscal years 1998 through 2003 (1) how VA nursing home workload has changed and (2) how VA noninstitutional long-term care workload has changed.

My testimony today is based on our ongoing review of long-term care workload for this Committee.[1] For this review, we measured nursing home

[1]We reported preliminary findings on nursing home workload in a testimony to this Committee on May 8, 2003. U.S. General Accounting Office, *Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs* GAO-03-756T (Washington, D.C.: May 8, 2003).

workload as defined by average daily census, which reflects the average number of veterans receiving nursing home care on any given day during the course of the year. We also measured noninstitutional workload using average daily census; however, the number of veterans receiving these services may be less than workload because a veteran may receive more than one service in a day. We analyzed data on nursing home workload that VA provided to determine how workload had changed from fiscal years 1998 through 2003. We also verified VA's nursing home workload numbers based on contacts with officials from VA's 21 health care networks and VA headquarters. To determine how noninstitutional long-term care workload has changed during this period, we analyzed data on visits for six noninstitutional services which VA either provides directly or pays for others to provide: home-based primary care, adult day health care, homemaker/home health aide, skilled home health care, home respite care, and home hospice care. We also interviewed VA officials at headquarters and obtained information from the networks to better understand the reasons for changes in nursing home workload during this period. In doing our work, we tested the reliability of the data and determined they were adequate for our purposes. We did our work in accordance with generally accepted government auditing standards from January 2003 through January 2004.

In summary, recent trends in VA nursing home and noninstitutional service delivery raise important questions, particularly whether access to services is sufficient to meet the needs of a rapidly growing elderly veteran population. VA's overall nursing home workload—average daily census—was 33,214 in fiscal year 2003, 1 percent below its fiscal year 1998 workload. The workload was below the fiscal year 1998 level each year, decreasing by as much as 8 percent below the fiscal year 1998 level in fiscal year 2000. Fourteen of 21 networks experienced declines in nursing home workload during this period. Moreover, VA's use of the three nursing home settings changed over this 6-year period. First, the percentage of workload met in state veterans' nursing homes increased from 43 to 50 percent as the number of state veterans' nursing homes receiving VA payment increased. The percentage of workload met in state veterans' nursing homes increased in 19 of VA's 21 health care networks. Second, the percentage of workload in VA's own nursing homes declined from 40 to 37 percent. Thirteen networks provided a smaller percentage of workload in VA-operated homes during this period. The percentage of workload provided in VA-operated homes declined, in part, because VA decreased the number of long-stay patients and increased the number of short-stay patients it treats in its own nursing homes. This is consistent with VA's policy to give priority to post-acute patients and certain other

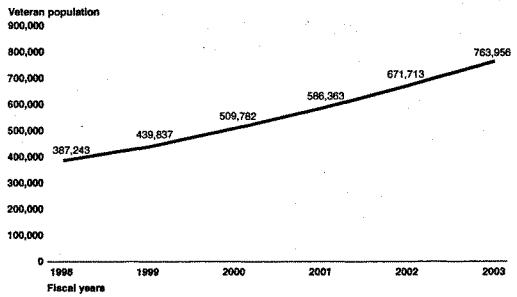
nursing home patients. VA generally provides long-term nursing home care as resources permit. Third, the percentage of workload in community nursing homes declined from 17 to 13 percent. Seventeen networks reduced the percentage of their nursing home workload provided in community nursing homes during this period.

VA's noninstitutional long-term care workload—average daily census—increased by approximately 75 percent from fiscal years 1998 through 2003. Workload increased by 4,655 during this period to 10,892, reflecting a change in VA's approach to care which includes meeting more long-term care need through noninstitutional services. Most of the growth in noninstitutional workload came from VA's greater use of contract skilled home health care, which includes medical services provided to veterans at home, and homemaker/home health aide services such as grooming and meal preparation. These services are most likely to help veterans prevent or delay the need for nursing home care.

Background

Meeting veterans' long-term care needs has become a more pressing issue as the veteran population ages. The elderly veteran population most in need of long-term care—those 85 years and older—grew dramatically from about 387,000 to about 764,000, an increase of about 100 percent from fiscal years 1998 to 2003. (See fig. 1.)

Figure 1: Growth in Veteran Population, 85 Years and Older, Fiscal Years 1998 Through 2003



Source: GAO analysis of VA data.

Over the past two decades the provision of long-term care has been shifting away from institutions and nursing homes towards more noninstitutional long-term care services in VA and in other programs. In recognition of this change in approach to how long-term care is provided, the Federal Advisory Committee on the Future of VA Long-Term Care recommended, in 1998, that VA update its long-term care policy by meeting the growing demand for long-term care through significant expansion of its capacity to provide home and community-based services—also known as noninstitutional long-term care services—while maintaining its nursing home capacity at the 1998 level.[2]

VA provides a continuum of noninstitutional long-term care services to provide care to veterans needing assistance. Long-term care provided in noninstitutional settings—including services provided in veterans' homes and community-based services such as adult day health care centers—is preferred by many veterans. Noninstitutional care also includes respite care services that temporarily relieve a veteran's caregiver from the

[2]*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).

burden of caring for a chronically ill and disabled veteran in the home. VA offers noninstitutional long-term care services directly or through other providers with which VA contracts. (See table 1 for the noninstitutional long-term care services in our review.)

Table 1: Selected VA Noninstitutional Long-Term Care Services

VA noninstitutional long-term care service	Definition	Source of care
Home-based primary care	Primary health care, delivered by a physician-directed interdisciplinary team of staff including nurses to homebound (often bedbound) veterans for whom visits to an outpatient clinic are not practical.	VA providers
Homemaker/home health aide	Personal care, such as grooming, housekeeping, and meal preparation services, provided in the home to veterans who would otherwise need nursing home care.	Contracted providers
Adult day health care	Health maintenance and rehabilitative services provided to frail elderly veterans in an outpatient setting during part of the day.	VA and contracted providers
Skilled home health care	Medical services provided to veterans at home.	Contracted providers
Home respite care	Services provided at home to temporarily relieve the veteran's caregiver from the burden of caring for a chronically disabled veteran.	Contracted providers
Home hospice care	Services provided at home to veterans whose primary goal of treatment is comfort rather than cure for an advanced disease that is life-limiting.	Contracted providers

Source: VA.

Veterans can also receive nursing home care and noninstitutional services financed by sources other than VA, including Medicaid and Medicare, private health or long-term care insurance, or self-financed. States design and administer Medicaid programs that include coverage for nursing home care and home and community-based services. Medicare primarily covers acute care health costs and therefore limits its nursing home coverage to short-term stays following hospitalization. Medicare also pays for home health care. State Medicaid programs are the principal funders of nursing home and home health care services, besides patients self-financing their care. We have estimated that private insurance pays for about 11 percent of nursing home and home health care expenditures.[3]

[3]See U.S. General Accounting Office, *Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets* GAO-02-544T (Washington, D.C.: March 21, 2002).

Nursing Home Workload Declined Slightly And Use Of Nursing Home Care By Setting Changed

VA's overall nursing home workload—average daily census—was 33,214 in fiscal year 2003, slightly below its fiscal year 1998 workload. However, the workload was below the fiscal year 1998 level each year, reaching its lowest level in fiscal year 2000. Over the last 6 years, VA's use of nursing homes by setting changed. These changes in workload and use of different settings to provide nursing home care varied by network.

Nursing Home Workload Declined Slightly from Fiscal Year 1998 through Fiscal Year 2003

VA's nursing home workload was 33,214 in fiscal year 2003, 1 percent below its fiscal year 1998 workload. (See table 2.) Nursing home workload varied over this period but was consistently below the fiscal year 1998 level, decreasing by as much as 8 percent in fiscal year 2000 from its fiscal year 1998 level. The distribution of the nursing home workload among the three nursing home settings shifted during this period. From fiscal years 1998 through 2003, workload in the nursing homes VA operates declined by 1,014. In addition, workload in community nursing homes declined by 1,434. In contrast, workload in state veterans' homes increased by 2,032.

Table 2: Change in Nursing Home Workload Provided or Paid for by VA in Fiscal Years 1998-2003

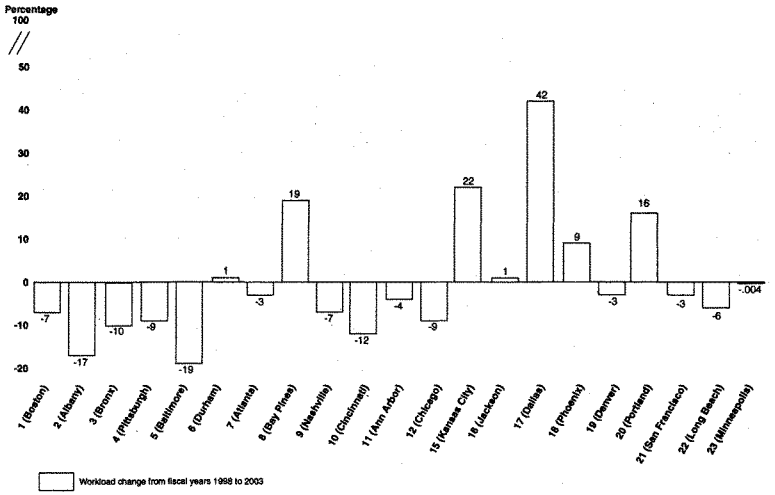
Type of nursing home	1998	1999	2000	2001	2002	2003	Change 1998-2003
VA-operated nursing homes	13,387	12,614	11,841	11,727	12,035	12,373	-1,014
Community nursing homes	5,636	4,575	3,799	4,163	4,080	4,202	-1,434
State veterans' nursing homes	14,607	15,046	15,259	15,533	15,985	16,639	2,032
Total	**33,630**	**32,235**	**30,899**	**31,423**	**32,100**	**33,214**	**-416**

Source: VA.

Note: The workload measure is average daily census, which represents the total number of days of nursing home care provided in a year divided by the number of days in the year.

Although VA nursing home workload did not change greatly from fiscal years 1998 through fiscal year 2003, some networks experienced significant increases or decreases. Fourteen of VA's 21 networks had lower nursing home workloads in fiscal year 2003 than in fiscal year 1998 for all three settings combined. (See fig. 2.) Network 5 (Baltimore) had the largest decline in workload—19 percent. Seven networks' nursing home workloads grew during this period. Network 17 (Dallas) had the largest increase in nursing home workload—42 percent.

Figure 2: Change in Nursing Home Workload by VA Network, Fiscal Years 1998-2003



Source: GAO analysis of VA data.

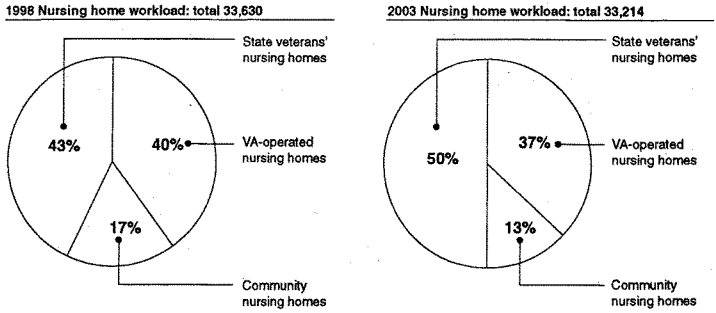
Note: Nursing home workload is measured using average daily census combined for VA-operated nursing homes, community nursing homes, and state veterans' nursing homes. Average daily census represents the total number of days of nursing home care provided in a year divided by the number of days in the year. VA merged networks 13 and 14 into network 23 in January 2002.

Use of Nursing Home Care Setting Changed from Fiscal Year 1998 through 2003

VA's use of nursing home care among the three settings changed from fiscal years 1998 through 2003. The percentage of workload met in state veterans' nursing homes increased from 43 to 50 percent. (See fig. 3.) This increase is attributable in large part to 18 more state veterans' nursing homes receiving payment from VA to provide such care. By fiscal year 2003, 109 state veterans' nursing homes received VA payment to provide this care. VA is authorized to pay for about two-thirds of the costs of

construction of state veterans' nursing homes and pays about a third of the costs per day to provide care to veterans in these homes.

Figure 3: Percentage of Nursing Home Workload By Setting, Fiscal Years 1998 and 2003



Source: GAO analysis of VA data.

Note: The workload measure is average daily census, which represents the total number of days of nursing home care provided in a year divided by the number of days in the year.

The percentage of workload provided in state veterans' nursing homes increased in 19 of VA's 21 health care networks. Network 17 (Dallas) had the largest increase in the percentage of workload provided by state veterans' nursing homes. The percentage of nursing home care provided by state veterans' nursing homes in this network increased from 0 to 30 percent during this period after the opening of four state veterans' nursing homes in Texas. By contrast, the percentage of workload provided by state veterans' nursing homes declined in 2 networks: Network 5 (Baltimore) by 3 percent and Network 21 (San Francisco) by 2 percent.

The percentage of nursing home workload provided in VA's own nursing homes declined from 40 to 37 percent during this period. Thirteen networks provided a smaller percentage of nursing home care in VA-operated nursing homes in fiscal year 2003 than in fiscal year 1998. Network 17 (Dallas) had the largest decrease in the percentage of

workload provided by VA-operated nursing homes, declining from 68 percent to 49 percent during this period. This resulted because the state veterans' nursing home workload increased substantially. By contrast, the percentage of care provided in VA-operated homes increased in 8 networks. Network 5 (Baltimore) had the largest increase, growing from 50 percent in fiscal year 1998 to 64 percent in fiscal year 2003. In Network 21 (San Francisco), the percentage of care in VA-operated nursing homes increased by 7 percent and in the remaining 6 networks the percentage of care in VA-operated nursing homes increased 3 percent or less.

Our analysis of length-of stay trends in VA-operated nursing homes shows that the decline in the number of veterans with long stays—90 days or more—largely explains the decline in nursing home workload during this period. The number of long-stay veterans declined from about 14,200 in fiscal year 1998 to about 12,700 in fiscal year 2002, the most recent year for which data are available.[4] At the same time the number of short-stay veterans—those with stays of less than 90 days—increased from about 26,700 to about 32,200. However, the increase in short-stay patients was not large enough to offset the decline in workload resulting from the decrease in long-stay patients. This results because multiple short-stay patients are required to generate the same workload as a single long-stay patient. For example, a single long-stay patient in a nursing home for 12 months creates a workload of an average daily census of 1 over a year. By contrast, 12 short-stay patients staying in a nursing home for one month each creates the same average daily census.

Among VA's networks, 16 had declines in the number of long-stay patients in VA-operated homes during this period. Five networks, however, had increases in the number of long-stay patients: Network 1 (Boston), Network 5 (Baltimore), Network 7 (Atlanta), Network 12 (Chicago) and Network 21 (San Francisco).

VA officials attribute some of the changes in nursing home workload in VA-operated facilities to an increased emphasis on short-term, post-acute rehabilitation care. VA's policy is to provide nursing home care in its own nursing homes as a priority to post-acute patients, patients who cannot be adequately cared for in community nursing homes or in noninstitutional

[4]This calculation requires complete data for the first 3 months of a fiscal year to determine if some patients in a prior fiscal year were in a VA-operated nursing home for 90 or more days. Data for the first 3 months of fiscal year 2004 were not available when we did our calculations. As a result, we provide our analysis for fiscal year 2002.

settings, and those patients who can be cared for more efficiently in VA's own nursing homes. In addition, VA may provide nursing home care, to the extent resources are available, to other patients who need long-term care for chronic disabilities. Consistent with VA's policy, the proportion of discharged veterans whose length of stays were less than 90 days in VA-operated nursing homes increased from 74 to 81 percent from fiscal years 1998 through 2003. This is similar to lengths of stay provided in facilities certified by Medicare—but not Medicaid—that provide post-acute skilled nursing home care.[5] About 81 percent of discharged patients in these certified Medicare facilities had length of stays of less than 90 days in fiscal year 1999.[6]

The percentage of workload in community nursing homes declined from 17 to 13 percent from fiscal year 1998 through fiscal year 2003. This decline occurred because VA reduced the number of patients served and the number of days paid for under contract in this setting. The number of patients in these settings declined from 28,893 to 14,032 during this period.[7] Some VA officials told us that in the past VA used community nursing homes for more patients and for longer-term contracts than currently. VA officials told us that now shorter-term contracts are often used to transition veterans to nursing home care, which is paid by other payers such as Medicaid. For example, some network officials told us that contracts for community nursing home care are often 30 days or less.

Of the 21 networks, 17 reduced the percentage of nursing home workload provided in community nursing homes during this period. Four networks reduced the percentage of nursing home care provided in community nursing homes by about 11 percent: Network 4 (Pittsburgh), Network 5 (Baltimore), Network 6 (Durham), and Network 17 (Dallas). By contrast, the percentage of workload provided in community nursing homes increased in 4 networks. The percentage of nursing home care provided in community nursing homes in Network 19 (Denver) increased by about 10 percent. The percentage of nursing home care provided in community nursing homes among the other 3 networks— Network 23 (Minneapolis),

[5]Some nursing home facilities are certified only by Medicare to provide skilled nursing home care. Others are certified by both Medicare and Medicaid.

[6]See A. Jones, The National Nursing Home Survey: 1999 Summary. National Center for Health Statistics, Vital Health Stat 13(152), 2002.

[7]These patient numbers are based on discharges and are not unduplicated because a single patient may be admitted more than once in the same fiscal year.

Network 20 (Portland), and Network 18 (Phoenix)—increased 3 percent or less.

VA Noninstitutional Long-Term Care Workload Increased

VA's noninstitutional long-term care workload—average daily census—for the six services in our review increased by approximately 75 percent from fiscal years 1998 through 2003. Workload increased by 4,655 during this period to 10,892. (See table 3.) Much of this growth came from increases in skilled home health and homemaker/home health aide care—services that are most likely to help veterans prevent or delay the need for nursing home care. One of the services that grew most rapidly was skilled home health care which increased by 127 percent during this period. Although noninstitutional long-term care workload increased, all veterans may not have access to these services because there are limitations in the availability of these services. We previously reported a number of limitations in access to noninstitutional services that veterans experienced in the fall of 2002. At that time some facilities did not offer some of these noninstitutional services at all, or offered them only in certain parts of the geographic area they served.[8] For example, more than half of VA's 139 medical facilities did not provide home-based primary care or adult day health care in the fall of 2002.[9]

[8]U.S. General Accounting Office, *VA Long-Term Care: Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions* GAO-03-815T (Washington, D.C.: May 22, 2003), and 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).

[9]We reported on 139 medical facilities, even though VA had 172 medical centers, because in some instances 2 or more medical centers had 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 had 139 facilities.

Table 3: Change in Noninstitutional Long-Term Care Workload Provided or Paid for by VA in Fiscal Years 1998-2003

Type of noninstitutional service	1998	1999	2000	2001	2002	2003	Change 1998-2003
Home-based primary care	923	964	890	908	903	944	21
Adult day health care[a]	1,023	1,215	1,106	1,201	1,310	1,220	197
Homemaker/home health aide	2,385	3,141	3,080	3,824	4,180	4,317	1,932
Skilled home health care	1,906	2,148	2,555	3,273	3,851	4,332	2,426
Home respite care	[b]	[b]	[b]	[b]	[b]	2	2
Home hospice care	[b]	[b]	[b]	[b]	[b]	77	77
Total[c]	**6,237**	**7,468**	**7,631**	**9,206**	**10,244**	**10,892**	**4,655**

Source: VA and GAO analysis of VA data.

Note: Workload is measured by average daily census which represents the total number of visits of noninstitutional care provided in a year divided by the number of days in the year. The average daily census calculation for adult day health care uses 251 rather than 365 days because this service is not always provided 7 days a week.

[a] Numbers include contracted adult day health care and VA-provided adult day health care.

[b] Data not available.

[c] Total workload is not a measure of unique patients daily because the same patient may receive more than one service in the same day.

The noninstitutional workload numbers for home-based primary care in table 3 are different from those reported by VA in its appropriations submissions to Congress and in recent VA testimony.[10] In its reports on noninstitutional workload, VA has measured home-based primary care services using enrolled days—the number of days a veteran is enrolled to receive a service—rather than the number of home-based primary care visits a veteran receives. However, VA has measured use of the other noninstitutional services in visits. Therefore, to ensure comparability across services, we used visits as the workload measure for home-based primary care. As a result, our workload total for home-based primary care is smaller than the number VA reports because veterans do not typically receive a home-based primary care visit for each day in which they are enrolled in home-based primary care. Specifically, we report the 2002 home-based primary care workload as 903 while VA has reported it as

[10]House Subcommittee on Health, Committee on Veterans' Affairs, Statement of the Under Secretary for Health, Department of Veterans Affairs, *VA's Long-Term Care Programs*, 108th Congress, 1st session, May 22, 2003, Department of Veterans Affairs *FY 2004 Budget Submission: Medical Programs Volume 2 of 5 Final* (Washington, D.C.: March 2003), 2-148, and Department of Veterans Affairs *FY 2002 Budget Submission: Medical Programs Volume 2 of 6* (Washington, D.C.: April 2001), 2-101.

8,081. Our consistent measure of all services in visits results in a lower total noninstitutional workload than that reported by VA.

Concluding Observations

Over the last 6 years, the veteran population most in need of long-term care has grown dramatically. During this period, VA's use of nursing home care by setting has changed so that state veterans' nursing homes now provide one-half of all nursing home workload provided or paid for by VA. At the same time, VA decreased the workload it serves in its own nursing homes consistent with VA's policy to emphasize short-stay, post-acute care in its own nursing homes. VA also used community nursing home care less as it transitioned more veterans who needed such care to care paid for by other payers such as Medicaid. In addition, VA increased the long-term care workload provided in noninstitutional settings.

These trends over the last 6 years raise important questions for how VA is meeting current long-term care need and what it may need to do to meet future long-term care need.

- What does the significant variation in nursing home workload change among the networks over this 6-year period mean for meeting veterans' long-term care needs in different parts of the country?
- What are the implications for access, quality, and costs of VA's significant shift to using state veterans' nursing homes to provide one-half of its nursing home care?
- How has VA's increased emphasis on post-acute care in its own nursing homes affected its ability to continue providing long-term care in its nursing homes for veterans with chronic disabilities?
- To what extent does total VA long-term care workload—composed of a fairly constant nursing home workload and a rapidly expanding but smaller noninstitutional workload—meet the needs of a rapidly growing elderly veteran population?

The continuing rapid rise in the veteran population likely to be in greatest need of long-term care—those 85 years and older—poses a major challenge for VA health care. Answers to these four questions can help policymakers, VA, and its stakeholders better understand the best ways to meet VA's long-term care challenge. We look forward to continuing to work with you on these significant issues.

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

Contact and Acknowledgments

For further information regarding this testimony, please contact me at (202) 512-7101. Individuals making key contributions to this testimony include James C. Musselwhite, Thomas A. Walke, and Pamela A. Dooley.

Related GAO Products

VA Long-Term Care: Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions. GAO-03-815T. Washington, D.C.: May 22, 2003.

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.

Medicare: Utilization of Home Health Care by State. GAO-02-782R. Washington, D.C.: May 23, 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.

VA Long-Term Care: Oversight of Community Nursing Homes Needs Strengthening. GAO-01-768. Washington, D.C.: July 27, 2001.

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STATEMENT OF

DR. JOHN D. DAIGH JR., M.D.

ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS

OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

BEFORE

THE UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS AFFAIRS

HEARING ON DEPARTMENT OF VETERANS AFFAIRS

COMMUNITY NURSING HOME PROGRAM AND

HOMEMAKER AND HOME HEALTH AIDE PROGRAM

JANUARY 28, 2004

INTRODUCTION

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss programs that directly impact the quality of life of millions of veterans who need long-term care services. Today I will present you with the results of our evaluation of the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) Community Nursing Home (CNH) Program and the Homemaker and Home Health Aide Program (H/HHA).

To provide you some background, VHA informed us that they have projected the number of veterans age 85 and older will increase from 645,000 in 2003 and will peak at 1.3 million in 2013. One of the methods that VHA uses to meet the growing challenge of providing health care to this population of veterans is providing nursing home care using contracts with privately owned nursing homes, state operated nursing homes, and VA-owned nursing home care units located in VA medical facilities nationwide. In addition to providing direct support for nursing home beds, VHA has established the H/HHA program under VHA Directive 98-022. This program provides

homemaker and home health aide visits to eligible veterans in their homes and communities using CNH funds. VA medical facility managers are required to coordinate and review the appropriateness of home care referrals, assess the most appropriate in-home services for patients, and monitor the appropriateness of costs. This program is consistent with the Veterans Millennium Health Care and Benefits Act, Public Law 106-117, which promotes the provision of non-institutionalized health care in community settings.

COMMUNITY NURSING HOME CARE

My office identified the need for VHA to strengthen CNH oversight and control practices as far back as January 1994. We found at that time that VHA needed to perform annual reviews, routinely use quality-of care information from state agencies in evaluating the quality and safety of CNHs, and conduct inspections and patient visitations to ensure veterans receive appropriate care. We also recommended that VHA develop standardized inspection procedures and criteria for approving homes for participation in the program to include quality oversight controls for monitoring the adequacy of care.

In October 2001, we reported to VHA that issues discussed in our 1994 report continued to exist at 17 facilities visited during Combined Assessment Program (CAP) reviews conducted from January 1999 through March 2001. In April 2002, we conveyed in our semi-annual report to Congress our concerns that VHA had still not responded to our recommendations to strengthen oversight of its CNH Program.

The General Accounting Office (GAO) also issued several reports on VHA's CNH Program dating as far back as 1987, and outlined similar control and monitoring vulnerabilities. A GAO report was issued in July 2001, and it discussed issues similar to those discussed in our 1994 report.

My inspectors reviewed past OIG and GAO reports on CNH activities and the status of recommendations that resulted from these reports. We visited 8 geographically diverse

VA medical facilities nationwide that contracted with 302 CNHs in their areas of jurisdiction. VHA CNH review teams monitored the care provided to 737 veterans in these nursing homes. We visited 25 of these CNHs, assessed the adequacy of VHA CNH oversight and control activities, and contract administration. We also reviewed a sample of 111 veterans' medical records at the VA medical facilities and CNHs. At each VA medical facility, we interviewed VHA CNH review team members and reviewed local policies. We interviewed the nursing home administrators and their directors of nursing, toured the physical plants, and interviewed veterans. We also reviewed data from the Department of Health and Human Services (HHS) Center for Medicaid and Medicare Services (CMS) On-Line Survey Certification and Reporting (OSCAR), contract files, and we interviewed State Ombudsman officials.

The veterans and families we visited informed us that they believed their respective CNHs provided generally good care, and they were mostly satisfied with CNH services and accommodations. However, the majority of VHA CNH review team members we interviewed were aware of reports that veterans were abused or neglected in CNHs under their jurisdiction. These teams acknowledged that they have generally reacted after the fact to these incidents. Actions have ranged from giving the affected families and veterans choices to transfer to other nursing homes, to removing veterans from nursing homes and canceling contracts. We found 9 reported cases of abuse, neglect, or financial exploitation during our review of the records of 111 veterans residing in 25 CNHs. This represents an average 8-percent incident rate in the sample population. We also found veterans who were not in our sample and non-veterans residing with our veterans in VHA-contracted CNHs who were subjected to serious adverse incidents. These conditions emphasized the need for VHA to strengthen oversight practices.

Rather than reacting to such adverse events, we believe VHA could reduce the risk of incidents occurring by strengthening their oversight of CNH activities. We found that similar program vulnerabilities as were discussed in prior OIG and GAO reports, continue to exist. Not all VHA CNH review teams analyzed CMS data before initiating contracts and prior to annual contract renewals. This was evidenced by the fact that the

8 VA medical facilities visited had placed 27 percent of the veterans in nursing homes that had been inspected and cited for serious violations. CMS provides detailed information about the performance of every Medicare and Medicaid-certified nursing home in the country. The data includes health care deficiencies found during the nursing homes' most recent state nursing home survey and from recent complaint investigations. The 8 VA medical facilities we visited had active contracts with 41 (14 percent) nursing homes listed on the CMS "Nursing Home Compare" website as having level 3 or 4 "level of harm" ratings – referred to as the "Watch List". Of these 41 CNHs, 7 (17 percent) were managed at VHA headquarters under regional contracts. The 41 CNHs were cited 273 times for administrative and quality of care violations.

My inspectors found that CNH contract procedures and inspection practices continued to vary widely among VA medical facilities. The standardization of contracting requirements and expectations placed on CNHs would reduce vulnerabilities and ensure veterans receive the same standard of care nationwide. Not all medical facility managers accepted the requirement that VHA employees visit and routinely monitor the adequacy of care provided to veterans. Therefore, while some VA medical centers conducted monthly CNH visits as required, others conducted visits only when patients experienced adverse events. In addition, VAMC clinicians needed to routinely obtain CNH performance monitors (e.g. resident falls, incident reports, and medication errors), to better monitor occurrences at these CNH facilities and to coordinate performance improvement initiatives.

My inspectors found that VHA CNH review teams do not meet annually with Veterans Benefits Administration (VBA) Fiduciary and Field Examination (F&FE) employees to discuss veterans of mutual concern as required by VBA policies. VHA does not have a corollary policy to discuss CNH patient issues with VBA representatives. We also found that VHA CNH review teams do not always contact VBA examiners when veterans' cognitive abilities change. The absence of effective communication between VBA and VHA reduces the VA's ability to adequately protect veterans from financial exploitation and protect VA-derived payments.

We made 10 recommendations to VHA[1], and the Under Secretary for Health (USH) agreed with all but one issue pertaining to monitoring patients who reside outside a 50-mile radius of VA facilities. We agreed that no immediate action was needed on this specific issue, but we encouraged VHA managers to closely oversee the adequacy of monitoring these veterans. We agreed only because VHA top managers assured us that they would consider visitation schedules on a case-by-case basis, and would tailor monitoring controls to the needs of each specific veteran residing in a CNH regardless of their distance to the VA medical facility. The USH provided acceptable implementation plans for the remaining recommendations. The Under Secretary for Benefits agreed with the recommendation to coordinate efforts with VHA in this area and establish proper procedures for exchanging information.

VHA published a new CNH policy on June 24, 2002, at the conclusion of our follow-up review in an effort to respond to earlier recommendations. We concluded this new CNH policy clarified and strengthened certain oversight controls and addressed many of the prior recommendations made in earlier reports, but the new VHA policy needed clarification. To date the CNH policy is still in draft stage and has not been released for concurrence.

HOMEMAKER AND HOME HEALTH AIDE PROGRAM

The H/HHA program began as a VA pilot program in 1993 to furnish personal care and health-related services in noninstitutional settings for certain eligible veterans. The program consisted of H/HHA services coordinated by VHA staff. The VHA's H/HHA Evaluation Project was completed in June 1995. The findings, published in the VA Guide to Long-Term Care Programs and Services, Volume 3, identified the following problems with the provision of services: dissatisfaction with the continuity of care (frequent changes in community health agency (CHA) care providers), quality control

[1] OIG Report No. 02-00972-44, *Healthcare Inspection Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program*

and staff training varied between vendors, and inadequate staffing to administer the program.

My inspectors reviewed the H/HHA program between October 2001 and September 2002.[2] As part of the OIG's CAP reviews, we inspected H/HHA programs at 17 VA medical facilities. Our sample was composed of 142 patients, at 16 sites, who were receiving H/HHA services at the times of the CAP review visits, or who had received H/HHA services during the first quarter of FY 2002. All sampled patients had received services for at least 6 months at the times of our visits. We also consulted with OIG auditors who assisted us on the financial aspects of the review.

One of the 17 facilities we visited had no veterans who met the selection criteria of receiving H/HHA services for at least 6 months. This facility limited contracts to 3 months to serve as many veterans as possible. No data from the medical record reviews or the satisfaction survey of patients from this facility were included in this report; however, other program information was included.

We reviewed local policies and interviewed H/HHA Program coordinators and team members from contracting, billing, nursing, and social work to assess their compliance with VHA directives. We reviewed CHA's documentation regarding supervision and patient satisfaction, and performance improvement data to assess the quality of the H/HHA services provided to veteran patients. We reviewed the medical records of 142 patients receiving care at 16 medical facilities to evaluate initial interdisciplinary assessments, clinical eligibility, and re-certifications for continued services. We contacted 70 of the 142 patients in our sample, or their caregivers, to assess their satisfaction with H/HHA services. We recorded the perceptions of the patients or their caregivers regarding the timeliness of H/HHA services, the courtesy shown by homemakers or home health aides, and the levels of satisfaction with the program. We reviewed contractual agreements between the VA medical facilities and CHAs and

[2] OIG report 02-00124-48, *Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program*

examined the invoices for patients receiving services during the first quarter FY 2002, to determine whether the CHAs complied with authorized rates and hours, and whether VA medical facility managers appropriately monitored the billings. We also compared the authorized rates to the local State Medicaid rates and the Department of Labor's Bureau of Labor Statistics Wage Rates to determine the reasonableness of the charges. We examined invoices for 142 patients. We utilized the Benefits Delivery Network (BDN) to determine whether veterans receiving H/HHA services were also receiving basic special monthly compensation or pension (SMC/P) benefits because of the need for basic aid and attendance.[3] We obtained copies of the rating decisions for 32 patients who were receiving SMC/P benefits to determine whether the SMC/P was provided for the same reasons for which the patients were receiving H/HHA services. We also determined whether H/HHA Program managers were aware of their veterans' SMC/P status. We verified the SMC/P status of 667 veterans.

We found that 20 (14 percent) of the 142 patients whose medical records we reviewed did not meet clinical eligibility requirements to receive H/HHA services. Five additional patients' medical records contained insufficient information to ascertain their clinical eligibility. According to VHA Directive 96-031, veterans eligible for H/HHA services are those who are in need of nursing home care. The phrase "...in need of nursing home care..." means that the patient's interdisciplinary team needs to make a clinical judgment as to whether such care is needed as defined by clinical indicators.

We found that 12 (8 percent) of 142 patients did not have any activities of daily living (ADL) dependencies documented in their initial assessments for H/HHA services yet were approved to receive services. In some cases, the interdisciplinary teams documented that the patients needed assistance with ADLs, but the patients were not dependent in any ADLs. In addition, we found that 7 (10 percent) of the 70 respondents interviewed said that they would not be in need of nursing home placement at this time

[3] In determining whether a veteran is in need of A&A, Veterans Benefits Administration adjudicators consider if the veteran's disabilities make it impossible to perform such basic functions of daily living as bathing, dressing, and eating without the assistance of another person.

even if they did not receive H/HHA services. The remaining 8 patients who did not meet clinical eligibility requirements had ADL dependencies, but did not have 2 or more of the other required conditions. We did not find any evidence of interdisciplinary assessments for referrals in 42 (30 percent) of 142 medical records reviewed.

H/HHA Program managers did not always appropriately manage their H/HHA resources in relation to wait-listed patients. We found that 10 (59 percent) of 17 VA medical facilities visited had waiting lists for placements in their programs. One facility had 23 patients on its waiting list, with 1 patient waiting 6 months for services. Another facility had eight patients on a waiting list to receive H/HHA services, and one patient had been on the list for 8 months. Three ineligible patients were receiving services through this latter facility, and a fourth (eligible) patient had repeatedly requested to terminate or reduce the hours of homemaker service he was receiving as he felt he did not have enough tasks to "...keep the homemaker busy." All eight wait-listed patients met eligibility criteria and may have been in greater need than some of the patients currently enrolled in this facility's H/HHA Program.

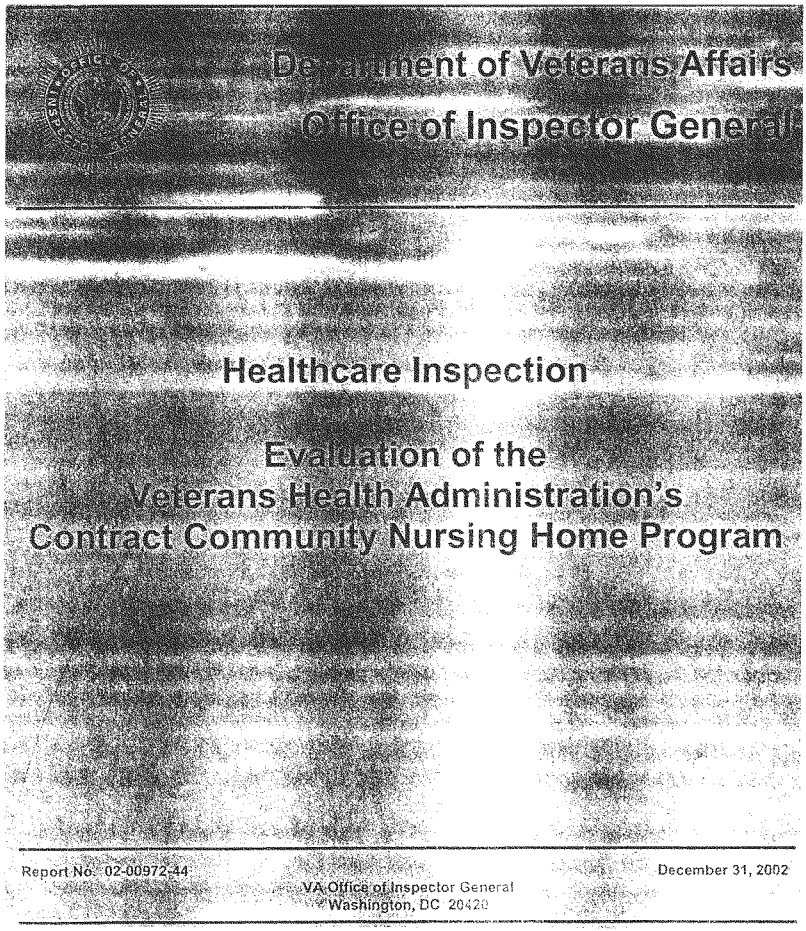
Contracts we reviewed showed hourly rates ranging from $9.86 to $30. We found that five sites negotiated rates below the prevailing State Medicaid rates, and saved about $6,800. Had the remaining 11 (69 percent) sites used the Medicaid rates, they could have avoided about $42,500 (16 percent) of the $265,849 in payments made for the patients in our sample, during the first quarter of FY 2002. In applying this percentage savings to projected FY 2003 payments for all H/HHA services, we estimated that the program could avoid, on average, about $10.7 million in costs annually. The H/HHA Program authorized services for 667 patients totaling at least $1.4 million at 16 sites we visited during the first quarter of FY 2002. Of these 667 patients, 163 patients (24 percent) also received basic SMC/P from the Veterans Benefits Administration due to their need for aid and attendance.

We recommended that the Under Secretary for Health (USH) issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that: patients

receive thorough initial interdisciplinary assessments prior to placement in the program, patients receiving H/HHA services meet clinical eligibility requirements, and that benchmark rates for these services are established. In addition, we recommended that VHA seek a General Counsel opinion as to whether a veteran's SMC/P status can be considered when prioritizing need for services and determining frequency of authorized H/HHA visits. If General Counsel determines that this consideration is appropriate, we recommend that policy reflect this decision. The USH agreed with the report's findings and concurred with the recommendations, but he expressed concerns about the monetary benefits that will be derived from implementing new policies and procedures. On September 10, 2003 VHA provided guidance that established benchmark rates for H/HHA services. Additional policy adjustments and the results of the General Council opinion, if available, have not been shared with the Office of Healthcare Inspections at this time.

CONCLUSION

In conclusion, we believe VHA needs to continue efforts to strengthen its long term care programs to ensure all veterans are receiving quality care and are safe from harm. My office continues to oversee this very important issue through the performance of program reviews and hotline investigations. We reviewed private homes providing health related services to veterans (Residential Care Homes) during CAPs performed in late FY 2003 and will be reporting on this issue in the near future. I want to thank you for the opportunity to participate at this hearing. I am available for questions.


Department of Veterans Affairs
Office of Inspector General
Healthcare Inspection
Evaluation of the
Veterans Health Administration's
Contract Community Nursing Home Program
Report No. 02-00972-44
VA Office of Inspector General
Washington, DC 20420
December 31, 2002

CONTENTS

EXECUTIVE SUMMARY

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an evaluation of the Veterans Health Administration's (VHA's) Community Nursing Home (CNH) Program. The purpose of the evaluation was to follow up on VHA's efforts to strengthen its monitoring of CNH activities, and ensure that veterans receive good care in safe environments.

The OIG received a request from Senator Christopher S. Bond to review VHA efforts to implement OIG and United States (U.S.) General Accounting Office (GAO) recommendations to strengthen oversight of the CNH program. The OIG identified the need to strengthen CNH oversight and control practices as far back as January 1994. The OIG reported that similar conditions and vulnerabilities continued to exist in a Combined Assessment Program (CAP) Summary Report dated October 30, 2001. GAO reported on CNH oversight and control concerns as far back as November 1987, and discussed similar oversight and control vulnerabilities in a 2001 report entitled, *VA Long Term Care: Oversight of Community Nursing Homes Needs Strengthening.* In this latter report, GAO found that VHA's adherence to oversight policies has been mixed. Senator Bond asked that we follow up on the progress of VHA's efforts to strengthen oversight and control procedures, and to determine whether veterans residing in these nursing homes were vulnerable to abuse, neglect, or financial exploitation.

During fiscal year (FY) 2001, there was a daily average census of 3,990 veterans residing in VHA-contracted CNHs. VHA program officials informed us that FY 2001 expenditures for the CNH Program totaled $325.6 million. We reviewed past OIG and GAO reports on CNH activities and the status of recommendations that resulted from these reports. We visited 8 VA medical facilities nationwide that contracted with 302 CNHs in their areas of jurisdiction. VHA CNH review teams monitored the care provided to 737 veterans in these nursing homes. We visited 25 of these CNHs, assessed the adequacy of VHA CNH oversight and control activities, and contract administration. We also reviewed a sample of 111 veterans' medical records at VA medical facilities and CNHs. At each VA medical facility, we interviewed the VHA CNH review team and reviewed local policies. We interviewed the nursing home administrators and the directors of nursing, toured the physical plants, and interviewed veterans and their family members. We also reviewed data from the Department of Health and Human Services (HHS) Center for Medicaid and Medicare Services (CMS) On-Line Survey Certification and Reporting (OSCAR) data, contract files, and we interviewed State Ombudsman officials.

We found that VHA has taken years to implement standardized inspection procedures for monitoring CNH activities and for approving homes for participation in the program. VHA policy for the CNH program has been under review since 1995. We believe this slow pace of revising policy has led to variances over time in the way local managers and clinicians administer and monitor CNH activities. In response to GAO's 2001 report, the Secretary agreed that VA's oversight of the CNH program needed

strengthening, and he committed VHA to publishing new directives before the end of FY 2001. VHA issued a draft policy proposal to field CNH clinicians in March 2002, and we provided more than 20 suggestions to strengthen proposed procedural changes. Further hindering the ability of VHA to provide the necessary leadership in implementing new CNH policy was the fact that the Chief Consultant of the Geriatrics and Extended Care position has been vacant since August 2001. The task of revising and clarifying CNH policy was given to this position and the Geriatrics and Extended Care Strategic Health Group several years ago.

VHA published a new CNH policy on June 24, 2002, at the conclusion of this follow-up review. We concluded this new CNH policy should clarify and strengthen certain oversight controls, but was silent on, or liberalized other procedures that had originally been designed to better monitor the care and safety of veterans. Overall, the new VHA policy still needs clarification to address these procedures.

The veterans we visited were generally well cared for, and mostly satisfied with CNH services and accommodations. However, the majority of VHA CNH review teams we interviewed were aware of reports that veterans were abused or neglected in CNHs under their jurisdiction. These teams generally reacted after the fact to these incidents. Actions have ranged from giving the affected families and veterans choices to transfer to other nursing homes, to removing veterans from nursing homes and canceling contracts. We found 9 reported cases of abuse, neglect, or financial exploitation during our review of the records of 111 veterans residing in 25 CNHs. There were three reported cases of neglect, three reported cases of abuse, and three reported cases of financial exploitation. This represents an average 8.1 percent incidence rate in the sample population. We also found veterans not in our sample and non-veterans residing with our veterans in VHA contracted CNHs who were subjected to serious adverse incidents. These conditions emphasize the need for VHA to strengthen, not liberalize, oversight practices.

Rather than reacting to such adverse events, we believe VHA could reduce the risk of incidents occurring by strengthening oversight of CNH activities. We found that similar program vulnerabilities as were discussed in prior OIG and GAO reports, continue to exist. Not all VHA CNH review teams analyzed CMS data before initiating contracts and prior to annual contract renewals. This was evidenced by the fact that 27 percent of the veterans at the 8 VA medical facilities visited were placed in CMS "watch listed" homes. CMS provides detailed information about the performance of every Medicare and Medicaid-certified nursing home in the country. The data includes health care deficiencies found during the nursing homes' most recent state nursing home surveys and from recent complaint investigations. Nursing homes confirmed as placing residents in harms-way or in immediate jeopardy are placed on a CMS watch list that identifies the nursing homes and the related issues or violations.

The 8 VA medical facilities we visited had active contracts with 41 (14 percent) nursing homes listed on the CMS watch list. Of the 41 CNHs on the watch list, 7 (17 percent) were managed at VHA headquarters under regional contracts. The 41 CNHs were cited 273 times for administrative and quality of care violations.

We found that CNH contract procedures and inspection practices continued to vary among VA medical facilities. The standardization of contracting requirements and expectations placed on CNHs would reduce vulnerabilities and ensure veterans receive the same standard of care. Not all medical facility managers accepted the requirement that VHA employees visit and routinely monitor the adequacy of care provided to veterans. Medical record documentation needed improvement. In addition, VAMC clinicians needed to routinely obtain CNH performance monitors (e.g. resident falls, incident reports, and medication errors) to better monitor occurrences at these CNH facilities and to coordinate performance improvement initiatives.

We found that VHA CNH review teams do not meet annually with Veterans Benefits Administration (VBA) Fiduciary and Field Examination (F&FE) examiners to discuss veterans of mutual concern as required by VBA policies. VHA does not have a corollary policy to discuss CNH patient issues with VBA representatives. We also found that VHA CNH review teams do not always contact VBA examiners when the cognitive competencies of veteran residents change. The absence of effective communication between VBA and VHA employees reduces the VA's ability to adequately protect veterans from financial exploitation and protect VA-derived payments.

We made recommendations to further clarify and strengthen the CNH oversight process and to reduce the risk that veterans in CNHs will be subject to adverse incidents.

Under Secretary for Health Comments:

The Under Secretary for Health concurred in all recommendations except one effecting contract nursing home residents residing more than 50 miles away from parent facilities. In addition, the Under Secretary announced that a new Chief Consultant for Geriatrics and Extended Care had been selected. VHA's action plans are in Appendix A.

Under Secretary for Benefits Comments:

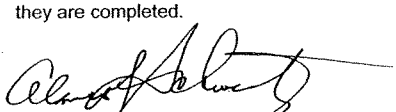
In general, the Under Secretary for Benefits concurred with the recommendation to coordinate improved lines of communication between appropriate VHA personnel, including CNH managers, and F&FE supervisors. The current F&FE program mandate, as outlined in M21-1, Part VIII, 6.08a, requires a meeting at least once yearly between these parties to discuss services to incompetent veterans. It should be noted that these meetings are not limited to CNH personnel but would also include VHA personnel involved with both the residential care program and VHA inpatients to the extent they involve incompetent veterans.

The Central Office F&FE Program staff reminded all Fiduciary Program managers nationwide of this requirement in an e-mail message on June 20, 2002. Additionally, this was an agenda item on the Veterans Service Center Managers' call on June 19, 2002, and extensively discussed in the quarterly F&FE Program Teleconference on July 18, 2002. Compliance with this requirement will be monitored during routine VBA site visits beginning in October 2002.

While the Under Secretary for Benefits agreed with the necessity of these annual meetings, he had reservations about some of the information to be shared as outlined in the second part of the recommendation, and who should be the recipient of the information. He therefore proposed that a meeting between Central Office VHA and VBA Fiduciary staff be held to determine what information would be of value to share and the proper procedures for this exchange of information. VBA's action plans are in Appendix B.

Inspector General Comments:

The Under Secretary for Health concurred with our findings and all but one of our recommendations (1i). Upon further review and consideration of the Under Secretary's response to recommendation 1i, we agree that no immediate action is required but we encourage VHA managers to closely monitor this important issue. The Under Secretary provided acceptable detailed implementation plans on the remaining recommendations. The Under Secretary for Benefits concurred with our findings and recommendation and proposed a meeting between VHA and VBA Central Office managers to determine what and how information should be shared. We will follow-up on the planned actions until they are completed.



ALANSON J. SCHWEITZER
Assistant Inspector General for
Healthcare Inspections

INTRODUCTION

Purpose

We conducted an evaluation of the VHA CNH Program. The purpose of the evaluation was to follow up on VHA's efforts to strengthen its monitoring of CNH activities, and ensuring that veterans receive good care in safe environments.

Background

The OIG received a request from Senator Christopher S. Bond to review the adequacy of oversight of VHA's CNH program. In Senator Bond's letter, he referenced CNH issues raised in an OIG report entitled, *OIG Combined Assessment Program (CAP) Summary Report at Veterans Health Administration Medical Facilities,* [1] and a U.S. GAO report entitled, *VA Long Term Care: Oversight of Community Nursing Homes Needs Strengthening.*[2] These reports discussed vulnerabilities in VHA CNH oversight practices. The reports discussed the need to standardize inspection procedures and criteria and noted that inspection procedures varied among VHA facilities, inspection team composition and processes needed improvement, and VHA clinicians did not always monitor the adequacy of care provided to veterans as required by policies.

Senator Bond's letter noted that OIG and GAO issued earlier reports on the same issues dating back many years and that similar problems continue to be identified. Senator Bond asked that we follow up on VHA's efforts to strengthen oversight and control procedures given that these same vulnerabilities have been identified over a number of years. Senator Bond also referenced two OHI reported incidents, which concerned the deaths of two veterans residing in CNHs.[3] [4] The Senator was hopeful that these were isolated incidents, and that other veterans were not vulnerable to adverse incidents. Senator Bond therefore asked that we broaden our review to determine whether other CNH veterans are vulnerable to adverse incidents.

History of Prior Reports and Issues

The GAO and OIG reported on CNH oversight and control vulnerabilities dating back to November 1987,[5] and January 1994,[6] respectively. In 1987, the GAO reported that VHA

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[1] OIG *CAP Summary Report at Veterans Health Administration Medical Facilities*, Report Number 01-00504-9, October 10, 2001

[2] GAO, *VA Long Term Care: Oversight of Community Nursing Homes Needs Strengthening* (GAO-01-768, Washington, D.C. 2001)

[3] OIG OHI, *Allegations of Wrongful Death in a VA Community Contract Nursing Home*, Report Number 01-00787-81, June 1, 2001

[4] OIG OHI, *Contract Nursing Home Issues, North Florida/South Georgia Veterans Health System*, Report Number 01-2889-60, February 26, 2002

[5] GAO Report *VA Health Care: Assuring Quality Care for Veterans in Community and State Nursing Homes*, Report Number GAO/HRD-88-18, November 1987

[6] *Audit of Veterans Health Administration Activities for Assuring Quality Care for Veterans in Community Nursing Homes*, Report Number 4R3-A28-016, January 11, 1994

needed to improve CNH oversight practices. GAO recommended that VHA employees perform annual CNH reviews, routinely use quality-of-care information from state agencies in evaluations, and conduct inspections and patient visitations every 30 days to ensure veterans receive good care.

In 1994, the OIG reported that VHA needed to improve controls over the CNH program and implement GAO's 1987 recommendations. The OIG recommended that VHA revise its oversight policies and develop standardized CNH inspection procedures and criteria for approving homes for participation in the program. The OIG also recommended using external data to better assess the quality of care provided at CNHs before and after contracting with them, and standardizing initial and annual inspection and contracting processes. Additionally, the OIG report recommended strengthening procedures for conducting routine staff visits to the CNHs, and establishing interdisciplinary quality management (QM) monitors to oversee the quality of care provided to CNH veterans.

In July 2001, the GAO issued a report that discussed similar issues to those discussed in the 1994 OIG report.[7] In October 2001, the OIG reported in its CAP Summary Report that VHA still needed to strengthen oversight of the CNH program. The CAP reviews found that VHA still needed to standardize evaluations, use external information to better assess the quality of care, and conduct inspections and routine patient visitations at prescribed intervals. Action was also needed to ensure VHA CNH review teams participated in the approval of CNH contracts prior to initiation and renewal, and to include CNH data in the collection and analysis of performance improvement reviews.

In April 2002, we reported in the OIG Semi-Annual Report (SAR) to Congress,[8] our concerns that VHA had still not implemented our recommendations to strengthen controls over the CNH Program. Additionally, there have been other Government reports on the nursing home industry over the past several years that highlighted concerns about CNH care and reported incidents of abuse and neglect.[9] [10] [11] [12] [13]

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[7] GAO Report *VA Long Term Care: Oversight of Community Nursing Homes Needs Strengthening* (GAO-01-768) (Washington, D.C. July 2001)

[8] OIG Semiannual Report to Congress, October 1, 2001 to March 31, 2002, Unimplemented Recommendations and Status, Page 53

[9] GAO, *Nursing Home Care-Enhanced HCFA Oversight of State Programs Would Better Ensure Quality* GAO/HEHS-00-6 (Washington, D.C.: 1999)

[10] *Abuse Complaints of Nursing Home Patients*, Department of Health and Human Services Office of Inspector General, Office of Evaluations and Inspections, May 1999 OEI-06-98-00340

[11] U.S. House of Representatives, *Abuse of Residents Is a Major Problem in U. S. Nursing Homes*, July 30, 2001 Minority Staff Special Investigations Division, Committee on Government Reform

[12] GAO, *Nursing Homes, Sustained Efforts are Essential to Realize Potential of the Quality Initiatives*, GAO/HEHS-00-197, (Washington, D.C.: 2000)

[13] GAO, *Nursing Homes: More Can Be Done To Protect Residents from Abuse*, (GAO-02-312, Washington, D.C. 2002)

The Under Secretary for Health issued new VHA CNH policies at the conclusion of this review.[14]

VHA CNH Program

The VHA CNH Program places veterans requiring nursing home care in community nursing facilities at VA expense. VA contracts with community nursing homes should require that the CNHs meet Medicare and Medicaid standards, and the most recent Life-Safety Code (LSC) standards, and provide good nursing care.

Veterans, who require care because of activities-of-daily-living (ADL) dependencies, medical or psychiatric illnesses, or the inability of informal and formal care systems to provide care in their homes or in their communities, comprise the population for CNHs.[15] The CNH population includes veterans in need of rehabilitation, special clinical care, and behavioral management. Statutory authority for the VA CNH program was established in Public Law 88-450. The applicable regulations are codified in 38 United States Code, 1720.

VHA policy, issued in 1995, required multi-disciplinary teams and coordinators to oversee and provide CNH program policy and supervision.[16] VHA medical facility contracting officers were instructed to negotiate local contracts in coordination with the facilities' CNH review teams. The review teams were expected to conduct initial inspections and perform annual evaluations of the CNHs. VHA CNH review teams were expected to provide monthly follow-up supervisory visits to monitor care, assure continuity of care, and assist in the veterans' transitions back to their communities.[17]

VHA also issued regional contracts (previously referred to as multi-state contracts) to provide CNH services. These contracts, administered by VHA headquarters program managers, were developed to reduce administrative and direct costs while improving access to nursing home care for veterans. VHA encourages its medical facilities to use regional contracts whenever feasible to place eligible veterans in CNHs. However, VA medical facilities may continue to use locally-negotiated nursing home contracts whenever it better serves the veterans' needs.

Unlike local contracts, which are required to have initial VHA inspections and annual renewal inspections by the local VHA CNH review teams, CNH facilities under regional contracts are not subject to initial or annual inspections. Rather, VHA headquarters program managers receive assurances from nationally recognized nursing home companies about the quality and safety of care provided, and conduct paper reviews as part of the regional contracting process. The new VHA policy, issued in June 2002, liberalized the process of conducting initial and annual inspections of locally-contracted CNHs. VHA CNH review teams now have the option of conducting paper reviews when applicable. The new VHA policy also liberalized the requirement for VHA CNH review

[14] VHA Policy CNH Handbook 1143.1, dated June 24, 2002
[15] Administration on Aging, U.S. Department of Health and Human Services (Washington, D.C.)
[16] VHA Policy M-5, Part II, Chapter 3, CNH, March 28, 1995
[17] VHA Policy M-5 Part II, Chapter 3, CNH, paragraph 3.10c, March 28, 1995

teams periodically visiting veterans placed in CNHs under local or regional contracts. The 1995 VHA policy required VHA CNH review team members to visit CNH veterans every 30 days. The new policy liberalizes visiting requirements to every 90 days for selected cases and removes the requirement for yearly comprehensive physical examinations for veterans on long-term placements.

Reporting of Incidents

Literature on incident reporting shows that each year thousands of older persons are reportedly abused, neglected, and exploited. Many victims are frail and vulnerable. They depend on others to meet their most basic ADL needs. According to a July 30, 2001 congressional report prepared by a Special Investigation Division of the House Government Reform Committee, reports of serious physical, sexual, and verbal abuse are "numerous" despite the increased awareness of abuse of the elderly in nursing home settings. The review showed that more than 40 percent of the 3,800 abuse violations recorded in a 2-year period had been discovered only after the filing of formal complaints.[18]

VA employees are required to identify and report suspected abuse and neglect.[19] [20] Nursing homes that are approved to receive Medicaid funds, and are subject to the review of the HHS CMS, must have policies and procedures for identifying, assessing, evaluating, managing, and reporting suspected patient abuse, neglect, and exploitation.

The Code of Federal Regulations (CFR)[21] defines abuse as "...willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." The CFR definition of neglect is "...failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

The CMS defines exploitation as the "...conscious deception or intimidation of a disabled adult or elderly person by a person who stands in a position of trust and confidence to obtain or use, or endeavor to obtain or use, the disabled adult's or elderly person's funds, assets, or property with the intent to temporarily or permanently deprive the person of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the exploited person." Examples include cashing an elderly person's checks without permission, forging an elderly person's signature, misusing or stealing an elderly person's money or possessions, coercing or deceiving an elderly person into signing any document, and the improper use of conservatorship, guardianship, or power of attorney.

[18] Minority Staff Report, House Committee on Government Reform, *Abuse of Patients is a Major Problem in U.S. Nursing Homes* (July 2001)
[19] VHA Policy M-2, Part I, Chapter 35, paragraph 35.05c
[20] VHA CNH Handbook 1143.1, dated June 24, 2002
[21] 42 CFR § 488.300 (Subpart E), Section 301

Eligibility and Coordination

Eligibility for placement in a CNH is determined by reviewing each veteran's medical and administrative records. Service-connected veterans with spouses retain rights to monthly benefits during the durations of their CNH stays. Social workers working with service-connected veterans rated as incompetent for financial purposes should work with VBA F&FE employees to ensure fiduciaries or guardians are assigned to manage the veterans' funds. F&FE employees are responsible for assuring that fiduciaries assert and protect the rights of VA beneficiaries and their dependents to VA benefits, other assets, and income.

F&FE employees and VHA CNH review teams are frequently involved in cases of mutual concern. VBA policy requires the fiduciary activity supervisor to meet at least annually with appropriate personnel from each VA medical facility his or her jurisdiction to discuss services provided to incompetent veterans, including VA-sponsored veterans in CNHs.[22]

Scope and Methodology

We reviewed VHA's efforts to strengthen CNH oversight controls and procedures, and assessed veterans' levels of vulnerability to incurring adverse incidents such as abuse, neglect, or financial exploitation. In preparation for this review, we met with VA Central Office CNH Program officials, and at their suggestion, visited one medical center CNH activity, and three of that medical center's CNHs to learn more about current oversight and control processes and procedures and to test our examination tools.

We reviewed prior OIG and GAO reports and VHA actions taken to respond to recommendations. We reviewed new VHA CNH procedures issued in June 2002. In order to obtain background data on the nursing homes under contract with VHA, we utilized CMS websites and obtained and analyzed complaint violation investigations and OSCAR data. The OSCAR data include information on the results of State Medicaid inspections.

We selected eight VA medical facilities for review based on their high average daily CNH census. At each of these eight medical facilities, we visited and physically inspected three CNHs. At one site we inspected one additional nursing home because of local nursing home placement patterns. Therefore, we visited 25 CNHs out of the total 302 CNHs under contract by the 8 VA medical facilities during the review.

There were 737 veterans residing at the 302 CNHs. We reviewed the medical records of 111 of these veterans during our visits. In FY 2001, the average daily census nationwide was 3,990 and CNH expenditures totaled $325.6 million.

We reviewed local CNH contract files. We reviewed the contract specifications for requirements for state licensing and CNH employee background check requirements,

[22] VBA Policy M21, Part VIII, 6.08

VHA access to incident reports, CNH performance improvement data flow, and CMS minimum staffing requirements.[23] We also reviewed relevant local VHA contract nursing home policies. We reviewed the medical records of selected veterans in CNHs.

We interviewed the members of the CNH review teams at each of the eight VA medical facilities. At the CNHs, we interviewed veterans, and the administrators and directors of nursing. We also reviewed veterans' CNH medical records and conducted environmental inspections of the nursing homes in the presence of CNH managers. Finally, we explored interactions between the VHA CNH review teams, local CNH ombudsmen representatives, and state nursing home ombudsmen officials.

The information contained in this report reflects the data collected on our patient sample and associated CNH inspections. It also includes data we elicited through interactions with VHA and CNH employees that related to reports of episodes of abuse and neglect at nursing homes that had contracts to care for veterans. We also reviewed procedures for sharing information between VHA and VBA officials with respect to safeguarding incompetent veterans' financial affairs.

We conducted the evaluation in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[23] http// www.hcfa.gov/Medicaid/reports/rp700hmp.htm *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* page E.S. - 6

RESULTS AND CONCLUSIONS

Issue 1: VHA Policy on CNH Activities

Findings

VHA took years to implement OIG recommendations to standardize CNH inspection procedures and criteria for approving nursing homes for participation in the program. We believe this lengthy process contributed to variances over time in the way local managers and clinicians administered and monitored CNH activities, and consequently caused many of the repeated findings in OIG and GAO reports.

In response to the 1994 OIG report on CNH oversight activities, VHA managers acted on March 28, 1995, to revise M-5, Part II, Chapter 3. The revised policy included provisions for the establishment of CNH oversight committees at VA medical facilities and integration of the CNH Program into QM Programs. The 1995 policy required VHA-sponsored veterans in CNHs to be visited by VHA employees at least every 30 days, and as a minimum, by a nurse every 60 days. The 1995 policy also required VA medical facilities to review CNH clinical indicators to include pressure ulcers, falls, and medication errors.

In April 1996, VHA informed the OIG that the Veterans Integrated Service Networks (VISN) would incorporate CNH QM data into a new VHA performance management system. On March 14, 1997, VHA responded to our 1994 recommendation to provide CNH teams access to the data in CMS online systems. VHA assured OIG that VHA CNH review teams were being provided access to OSCAR data and would use it to evaluate and monitor CNH activities. At that time, the 1994 OIG recommendation to develop standardized CNH inspection procedures and criteria for approving CNHs for participation in the program remained unresolved.

The GAO, in its July 2001 report, again asserted that VHA's adherence to oversight policies had been mixed. The GAO found that VHA lacked a department-wide approach to monitoring medical center CNH activities. The GAO findings essentially paralleled the findings of the OIG's 1994 report. On June 27, 2001, the VA Secretary responded to the GAO report, and agreed that VHA's oversight of the CNH program needed strengthening. The VA Secretary informed the GAO that VHA would publish new policy before the end of the 2001 fiscal year.

In September 2001, and again in February 2002, VHA placed into its concurrence process a draft policy on CNH evaluation and follow-up services that would address both the OIG 1994 and GAO 2001 reports. On March 1, 2002, CNH headquarters program managers sent a VHA-proposed draft policy entitled, *VHA Community Nursing Home Procedures* to field activities for comments. The OIG also commented on the draft document on March 12, 2002, and made more than 20 suggestions to strengthen

controls discussed in the draft policy. OIG expressed concern that the draft policy sought to liberalize and not strengthen oversight processes.

In April 2002, we reported in the OIG SAR to Congress, our concerns that VHA had still not responded to our recommendation to strengthen oversight of its CNH Program. Further hindering the ability of VHA to provide the necessary leadership in implementing new CNH policy was the fact that the Chief Consultant of the Geriatrics and Extended Care position has been vacant since August 2001. The task of revising and clarifying CNH policy was given to this position and the Geriatrics and Extended Care Strategic Health Group several years ago.

The Under Secretary for Health signed a new VHA CNH policy on June 24, 2002, at the conclusion of this review. The June 2002 CNH policy addressed some of our earlier recommendations and some of the conditions identified during this review. The new VHA policy emphasizes the need for CNH review teams to critically review and score CMS information, which was a weakness identified during this review. It also establishes CNH exclusion and termination criteria and actions to be taken against local homes, thereby addressing recommendations made in our 1994 report. The new CNH policy requires reporting of all sentinel events or adverse patient occurrences to senior managers in the field and headquarters. The policy also requires CNH review teams transferring patients to CNHs outside their jurisdiction to coordinate the transfers with the responsible receiving CNH review teams overseeing the CNHs. This requirement was consistent with an OIG recommendation resulting from a recently issued Healthcare Inspection of a CNH.[24] Additionally, the new policy enforces the need to integrate CNH activities into the VA medical facilities' QM programs, which was a weakness identified during this review.

The new CNH policy, however, also differed in important details from the 1995 VHA policy. The 1995 policy required medical facilities to establish CNH oversight committees, but the June 2002 policy is silent on this requirement. The new policy does not clarify if it was the intent of policy makers to have VHA CNH review teams assume the responsibilities of the CNH oversight committees. This would include such functions as the oversight of placements, expenditures, and budgets. The new policy is not clear as to whether these functions would be the responsibility of the CNH review teams or other oversight committees.

The June 2002 VHA policy liberalizes standards for conducting initial reviews of prospective CNHs and deletes the requirement that new local contracts have inspections performed by VA employees. The initial reviews of locally-facilitated contracts differ from reviews of regional contracts. By not consistently applying criteria and inspection standards for both types of contracts VHA creates a risk of providing differing standards of care. By removing the requirement for initial inspections of CNHs under local contracts, VHA oversight of CNHs is weakened not strengthened.

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[24] OIG OHI, *Allegations of Wrongful Death in a VA Community Contract Nursing Home*, Report Number 01-00787-81, June 1, 2001

For example, the recently issued VHA policy permits a VA representative from the CNH review team to visit the CNH in lieu of conducting a multi-disciplinary initial inspection if the paper review does not reveal deficiencies. The policy does not clarify what is to be done if the visit raises additional concerns. The policy does not clarify whether the visits preclude Safety Officers from conducting LSC inspections, or whether a VA representative or Safety Officer would visit, or whether a Safety Officer alone could be the VA representative in these cases.

The recently issued VHA policy is also not consistent with instructions issued by the Deputy Under Secretary for Health for Operations and Management, who required that LSC inspections be conducted annually, or in some cases every 3 years.[25] As written, the new VHA policy requires locally-contracted CNHs to have initial LSC inspections, but there is no provision for mandatory subsequent reviews. This further liberalizes CNH oversight activities.

There are no provisions in the June 2002 VHA policy for requiring CNHs to provide VA assurances that their employees' clinical qualifications are current, or that CNH employees do not have criminal histories, and are free from substance abuse. These are standards required of VHA clinicians entering employment at parent VA medical facilities.

Additionally, the recently issued CNH policy liberalizes the requirement for CNH review teams to routinely visit veterans who are long-term placements, or are residing in CNHs more than 50 miles away from the parent VA medical facility, under certain circumstances. These CNH veterans could be seen every 90 days, or in some cases over longer periods.

Conclusions

VHA acted to implement new CNH policy on authorizing, overseeing veterans' care, and monitoring compliance, at the conclusion of this review. However, the new VHA CNH policy liberalizes or is silent on several important oversight controls that were established in 1995.

As written, the policy needs some modification to make it more likely that veterans will receive good care. Also, it does not remove discrepancies in the evaluation requirements between locally-contracted and regionally-contracted nursing homes. Rather, it appears the policy was liberalized to reduce operating costs and employee resources that would need to be devoted to CNH oversight functions. We concluded that the VHA policy continues to need clarification in prescribing the responsibilities of CNH review teams, inspection procedures, monitoring requirements, and contracting provisions.

[25] VHA Information Letter (IL 10N-2000-002)

Issue 2: Risk of Adverse Incidents

Findings

We concluded that veterans in CNHs are vulnerable to incurring abuse, neglect, and financial exploitation. The veterans and families we visited were generally well cared for, and mostly satisfied with CNH services and accommodations. However, our review found reports of veterans in CNHs subjected to abuse, neglect, and financial exploitation, and veterans residing in CNHs in which non-veterans have been subjected to such adverse incidents. Sixty-three percent of the CNH review teams we interviewed knew of veterans who reported abuse or neglect while residing in CNHs. These CNH review teams had taken actions that ranged from the removal of a veteran from a CNH to canceling the CNH contract and reporting the incident to appropriate Government agencies. Rather than reacting to such incidents, we believe VHA could reduce the risk of such occurrences by strengthening oversight controls.

Currently, VA policies prescribe that VHA health care employees are responsible for immediately reporting suspected abuse.[26] If criminal abuse or exploitation is suspected, the information should be forwarded to the VA facility police and regional counsel.[27] A copy of the incident should be forwarded to the OIG for information. VHA clinicians and managers also need to determine whether the suspected infractions, if confirmed, warrant further actions against the CNHs. Such actions might include reporting the information to State Licensing Boards and pertinent Federal agencies, and transferring veterans to other facilities. The June 2002 VHA policy, Part 11 (f) 1, instructs VHA CNH review teams visiting CNHs to observe and gain impressions about the overall care provided to CNH residents and document them. The new VHA policy requires CNH review teams to review CNHs for patient abuse or neglect, and the quality of sensory and environmental aesthetics. The new VHA policy requires potential abuse or neglect and other adverse conditions to be reported to the VHA CNH review team and to the VISN office.

CMS-approved nursing homes are required to have policies and procedures for identifying, assessing, evaluating, managing, and reporting suspected abuse, neglect, and exploitation. The CMS requires that states designate a specific telephone number for reporting complaints and that all nursing homes publicize these numbers. Residents, families, friends, physicians, and nursing home employees can submit complaints.

We visited 25 CNHs and sampled 111 patient records. We found incidents in which veterans were reportedly subjected to abuse, neglect, or financial exploitation, and other incidents in which non-veterans in the homes were reportedly subjected to abuse or neglect. The study sample of 111 veterans residing in CNHs had an average age of 72.5 years (range 46-93 years). Sixty-five percent of the veterans had diagnoses of significant psychiatric disorders. Thirty-one percent of the veterans had diagnoses of

[26] VHA Policy M-2, Part I, Chapter 35, paragraph 35.05c
[27] 38 C.F.R. 14.560

dementia. Twenty-nine percent of the veterans suffered from serious heart problems and 13 percent were epileptic.

We found that 36 percent of the CNH administrators in our sample held their positions for a year or less. Similarly, about the same ratio of directors of nursing at these CNHs were in their positions less than a year.

We were able to interview 72 of the 111 veterans in our sample. The remaining veterans were not able to carry on rational conversations, or were not able to speak with us because they were at clinics or were otherwise unavailable. Of the 72 veterans interviewed, 49 (68 percent) told us they relied on someone to help them make medical decisions on their behalf and handle their finances.

We found 9 (8 percent) of the 111 veterans whose records we reviewed had been subjects of reported abuse, neglect, or financial exploitation.[28] The reported incidents identified consisted of three cases of neglect, three cases of verbal or physical abuse, and three cases of financial exploitation. Examples of CNH-reported adverse incidents follow:

> A 59-year-old veteran sustained a burn at a CNH when hot coffee spilled in his lap. His spouse alleged that nursing home employees failed to adequately care for his burns. Because the CNH did not conscientiously address the injury when it occurred, the veteran's condition worsened, and he eventually had to be admitted to a VHA medical facility where he received surgical debridement of his wounds and skin grafting. Upon completion of this surgery, the patient's spouse and VHA physician were reluctant to return the veteran to the nursing home for continued care. The incident prompted CNH managers to revise procedures for serving coffee and promptly responding to such incidents. The veteran returned to the CNH.
>
> In another case, a Certified Nursing Assistant (CNA) taunted an 81-year-old veteran resulting in a violent reaction that led the patient to strike, punch, and curse at other members of the nursing home staff. In this case the CNA was fired.

While not in our sample, we found other examples of veterans at the VHA CNHs who experienced adverse incidents. For example:

> A veteran at a contracted CNH we visited fell from his chair in February 2001, and was taken to a local emergency room where he received 12 stitches to repair a head laceration. Despite the stitches, his head wound continued to bleed (he was taking two medications that impaired blood clotting) thus requiring the veteran to return to an emergency room to

[28] The confidence level was 95 percent with a sample size of 111 and a population of 737, which yielded an average 8.1 percent [+- 4.7 percent] or a 3.4 to 12.8 percent range of incidents in the population

have his stitches replaced. He sustained a second fall 2 days later at the nursing home. The CNH did not timely contact the family after the veteran fell. The veteran's daughter arrived at the nursing home and he did not recognize her. The daughter insisted that the veteran be taken to the VA medical facility for further evaluation and treatment. The veteran was admitted to the Intensive Care Unit at the VA medical facility and died 16 days later. The veteran's daughter reported the incident, which is currently under review by the state Ombudsman.

A 100-percent service-connected veteran CNH resident with multiple sclerosis was found by a court to have suffered a loss of at least $13,974 from his personal checking accounts. This was done through the deliberate and wrongful actions of a CNA who was employed first by the nursing home and then by the patient. The court found the CNA guilty of misappropriating the veteran's property under the provisions of the Federal Nursing Home Reform Act. [29] [30]

During the course of our CNH visits we also found examples of abuse and neglect of non-VA residents. For example:

In October 2001, a non-VA female resident with Alzheimer's disease wandered from her room into the CNH's fenced-in courtyard on a night when the temperature was reportedly around 40 degrees. The patient wandered outside unnoticed because nursing home employees deactivated the door alarm to allow for smoking breaks. She was found dead around 4:30 a.m., outside the facility. Nursing home employees did not immediately notify the resident's family of this tragic situation but instead returned the dead patient to her room. An autopsy determined that the patient had died of heart disease aggravated by exposure to the cold. An investigation is currently underway to determine the circumstances surrounding this death.

At the time of our inspection, two CNAs were arrested for an assault on an 89-year-old non-VA resident that left him with 3 broken ribs.[31] The two CNAs were arrested for physically assaulting the resident. Two VA-sponsored veterans were residents in the CNH and another veteran was pending discharge and scheduled to be placed at the CNH. At our suggestion, the CNH review team notified the veteran residents and their families of the incident and gave them the option of staying or transferring to another CNH. We also encouraged the CNH review team to place a hold on placements pending the outcome of the investigation, and

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[29] Department of Public Health, Petitioner V. Julia T. Tebeau respondent docket number 97-0195 Common Wealth of Massachusetts

[30] 42 U.S.C. §1396r and §1395i - 3

[31] http://ap.tbo.com Tampa Bay on line quote police; 89-Year-Old Man Assaulted by Largo Nursing Home Staff" Associated Press, March 28, 2002

suggested they conduct an immediate inspection of the facility as opposed to waiting until the CNH's annual contract renewal date, which was about 5 months away.

The examples highlighted above illustrate the importance of VHA implementing safeguards to protect residents from potentially significant adverse incidents.

Conclusions

Veterans in CNHs constitute an elderly, frail population who are reliant upon others when making significant medical and financial decisions. The apparent instability of CNH leadership in our sample punctuates the importance of VA oversight of veterans in CNHs to ensure that our veteran residents' continuity of care is adequately followed.

VHA has been slow in providing new policy for the CNH program in response to OIG and GAO program findings and recommendations. VHA CNH review teams confirmed to us during interviews that veterans are at risk for abuse and neglect in CNHs. Our review identified reports of abuse and neglect with an average incidence of 8 percent. The risk for abuse and neglect is faced not only by veterans, but by all residents who reside in CNHs, as this report demonstrates. VHA needs strong oversight policy that will safeguard veterans from adverse incidents and ensure they receive good care while in non-VA CNH facilities.

Issue 3: Follow-up on the Unresolved Recommendations and Implementation of CNH Oversight Controls

Findings

VHA responded to the OIG's 1994 recommendation to strengthen its oversight policies by developing and publishing standardized CNH inspection procedures and criteria for approving homes for participation in the program, at the conclusion of this review. However, during this review, the implementation of OIG and GAO prior recommendations by local VHA CNH review teams still varied among medical facilities.

We found that CNH coordinators and review teams still were not using available CMS information to assess whether CNHs under review had been the subjects of reported violations and investigations. VHA CNH review teams did not consistently conduct initial reviews or annual inspections of the CNHs in their jurisdictions. Also, we found contracting processes needed strengthening, and CNH review teams still were not visiting veteran residents monthly to ensure that the provisions of the contracts were upheld, and that veterans were receiving good, safe care. In addition, we found that CNH activities were still not integrated into each medical facility's QM programs, and that interdisciplinary QM program monitors to address the quality of care for CNH veterans were not implemented.

Use of CMS External Information During Initial and Follow-up Inspections

Our review showed that VHA managers were not always using CMS external information to assess the quality of care provided at CNHs. We reviewed CMS investigations and OSCAR annual state inspection reports available from Government websites. CMS provides detailed information about the performance of every Medicare and Medicaid-certified nursing home in the country. The data include health deficiencies found during the nursing homes' most recent state nursing home surveys and recent complaint investigations. Substantiated violations of nursing homes cited for placing residents in harms-way or in immediate jeopardy result in the nursing homes being placed on a CMS "watch list" that identifies the nursing homes and the offending issues or violations.

We reviewed the watch list for all nursing homes that had active contracts with VA medical facilities at the eight sites we visited. Seven of the 8 VA medical facilities had active contracts with 41 nursing homes listed on the CMS watch list. Of the 41 nursing homes on the watch list, 7 (17 percent) were managed at VA headquarters under regional contracts.

It is significant to note that veterans were disproportionately placed in CNHs that were on the CMS watch list.[32] This condition suggests that managers have not adequately monitored CMS information, which adds risk to CNH placements. There were 198 (27 percent) of the 737 CNH veterans in our population residing in these 41 nursing homes. Nineteen (10 percent) of the 198 veterans residing in watch-listed nursing homes were in CNHs under regional contracts. The watch list cited the 41 nursing homes 273 times for administrative and quality of care violations. Of the 273 violations, 140 (51 percent) were quality of care violations.

We found that VHA CNH review teams did not always analyze OSCAR data and other relevant data before initiating the contracts or conducting annual follow-up inspections. Our results showed that 75 percent of the CNH review teams (6/8) reported conducting annual inspections and reviewing the deficiency reports prior to the annual inspections. Only 13 percent of the CNH review teams (1/8) reported that they reviewed the Quality Improvement profiles of the nursing homes participating in the program, annually. Moreover, only 25 percent of the CNH review teams (2/8) told us that they reviewed the OSCAR report annually. CNH coordinators also told us they did not routinely communicate with ombudsman officials in each state to determine whether any quality of care issues existed.

VHA CNH review teams told us these conditions existed because they considered other factors when placing veterans in nursing homes and because of resource constraints. In some cases, CNH coordinators kept veterans in these nursing homes at the families'

[32] Veterans in watch list homes = 198/737 or 27 percent; watch list homes = 41/302 or 14 percent

requests because of the close proximity to their homes. In other cases, the veterans were difficult to place elsewhere because of psychosocial problems.

Many of the CNH review team members told us that overseeing CNH activities was a collateral duty, and they did not always have the time to research and monitor external program data. Not using CMS data to research the histories of CNHs prior to entering into contracts and selecting homes for veterans to reside in increases the risk of placing veterans in CNHs that have histories of providing questionable care.

Standardized Inspection Procedures

Initial and Follow-up Inspections of CNHs

We found that multi-disciplinary teams were not always used for initial and follow-up inspections of CNHs, a condition described in prior OIG and GAO reports. VHA requires that Medical Center Directors designate CNH review teams which consist at a minimum of a registered nurse, a social worker, a physician, a dietician, a pharmacist, a fire safety officer, a contracting officer, an environmental management specialist, and a medical administration specialist.[33] The functions of the CNH review team include: reviewing all annual and interim inspection findings of other agencies and following up on these findings; reviewing appropriate available findings of the state Ombudsman or local complaint office; and evaluating the use of quality assessments and performance improvement activities to improve care and correct problems.

CNH review teams are supposed to use these tools to determine whether to contract with the CNHs to care for veterans, to continue services, or to discontinue the use of the CNHs' services. New VHA policy provides local managers discretion in the disciplines that constitute these CNH review teams for overseeing CNH activities. This change in policy adds further variation to the mix of disciplines that will review the adequacy of CNHs for potential veteran residents.

In regard to inspections of nursing homes prior to initial contract awards, we found that 15 (88 percent) of the 17 local contract files that we reviewed contained inspection reports by social workers and nurses.[34] Dietitian inspections were completed only 41 percent of the time (7/17). Safety officer inspections were only documented 59 percent of the time (10/17). Pharmacist input to inspections was only documented 29 percent of the time (5/17).

We visited eight nursing homes with multi-state CNH contracts. These contracts were not available at the VA medical facilities. Through interviews with the CNH coordinators and review teams, we learned that these nursing homes were not physically inspected at the initiation of the contracts or annually thereafter. The variation in inspection

[33] VA Policy M-5, Part II, Chapter 3, CNH Program

[34] We reviewed 17 locally issued contracts that required initial and annual inspections by CNH review teams. The remaining eight CNHs were operating under regional contracts, and did not require initial or annual inspections. These contracts were retained in VHA headquarters.

requirements between local and regional contracts adds another potential vulnerability to the overall CNH oversight process.

VHA CNH review teams told us that forming complete teams was not always possible because of the utilization of part-time employees who had other principal duties and could not devote sufficient time to overseeing CNH activities as a collateral duty. This factor, and other resource constraints, caused managers not to fully staff CNH review teams with all the required disciplines as outlined in the 1995 VHA CNH policy. It also appears this led to the June 2002 CNH policy giving managers more flexibility in whether to conduct initial or annual inspections.

Standardizing CNH Contracting Criteria

We identified several contracting features that, if standardized, could reduce the risk of patient abuse, neglect, and exploitation. At the 8 VHA sites, we evaluated 17 locally-developed contracts.[35] We found that only 59 percent of the local contracts (10/17) required CNHs to have state licenses, and only 35 percent of the local contracts (6/17) required CMS certification. One of the 25 CNHs we visited did not have a current state license on file. Upon further inspection, we found that the CNH had applied for license renewal but the state was slow to respond. At another site, the contracting officer was not aware the CNH had been sold and was under new ownership. Therefore, an assurance that the new owner had a license was not obtained. Ensuring that CNH facilities are licensed reduces the risk that they are not following prescribed state requirements. Also, using CMS-approved CNHs to the fullest extent possible strengthens the oversight of the nursing homes by other Government agencies.

Contracts did not require CNHs to provide VHA CNH Program coordinators routine performance data on issues such as the incidence and treatment progress for residents' skin breakdowns, medication errors, or patient falls. None of the contracts required the nursing homes to assure that their employees did not have criminal backgrounds or substance abuse histories. This differed from practices at our pilot VHA medical facility and three of its CNH sites in that all of the nursing homes submitted routine performance improvement data, conducted state background investigations, and required employees to agree to state drug testing.

We found that only 12 percent of the contracts reviewed (2/17) set standards equal to the CMS minimum-acceptable staffing required for VA residents. Of the CNHs visited, 40 percent of them provided less than the CMS minimum standard of 2 hours of CNA time per patient day. We also found that 32 percent of the CNHs did not provide the CMS minimum standard of 0.45 hours per resident per day of Registered Nurse (RN) time.[36]

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[35] We reviewed 17 local contracts and 8 regional contracts at VHA Headquarters

[36] http//: www.hcfa.gov/Medicaid/reports/rp700hmp.htm *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* Page E.S.- 6

Additionally, contracting officers generally did not routinely discuss negotiations and contract issues with VHA CNH review teams before awarding contracts. Designating the CNH coordinator or other applicable clinician as the contracting officer's technical representative would enhance the contract administration process.

We noted that CNH contracts did not prescribe transportation requirements for veterans who would require frequent visits back to the VA medical facilities for rehabilitation or other medical needs. In fact, we found the issue of transporting CNH veterans between facilities a cumbersome process that needed improvement. CNH veterans often require transportation to their supervising VA medical facilities for routine and complex medical care, such as physical therapy, even when the care is offered at the CNHs. This is necessary because contracts have been limited to only providing for the placement of the veterans into CNHs with the expectation that VHA facilities would provide ancillary services.

Transports, which were paid under different contracts, often delivered the veterans to their VA medical facilities prior to their appointments. Following the appointments, there were often delays in obtaining transport back to the CNHs. During these periods of waiting, veterans were often unsupervised and had difficulty obtaining regularly scheduled medications, appropriate meals, and bathroom access. This was clearly a significant issue for most of the CNH veterans whom we interviewed, but there was little evidence in the medical records that VHA managers and clinicians were monitoring this issue to ensure these transportation problems were minimized.

New VHA CNH policy allows veterans to receive rehabilitation therapies at VA expense at CNHs. This should reduce the risk and inconvenience associated with veterans having to be transported to and from VA medical facilities 3-4 days per week and left unsupervised for sometimes lengthy periods of time. However, the new CNH policy is not clear as to whether this provision could apply to other treatment needs such as speech therapy or psychiatric consultations when veterans have acute episodes warranting immediate attention and a psychiatrist is on the CNH staff.

VHA Monthly Visits to CNHs

Not all VHA medical facility managers accepted the requirement that CNH review team members visit veterans in CNHs every 30 days. Some VHA managers asserted that this process duplicated state inspections, and was inefficient because the VA clinical staff assigned to these duties could better be utilized elsewhere in the VA medical facility. Half of the 111 VA medical records we reviewed did not contain evidence of nursing progress notes every 60 days and only 56 percent of the VA charts contained social worker or nurse progress notes every 30 days. Only 50 percent of the nurse progress notes that we reviewed contained evidence that nurses physically examined the veterans while 73 percent of the social work notes contained relevant information about the veterans' psychosocial issues.

We accompanied nurses and social workers, assigned to oversee CNH activities, to the nursing homes. We observed some CNH review team members, who had been assigned to teams for some time, introducing themselves to the nursing home personnel as if they were strangers. The records at the VA medical facilities and CNHs visited, contained inadequate documentation by the CNH review teams, and visiting nurses and social workers, to demonstrate that CNH residents were receiving good nursing home care. CNH policy encourages maximizing first-hand knowledge of the care provided in nursing homes and encouraging the VA medical facilities to utilize those CNHs that will provide the best care to veterans. In a substantial number of cases, we believe the personal monitoring of veterans by VHA clinicians was not always being effectively accomplished.

In contrast, during our inspection at one of the CNHs, we learned that veterans complained directly to a CNH review team nurse of poor care. In reaction to these complaints, VHA managers further investigated the complaints and determined that veterans' skin care at the CNH was not adequate. CNH review team members promptly removed all veterans from the nursing home due to their findings of inadequate care. This example of CNH review team intervention was possible because the medical facility demonstrated a proactive approach to ensuring the safety and well being of our veterans in non-VA institutional settings.

The June 2002 VHA policy reduces the need for CNH review teams to routinely visit long-term veteran placements, or residents residing more than 50 miles away under certain circumstances. These CNH veterans could be seen every 90 days instead of every 30 days, which was the standard prescribed by VHA's 1995 CNH policy. The new CNH policy does not clarify exceptions to this new rule (e.g. long-term placements and residents residing more than 50 miles away who need to be seen more frequently because of their medical conditions and veterans who do not have family support systems). The risk of adverse incidents occurring and not being addressed increases once VHA CNH review teams extend periodic visits to veterans in nursing homes from 30 days to 90 days.

CNH Performance Data and QM Oversight

Because contracts did not require performance data, none of the VHA CNH review teams interviewed reported receiving and critically analyzing performance improvement data from nursing homes (e.g. monitors of bedsores, falls, medication errors, complaints, and other indicators). In one veteran's medical record, we found that a VHA medical facility admission history and assessment form (Part 7) "...suspected abuse/neglect screening" was not properly utilized on several admissions to a VHA medical facility. In the last months of this veteran's life he was transferred between the VHA medical facility and the nursing home several times. As he medically deteriorated he progressively developed multiple areas of skin breakdowns. In this case, the failure of quality improvement processes to monitor and trend data routinely available on veterans' VHA admission records resulted in a missed opportunity for VHA clinicians to

intercede in the care of this veteran who was slowly medically deteriorating as he was transferred between facilities.

We also found that VA medical facility QM programs had not integrated CNH performance into their plans. Of the eight sites visited, none incorporated CNH activities into their QM Programs. Consequently, CNH performance data was not reviewed or analyzed to permit VA clinicians to work with CNH employees to improve clinical issues that would benefit from performance improvement initiatives.

Conclusions

We concluded that VHA's efforts to strengthen CNH oversight controls as recommended by prior OIG and GAO reports continued to need improvement. VHA CNH initial and annual inspections were inconsistently performed and when performed they were done without the data available online through CMS websites. CNH review teams were not ensuring that veteran residents were visited monthly as required. The fact that CNH review teams placed 27 percent of the veterans in our sample in CMS watch listed homes is an indication that this information is not reviewed or used when considering veteran placements.

Current VHA local contracts do not set appropriate standards for the procurement of health care in that they frequently do not require that CNHs meet basic standards of state licensure, CMS certification, and minimum CMS-recommended staff-to-patient ratios. Local contracting officers did not have, and were not familiar with, the provisions of regional contracts. Local and regional contract provisions must sufficiently align to ensure one standard of care is provided to veteran residents regardless of whether they are placed under the provisions of local contracts or regional contracts. None of the eight sites we visited incorporated data from the CNH Program into their ongoing QM programs.

VHA program managers issued new CNH policy at the conclusion of this review. VHA needs to strengthen and clarify this policy, and discuss the need to strengthen CNH oversight in VISN and VHA facility manager meetings, and educate VHA facility coordinators, teams, contracting personnel, and other applicable employees of the need to consistently apply these requirements to all CNHs in their programs. VHA CNH review teams need to more critically analyze reported incidents of abuse, neglect, and exploitation, and increase efforts to work closer with state ombudsmen officials to ensure CNHs are not contracted if they are not CMS-approved.

VHA CNH expectations and requirements must be clearly documented and communicated to CNH administrators, and VHA managers need to strengthen controls to ensure VHA clinicians and managers effectively and routinely monitor veterans' care at CNHs, and while they are in transport to and from these facilities. VA medical facilities' QM programs need to include reviews of the quality of the care provided to veterans residing in CNHs.

Issue 4: Coordination between VHA and VBA

Findings

Strengthening efforts to share information on CNH veterans' health statuses could enhance VHA and VBA oversight of veterans' care and financial welfare. We found several examples of veterans who were incompetent to handle their own financial affairs that needed to be referred to VBA for action. Conversely, we found VBA field examiners could benefit from exchanging information with VHA CNH coordinators on veterans of mutual concern.

F&FE units, located in VA Regional Offices (VAROs), are responsible for assuring that fiduciaries assert and protect the rights of VA beneficiaries and their dependents to VA benefits, other assets, income, and other benefits, regardless of the source. To fulfill these responsibilities, F&FE personnel perform initial and subsequent field examinations and analyze and audit accountings prepared by the fiduciary.

F&FE employees, and social workers or other case managers at VA medical facilities are frequently involved in cases of mutual concern. VHA has primary responsibility for the coordination of all services to veterans enrolled in the CNH program. F&FE employees are responsible for protecting the VA-derived income of incompetent veterans. To provide the best possible services to veterans and their dependents and to prevent duplication of efforts, there must be an understanding by employees in each program of the others' goals and priorities, and the recognition of the need for joint cooperation and consultation in areas of mutual concern. Currently, VBA policy requires the fiduciary activity supervisor to meet with appropriate personnel from each VA medical facility in his or her jurisdiction at least once each year for this purpose.[37]

The importance of protecting the VA-derived income of incompetent veterans has recently been enhanced by legislation that repealed the ($1,500) limitation of veterans' benefits. Public Law 107-103, the Veterans Education and Benefits Expansion Act of 2001, Section 204, repeals the limitation of benefits for incompetent institutionalized veterans and amends 38 U.S.C. Section 5503.

F&FE employees have a duty to assist all VA beneficiaries. This responsibility applies when oral or written information is received on veterans not within the fiduciary program, from VHA or other sources, and when the veterans can be assisted within the scope of VA responsibility. When information is received that a veteran may not be capable of handling his or her funds, or is being deprived of his or her rights, further inquiry should be made to determine the facts, by field examination if necessary.[38]

Fiduciary activity supervisors should meet with appropriate VA medical facility personnel at least annually to discuss areas of mutual concern, because VBA policies do not require examiners to closely follow incompetent veterans under VHA supervision in

[37] VBA Manual M21-1, Part VIII, Section 6.08
[38] VBA Manual M21-1, Part VIII, Section 2.05

CNHs. F&FE employees are required to contact VA medical facilities, domiciliaries, or CNHs by telephone every 3 years to confirm that incompetent veterans, supervised by court-appointed fiduciaries or guardians, have remained at the facilities. The examiners are required to ensure there are no anticipated release dates, and determine the sizes of the estates during these telephone conversations.[39]

We found the VHA CNH review teams and coordinators do not meet annually with F&FE activity supervisors to discuss veterans of mutual concern. We also found that CNH clinicians and managers do not always contact F&FE employees or other appropriate VBA personnel when CNH veterans' cognitive capacities change (e.g. competent to incompetent). VHA CNH clinicians and managers confirmed with us their belief that veterans under their care are not the responsibility of VBA, and therefore, communication has been limited, even to 3-year intervals. VBA officials also confirmed with us that their F&FE employees generally defer to VHA when veterans are residing in contracted CNHs. Better communication between these groups could reduce the risk of financial exploitation and protect VA-derived payments.

We believe this is important because one-third of the reported abuse and neglect that we identified in our study sample represented financial exploitation. VHA is charged with determining the medical status of veterans under its care, to include their cognitive capabilities. VBA has the responsibility of ensuring that money provided to veterans through the VA is utilized to benefit the veteran. When a veteran is determined to be incompetent, VBA will take administrative actions to provide proper fiduciary control of the veteran's assets.

Our review of the veterans' VHA medical facility discharge summaries found that statements regarding the veterans' competence to handle their financial affairs were most often absent. There appeared to be no consistent or timely method of alerting VBA to changes in the competency levels of veterans or changes in marital status that might affect benefits. VHA CNH review teams and F&FE employees also rarely share information such as OSCAR data, and F&FE Reports of Adverse Conditions in the Distribution of Operational Resources (DOOR) system. However, F&FE officials acknowledged that the data in these DOOR system reports are not always complete.

Increasing communication and coordination between VHA and VBA officials could achieve positive results. For example, we discussed the conditions of 12 veterans residing in 3 CNHs with F&FE employees at a VARO. The following 3 cases describe the importance of VHA communicating changes in CNH veterans' conditions to VBA.

> One veteran, receiving 100-percent service-connected compensation of $2,287 monthly, had been admitted to a CNH in November 2000. During our interview with the veteran, review of the medical record, discussions with the VHA social worker, and interview with his daughter, we became concerned that the veteran was not competent to handle his own affairs. We also learned from the daughter that the veteran's spouse had died.

[39] VBA Manual M21-1, Part VIII, Section I (6-13)

We discussed this case with the F&FE employee, and he obtained a copy of the spouse's death certificate from the daughter, and a physician's statement from the VHA medical facility documenting that the veteran was incompetent. After a 60-day due process period, the final rating of incompetence will be initiated, and a field examiner will visit the CNH to appoint a fiduciary for the veteran's benefits and begin accounting for the VA-derived funds. VBA will adjust the veteran's award, and begin following up on the account to ensure his funds are safeguarded.

Another veteran, receiving 100-percent service-connected compensation of $2,546 monthly, had been admitted to a CNH in December 2001. During our interview with the veteran, and review of the medical record, we became concerned that the veteran was not competent to handle his own affairs. VBA records showed the veteran was married. However, the checks were forwarded to his sister via direct deposit. We discussed this case with the VHA social worker, and F&FE employee and they obtained the necessary documentation confirming that the veteran was incompetent. After a 60-day due process period, the rating of incompetence will be resolved. A field examiner has been assigned to visit the family and the veteran to determine the status of the spouse and funds. Action will be taken to appoint an appropriate payee at that time to ensure the veteran's VA-derived funds are protected.

Another service-connected veteran rated 40 percent for hypertension and stroke was admitted to a CNH on April 9, 2001. After reviewing the medical record and discussing the case with the VHA social worker, we became concerned about the competency status of the veteran, and the spouse's ability to financially manage the veteran's funds. We discussed the case with a VBA F&FE employee, who conducted a field examination. As suspected, VBA was required to replace the spouse as the payee, and appoint a professional guardian as legal custodian to safeguard the veteran's benefits.

F&FE employees told us that these conditions existed because reductions in VBA field resources and increasing workloads have made it difficult for F&FE employees to routinely meet with VHA CNH review teams. They also told us that annual visits with VHA personnel were discontinued several years ago.[40] VBA program officials were aware that their reporting of adverse incidents in the DOOR system needed improvement and they were in the process of addressing this issue. VBA program officials also acknowledged that communication efforts have declined over the past several years because of resource constraints and increasing workloads, and informed us they have begun addressing this issue. They also pointed out to us that VHA does not have a similar policy to meet with VBA annually, which made compliance with their VBA policy problematic. VHA CNH coordinators and review teams were unaware of the VBA policy, or informed us that VHA does not have a similar policy to meet at least

[40] VBA Senior Managers indicate that annual meetings are still required by M21-1, VIII, 6.08.

annually with VARO F&FE employees. Because there was no VHA requirement to meet with F&FE employees routinely, this was not done.

Conclusions

We believe it is important for effective communication to exist between VHA and VBA because it maximizes the likelihood that a fiduciary is appointed when needed given the vulnerability of the elderly CNH population. Veterans could be better served, and actions could be taken to reduce risks of adverse events, if VHA CNH clinicians and managers and VBA F&FE employees would meet annually, increase the sharing of information pertaining to changes in veterans' competency statuses, share inspection and evaluation data, and routinely communicate telephonically.

RECOMMENDATIONS AND COMMENTS

Recommendation 1:

The Under Secretary for Health needs to ensure that:

a. VHA medical facility managers devote the necessary resources to adequately administer the CNH program.

b. Critical aspects of the new VHA policy are discussed with senior managers, CNH review teams, and other applicable QM Program employees using education and training mediums.

c. VHA medical facility managers emphasize the need for CNH review teams to access and critically analyze external reports of incidents of patient abuse, neglect, and exploitation, and to increase their efforts to collaborate with state ombudsman officials.

d. Clarify whether the new VHA policy intended the responsibilities of CNH oversight committees to be extended to CNH review teams or some other committee.

e. Consistently apply local and regional contracting requirements to preclude the potential for them to provide differing standards of care.

f. Survey requirements for LSC compliance are clarified between the recently issued CNH policy and instructions issued by VHA in April 2000.

g. Contracting officers strengthen the contracting process by requiring CNHs to produce current state licenses, CMS certifications, assurances of the clinical competency and backgrounds of CNH clinical employees, CMS or State minimum standards for staffing levels to provide direct nursing care to veterans on a daily basis, and submissions of routine performance improvement data.

h. CNH review teams are reminded to critically evaluate and mitigate the risks associated with routinely transporting veterans between CNHs and VA medical facilities.

i. Clarify exceptions to visiting long-term placements and residents residing more than 50 miles away from the parent medical facilities at least quarterly, particularly in the cases of veterans who need to be seen more frequently because of their medical conditions or absence of family support systems.

j. Managers integrate CNH activities into medical facility QM programs and review performance data to monitor bedsores, medication errors, falls, and other treatment quality indicators that may warrant their attention.

Recommendation 2:

The Under Secretary for Health needs to coordinate efforts with the Under Secretary for Benefits to determine how VHA CNH managers and F&FE employees can most effectively complement each other and share information such as medical record competency notes, OSCAR data, and F&FE Reports of Adverse Conditions, to protect the financial interests of veterans receiving health care and VA-derived benefits.

Under Secretary for Health Comments

The Under Secretary concurred with all the recommendations except 1i. See Appendix A for the Under Secretary's comments and corrective action plans.

Under Secretary for Benefits Comments

The Under Secretary agreed with the findings and the recommendation. The Under Secretary proposed that Central Office VHA senior managers and VBA Fiduciary staff meet to determine what information would be of value to share and the proper procedures for this exchange of information. See Appendix B for the Under Secretary's comments and corrective action plan.

Inspector General Comments:

The Undersecretary for Health concurred with our findings and all but one of our recommendations (1i). Upon further review and consideration of the Under Secretary's response to recommendation 1i, we agree that no immediate action is required but we encourage VHA managers to closely monitor this important issue. The Undersecretary provided acceptable detailed implementation plans on the remaining recommendations. The Under Secretary for Benefits concurred with our findings and recommendation and proposed a meeting between VHA and VBA Central Office managers to determine what and how information should be shared. We will follow-up on the planned actions until they are completed.

Appendix A

UNDER SECRETARY FOR HEALTH COMMENTS

Department of Veterans Affairs

Memorandum

Under Secretary for Health (10/105E)

OIG Draft Report: ***Healthcare Inspection-Review of VHA Community Nursing Home (CNH) Program*** (Project No. 2002-00972-HI-0129) (EDMS 193404)

Assistant Inspector General for Healthcare Inspections (54)

1. In VHA's August 28, 2002 initial response to the referenced report, I noted my charge to the Health Systems Committee of the National Leadership Board to convene a work group to fully explore your findings and recommendations and develop a viable plan of corrective action to address identified deficiencies. I am very pleased to report that the group did an outstanding job in both systematically defining the expected elements of a first rate CNH oversight process, as well as in delineating specific steps that will be taken within VHA to assure implementation of corrective actions in response to report recommendations. Attached is the work group's proposal, which serves as VHA's official response to this report.

2. As detailed in the proposal, VHA concurs in all recommendations but 1i: that the newly-developed CNH Handbook clarify expectations on visiting (at least quarterly) long-term placements and residents residing more than 50 miles away from the parent facilities. We believe that the current Handbook approach is specific and practical in addressing this issue, and our comments detail our reasoning in this regard. If you have some specific points in mind regarding the visit expectations, we welcome your comments.

3. I am also pleased to announce that a new Chief Consultant for Geriatrics and Extended Care has recently been selected. Dr. James F. Burris, previously VA's Deputy Chief Research and Development Officer, brings extensive experience in geriatric medicine to this position. Dr. Burris has been briefed about the CNH work group proposal, and will oversee implementation of the approved action plan.

4. Thank you for your assistance in helping us to prioritize improvement opportunities in our CNH oversight processes. Under the supervision of Dr. Burris and other members of the Geriatrics and Extended Care staff, I am confident that the proposed actions will be fully implemented. We look forward to sharing our progress to you through upcoming status updates. If additional information is required, please contact Margaret M. Seleski, Director, Management Review and Administration Service (105E), Office of Policy and Planning (105), at 273-8360.

Robert H. Roswell, M.D.

Attachment

OIG Recommendation 1a:
"VHA medical facility managers must devote the necessary resources to adequately administer the CNH program"

Workgroup response: Concur

Action Plan:
It is recommended that:

1) the Chief Consultant, Patient Care Services (or designee) collaborate with the CC-GEC and with the Chief Consultant, Office of Quality and Performance to identify one or more Network Director indicators (e.g., self-report), initially, and annually thereafter, that reflect process and outcomes associated with CNH oversight. This will require presentation of the concept to OQP, as well as requesting to be on the agenda of that office's Performance Measures Workgroup. The 2003 measures have already been determined. The action plan target date must therefore be for 2004 and all activities contributing to accomplishment must be completed by March 2003 at the latest. The proximity of this date means that the 2004 indicators will likely be procedural, inasmuch as identification of actual outcome indicators—dependent on the recommendations of other workgroups described further below in this work plan—will be proposed for 2005 or beyond. These ongoing actions will be facilitated by collaboration between the GEC SHG's OPQ Liaison and the OPQ's GEC Liaison.
2) the CC-GEC negotiate with the Senior Advisor to the Undersecretary of Health to identify suitable VACO- and field-based representatives of GEC, OIT, and DSS to collaboratively agree upon appropriate, standardized stop codes for reporting CNH visits. The CC-GEC will provide a preliminary report on this activity to the HSC by April 15, 2003. A final report will be due to the HSC by June 1, 2003.
3) the CC-GEC, develops and provides education (as described in greater detail under "OIG Recommendation 1b", following) to VAHCF managers on the revised procedures for CNH Oversight (as described in greater detail throughout the remainder of these recommendations) and workload reporting (as articulated in the preceding section).

OIG Recommendation 1b:
"Critical aspects of the new VHA policy are discussed with senior managers, CNH review teams, and other applicable QM program employees using education and training mediums"

Workgroup response: Concur

Action Plan:
It is recommended that:

1) the CC-GEC add an element to the GEC strategic plan, and specify an outcome measure or measures, that will drive timely development of educational information and materials to support effective implementation of new procedures concerning CNHs. The CC-GEC will identify field- and VACO-based GEC representatives and EES representatives who will be able to provide ongoing input on content, format, and target audiences. Education and training needs will have to constantly incorporate new knowledge about quality measures and sources from CMS, for example the new facility-specific quality measures for each Medicare and Medicaid-certified nursing home. Further information is available at http://www.medicare.gov/NHCompare/home. The elements of strategic plans for 2003 have already been formalized. A strategic plan element for 2004 is to be added by August 1, 2003 and the educational outcome measure identified no later than that date, with reporting no less frequent than twice annually, beginning March, 2004.
2) the CC-GEC to present in a timely manner (by self or designee) to NLB at one or more of their monthly meetings; to VHA Senior Management at the January meeting; and to facility directors at one or more of their monthly calls, on topics selected by the process described in the preceding paragraph that will include but will not necessarily be limited to the developmental status or definitive version of these aspects of CNH oversight: renewal of the Oversight Committee requirement, access to and use of CMS databases, integration of CNH and facility QM programs, reporting of CNH sentinel events, and new Network Director Performance Measure(s). These educational activities are to begin as soon as the procedural elements called for in these recommendations begin to adopt their final forms. The activities will continue until formal training on the amended Handbook has been completed in December 2003.
3) the CC-GEC develop in a timely manner one or a series of educational interactive teleconferences for field-based, front-line personnel, providing operational specifics on workload reporting and accessing MDS-based performance data on CNHs, as advised in (1) above. Timing is as described in preceding paragraph.

OIG Recommendation 1c:
"VHA medical facility managers must emphasize the need for CNH review teams to access and critically analyze external reports of incidents of patient abuse, neglect, and exploitation, and to increase their efforts to collaborate with state ombudsman officials."

Workgroup response: Concur

OIG Recommendation 1d:
"Clarify whether the new VHA policy intended the responsibilities of CNH oversight committees to be extended to CNH review teams or some other committee."

Workgroup response: Concur

Action Plan:
It is recommended that:

1) the CC-GEC identify and oversee suitable field- and VACO-based expertise in GEC and OIT to develop a mechanism for web-based, timely reporting by VAHCFs, of review status of CNHs and annual CNH summary data. The CC-GEC will provide a preliminary report on this activity to the HSC by April 15, 2003. A final report will be due to the HSC by June 1, 2003.
2) the CC-GEC identify and task suitable field- and VACO-based expertise to draft amendments to the CNH Handbook to specify the need for and different scope of responsibilities of CNH Oversight and CNH Review teams, as described on pp. 8-10 of this report; and employing the mechanism developed in (1) preceding.
3) recommended wording of Handbook amendments will be provided to the HSC by CC-GEC by July 1, 2003.
4) the proposed revisions to the Handbook, when they have assumed their final form, will be communicated by the CC-GEC to the GEC/EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1e:
"Consistently apply local and regional contracting requirements to preclude the potential for them to provide differing standards of care"

Workgroup response: Concur

Action Plan:
It is recommended that:

1) CC-GEC propose to amend the CNH Handbook to require of all local and regional contracts CNH SOW elements identified as described under "OIG Recommendation 1c" and "OIG Recommendation 1g" above. Recommended wording of Handbook amendment will be provided to the HSC by CC-GEC by July 1, 2003.
2) the proposed revision to the Handbook, when it has assumed its final form, will be communicated by the CC-GEC to the GEC-EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1f:
"Survey requirements for LSC compliance must be clarified between the recently issued CNH policy and instructions issued by VHA in April 2000."

Workgroup response: Concur

Action Plan:
It is recommended that:

1) CC-GEC propose to amend the CNH Handbook with language clarifying the recission of the conflicting section of IL 10N-2000-002 by July 1, 2003.
2) in light of the multiple Handbook revisions that will be recommended by CC-GEC and the time necessary to effect adoption of a new Handbook, CC-GEC issue an Information Letter on this topic, to be issued no later than January 31, 2003.
3) this Information Letter and the revision to the Handbook be communicated by the CC-GEC to the GEC-EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1g:
"Contracting officers must strengthen the contracting process by requiring CNHs to produce current state licenses, CMS certifications, assurances of the clinical competency and backgrounds of CNH clinical employees, CMS or State minimum standards for staffing levels to provide direct nursing care to veterans on a daily basis, and submissions of routine performance improvement data."

Workgroup response: Concur

Action Plan:
It is recommended that:

1) CC-GEC specify to the group identified in "OIG Recommendation 1c" above that the elements listed in "OIG Recommendation 1g" be included in the SOW.
2) CC-GEC request the Deputy Under Secretary for Health Policy Coordination to make necessary and appropriate arrangements with representatives of the Department of Health and Human Services to: 1) actualize the development and drive the implementation of workable processes, particularly electronic forms of access, to make available to VAHCFs on an on-demand basis the quality reports generated by RAI/MDS; and 2) develop and implement a mechanism for immediate notification to the VACO GEC SHG by CMS regional offices of any home that receives a rating of "immediate jeopardy". The CC-GEC will provide a preliminary report on this activity to the HSC by April 15, 2003. A final report will be due to the HSC by June 1, 2003.

3) CC-GEC propose to amend the CNH Handbook with language: to require of all local and regional CNH contracts the SOW elements identified as described under "OIG Recommendation 1c" above; to specify means developed through (2) preceding for accessing quality reports generated by the RAI/MDS; and to articulate the procedure to follow in the event a VAHCF is alerted by GEC SHG that a CNH with which it has a contract has received a rating of "immediate jeopardy".
4) Recommended wording of Handbook amendment will be provided to the HSC by CC-GEC by July 1, 2003.
5) the proposed revision to the Handbook, when it has assumed its final form, will be communicated by the CC-GEC to the GEC-EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1h:
"CNH review teams are reminded to critically evaluate and mitigate the risks associated with routinely transporting veterans between CNHs and VA medical facilities."

Workgroup response: Concur

Action Plan:
It is recommended that:
1) the CC-GEC identify and task suitable field- and VACO-based expertise, as necessary, to draft amendments to specify that routine medical services are already covered under contract provisions and that travel to VHA to obtain these services should be discouraged unless it is in the patient's best interest. Recommended wording of Handbook amendment will be provided to the HSC by.CC-GEC by July 1, 2003.
2) the CC-GEC identify and task suitable field- and VACO-based expertise, as necessary, to amend the CNH Handbook to emphasize to VHA CNH program staff that fee basis authority exists to pay for medically necessary specialty services on-site in the CNH when VAHCF CNH program staff deem that transportation to the parent VHA facility would be costly, onerous or deleterious to patient health. Recommended wording of Handbook amendment will be provided to the HSC by CC-GEC by July 1, 2003.
3) the CC-GEC identify and task suitable field- and VACO-based expertise, as necessary, to amend the CNH Handbook to clarify the principles and procedures VAHCFs are to follow when a CNH in which reside veterans on CNH contract is found to have one or more of the characteristics listed in section 13 of the Handbook; local alternative resources are not available; and quality of care is not so much the issue as is an administrative situation (e.g., loss of liability insurance). Recommended wording of Handbook amendment will be provided to the HSC by CC-GEC by July 1, 2003.

4) the proposed revisions to the Handbook, when they have assumed their final form, will be communicated by the CC-GEC to the GEC-EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1i:
"Clarify expectations on visiting long-term placements and residents residing more than 50 miles away from the parent medical facilities at least quarterly, particularly in the cases of veterans who need to be seen more frequently because of their medical conditions or absence of family support systems."

Workgroup response: Do Not Concur

Comment:
The workgroup is of the opinion that the approach advocated in the Handbook for addressing the need for ongoing oversight of veterans residing in CNHs at considerable distance from the VAHCF is specific, practical, reasonable, and appropriately patient-centered in its present iteration. The Handbook stresses that every plan for post-discharge care is to "delineate, on an individual patient basis, the particular needs and services to be provided to the patient;" and that it unambiguously directs that the patient's needs are to dictate the particulars of the post-placement plan. Residents placed at distance from the VAHCF who (in the words of the OIG draft report) "need to be seen more frequently because of their medical conditions or absence of family support systems" will, per the Handbook, be seen more frequently, as their needs dictate. In much the same way, a veteran residing in a CNH closer than 50 miles to the VAHCF may not require monthly visits and paragraph 12c addresses this contingency as well. Essential to the successful implementation of the Handbook's direction in this matter is a thorough and rigorous program of quality oversight, directed both to the performance of the facility (through the OSCAR 3 and 4, the QIs, and all other reports indicated for the particular situation), and to the patient's own status (through monitoring the patient's MDSs, discussions with CNH staff, and family).

OIG Recommendation 1j:
"Managers integrate CNH activities into medical facility QM programs and review performance data to monitor bedsores, medication errors, falls, and other treatment quality indicators that may warrant their attention."

Action Plan:
is addressed under "OIG Recommendation 1c" and "OIG Recommendation 1d" above

OIG Recommendation 2a:

"The Under Secretary for Health needs to coordinate efforts with the Under Secretary for Benefits to determine how VHA CNH managers and F&FE employees can most effectively complement each other and share information such as medical record competency notes, OSCAR data, and F&FE Reports of Adverse Conditions, to protect the financial interests of veterans receiving health care and VA-derived benefits."

Workgroup response: Concur

Action Plan:
It is recommended that:

1) the Senior Advisor to the Under Secretary for Health request that the Secretary of Veterans Affairs direct that a standing committee of representatives from VHA and VBA be convened to determine how VHA CNH managers and F&FE employees can most effectively complement each other and share information such as medical record competency notes, OSCAR data, and F&FE Reports of Adverse Conditions.
2) This committee will report to the Secretary at 6-month intervals. The initial report, due June 30, 2003, will provide concrete recommendations and action plans for all of the elements specified in the preceding paragraph. Succeeding reports will address processes, initially articulated in the first report, that have needed to be changed in the interim as the two agencies' internal processes evolve.

Appendix B

UNDER SECRETARY FOR BENEFITS COMMENTS

In general, we concur with the recommendation to coordinate improved lines of communication between appropriate VHA personnel, including CNH managers, and Fiduciary activity supervisors. The current Fiduciary program mandate, as outlined in M21-1, Part VIII, 6.08a, requires a meeting at least once yearly between these parties to discuss services to incompetent veterans. It should be noted that these meetings are not limited to CNH personnel but would also include VHA personnel involved with both the residential care program and VHA inpatients to the extent they involve incompetent veterans.

The Central Office Fiduciary Program staff reminded all Fiduciary Program managers nationwide of this requirement in an e-mail message on June 20, 2002 (copy attached). Additionally, this was an agenda item on the Veterans Service Center Managers' call on June 19, 2002, and extensively discussed in the quarterly Fiduciary Program Teleconference on July 18, 2002 (copies attached). Compliance with this requirement will be monitored during routine site visits beginning in October 2002.

While we agree with the necessity of these annual meetings, we have reservations about some of the information to be shared as outlined in the second part of the recommendation, and who should be the recipient of the information. We recommend that a meeting between Central Office VHA and VBA Fiduciary staff be held to determine what information would be of value to share and the proper procedures for this exchange of information.

Appendix C

DISTRIBUTION

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- Committee on Governmental Affairs, U.S. Senate
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- Committee on Veterans' Affairs, U.S. House of Representatives
- Committee on Appropriations, U.S. House of Representatives
- Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives

Subcommittee on National Security, Veterans' Affairs, and International Relations, Committee on Government Reform, U.S. House of Representatives
Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Benefits, Committee on Veterans' Affairs, U.S. House of Representatives
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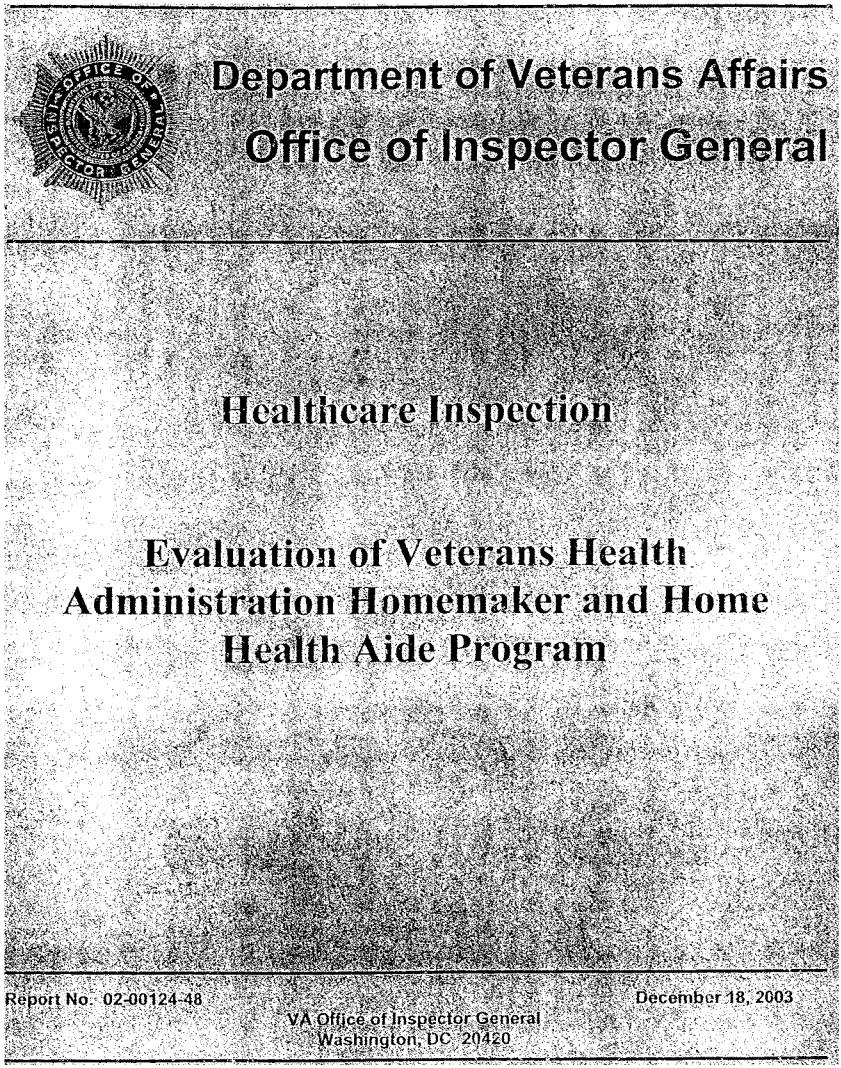
Congressional Staff Directors:
Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives


Department of Veterans Affairs
Office of Inspector General
Healthcare Inspection
Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program
Report No. 02-00124-48
December 18, 2003
VA Office of Inspector General
Washington, DC 20420

EXECUTIVE SUMMARY

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an evaluation of the Veterans Health Administration's (VHA) Homemaker and Home Health Aide (H/HHA) Program. The evaluation was conducted to determine whether H/HHA programs at VA medical facilities were in compliance with VHA policy and whether H/HHA services provided to patients were clinically appropriate, cost effective, and met customer expectations.

As part of the OIG's Combined Assessment Program (CAP) reviews, we inspected H/HHA programs at 17 VA medical facilities. We sampled 142 patients at 16 sites who were receiving H/HHA services at the times of the CAP review visits, or who had received H/HHA services during the first quarter of FY 2002. All sampled patients had received services for at least 6 months at the times of our visits. Although the VHA Directive related to H/HHA Program operations expired in December 1997, continued compliance is expected until a new policy is issued.

Our reviews showed that 20 (14 percent) of the 142 patients whose medical records we reviewed did not meet clinical eligibility requirements to receive H/HHA services. Five additional patients' medical records contained insufficient information to ascertain their clinical eligibility.

We also found that 12 (8 percent) of 142 patients did not have any activities of daily living (ADL) dependencies documented in their initial assessments for H/HHA services, yet were approved to receive services. In some cases, the interdisciplinary teams documented that the patients needed assistance with ADLs, but the patients were not dependent in any ADLs. In addition, 7 (10 percent) of the 70 respondents we interviewed said that they would not be in need of nursing home placements at this time even if they did not receive H/HHA services. The remaining 8 patients who did not meet clinical eligibility requirements had ADL dependencies, but did not have 2 or more of the other required conditions prescribed by VA policies and procedures.

H/HHA Program managers did not always appropriately manage their H/HHA resources in relation to wait-listed patients. We found that 10 (59 percent) of 17 VA medical facilities visited had waiting lists for placements in their programs. One facility had 23 patients on its waiting list, with one patient waiting 6 months for services. Another facility had eight patients on its H/HHA waiting list, one of whom had been on the list for 8 months.

In addition, we did not find any evidence of interdisciplinary assessments for referrals in 42 (30 percent) of 142 medical records reviewed. VHA policy requires that the physician, nurse, and social worker, at a minimum, complete an interdisciplinary assessment of a patient's need for H/HHA services.

We found many areas wherein program managers did not comply with VHA policy. All but 1 VA medical facility had designated coordinators of the programs; however, 8 (47 percent) of 17 facilities did not have local oversight committees monitoring program

operations or the quality of patient care. Policy requires that VHA employees reassess their patients' continued needs for services every 3 months. We found that only 8 (47 percent) of 17 VA medical facilities were performing these reassessments in the time frame prescribed. Timely reassessments are necessary to evaluate patients' continued needs for services, and to reallocate resources to wait-listed patients whenever possible.

Community health agencies (CHAs) provided quarterly documentation of performance improvement activities to VA program managers in only 3 (18 percent) of 17 facilities visited. H/HHA Program managers cannot adequately monitor quality of care without reviewing CHAs' quality assurance measures and outcome data. Although VHA policy requires that only licensed providers be utilized, we found that six VA medical facilities visited allowed some unlicensed CHAs to provide services to VA patients. This occurred mostly in localities with limited home health care resources, and usually applied to homemaker services only.

VHA has not established guidelines for contracting for H/HHA services or provided contracting officers with benchmark rates for determining the reasonableness of charges as recommended in a 1997 OIG report. Contracts we reviewed showed hourly rates ranging from $9.86 to $30. Two of the VA medical facilities established rates on a per visit basis. We found facilities in high cost of living localities contracted for lower rates than facilities where the cost of living was low. The five VAMCs that obtained the best rates typically performed wide-ranging research into the H/HHA standard rates, and often utilized State Medicaid rates or Bureau of Labor Statistics rates for their localities during negotiations for services. We compared the State Medicaid rates for personal care services and the rates the VA medical facilities authorized, and found that 5 (31 percent) of the 16 sites, through their own initiative, considered State Medicaid rates in contracting for H/HHA services. We found that the 5 sites negotiated rates below the prevailing State Medicaid rates, and saved about $6,800. Had the remaining 11 (69 percent) sites used the Medicaid rates, they could have avoided about $42,500 (16 percent) of the $265,849 in payments made for the patients in our sample, during the first quarter of FY 2002. In applying this percentage savings to projected FY 2003 payments for all H/HHA services, we estimated that the program could avoid, on average, about $10.7 million in costs annually.

We found that 163 (24 percent) of the 667 veterans receiving H/HHA services during the first quarter of FY 2002 at 16 sites we visited also received basic special monthly compensation or pension (SMC/P) benefits from the Veterans Benefits Administration due to their need for aid and attendance (A&A). VHA program managers were unaware that 72 (44 percent) of those 163 veterans were receiving this benefit. At the same time, eight of the sites had about 107 other patients on waiting lists. We found nothing that precluded the consideration of the veteran's receipt of SMC/P benefits, along with other personal resources, prior to and during the authorization of H/HHA services. These benefits could help defray the cost of personal care services and allow a greater number of patients to be served by the H/HHA program.

We recommended that the Under Secretary for Health issue a policy replacing the expired VHA Directive 96-031 and provide additional guidance requiring that patients receive thorough initial interdisciplinary assessments prior to H/HHA Program placement. We also recommended that patients receiving H/HHA services meet clinical eligibility requirements, and that benchmark rates for these services are established. We further recommended that the Under Secretary seek General Counsel opinion on whether veterans' SMC/P status may be considered when prioritizing need for services and determining frequency of authorized visits. If General Counsel determines that this consideration is appropriate, the new policy should reflect this change.

The Under Secretary for Health (USH) concurred with the findings and recommendations, but he had expressed concerns that the initially estimated $11.4 million in better use of funds derived from the implementation of benchmarks needed to consider additional variables and planned program criteria changes in the future. We met again with VHA officials to resolve these concerns, and as a result, reduced the estimated monetary benefits to $10.7 million. The USH provided acceptable improvement plans. We will follow-up until the planned actions are completed. The full text of his comments are shown in Appendix A. This report was prepared under the direction of Ms. Victoria Coates, Director, Atlanta Regional Office of Healthcare Inspections.

ALANSON J. SCHWEITZER
Assistant Inspector General for
Healthcare Inspections

INTRODUCTION

Purpose

The Department of Veterans Affairs Office of Inspector General's Office of Healthcare Inspections conducted an evaluation of the Veterans Health Administration Homemaker and Home Health Aide Program. The evaluation was conducted to determine whether H/HHA programs at VA medical facilities were in compliance with VHA policy and whether H/HHA services provided to patients were clinically appropriate, cost effective, and met customer expectations.

Background

As of September 30, 2001, approximately 9.6 million veterans were age 65 or older and more than 600,000 of those veterans were age 85 or older.[1] A substantial number of these veterans have, or will have long-term care needs. The VA has recognized that home-based care is a vital component of an integrated health care delivery system, and is needed to meet the long-term care needs of our aging veterans. The H/HHA Program operates under the authority of Title 38 United States Code (USC) Section 1720C, which allows the Secretary to furnish home health services as necessary or appropriate for the effective and economical treatment of veterans.

VHA Directive 98-022 prescribes the implementation of several VHA programs created to meet the long-term care needs of veterans. One such activity discussed in this directive is the H/HHA Program. The program provides homemaker and home health aide visits to eligible patients in their homes and communities using contract nursing home funds. VA medical facility managers are required to coordinate and review the appropriateness of home care referrals, assess the most appropriate in-home services for patients, and monitor the appropriateness of costs. Expenditures for a patient receiving home health services cannot exceed 65 percent of the average VA nursing home per diem rate. This program is consistent with the *Veterans Millennium Health Care and Benefits Act* (the Millennium Act), Public Law 106-117, which promotes the provision of non-institutionalized health care in community settings.

VHA considers H/HHA services to be an alternative to nursing home care. When veterans are referred for these services, clinicians have judged that the veterans would, in the absence of H/HHA services, need nursing home care. The goal of providing these services is to prevent or delay institutional placement. The program provides H/HHA visits through CHAs to eligible beneficiaries using contract nursing home funds. Veterans enrolled in this program must be receiving primary health care from VHA and must meet clinical and administrative eligibility criteria.

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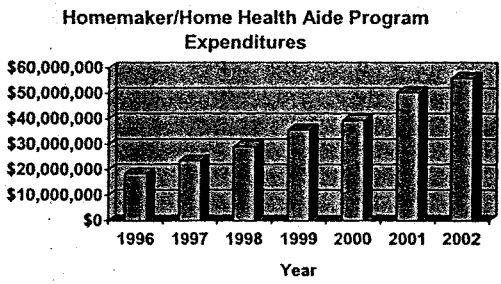
[1] Department of Veterans Affairs FY 2001, Annual Accountability Report Statistical Appendix.

By the end of Fiscal Year (FY) 2001, 125 VA medical facilities were providing H/HHA services to about 8,645 veterans.[2] The following chart shows the increase in VA expenditures for providing H/HHA services since 1996:[3]



In 1993, VA conducted a pilot program to furnish personal care and health-related services in noninstitutional settings for certain eligible veterans. The program consisted of H/HHA services coordinated by VHA staff. The VHA's H/HHA Evaluation Project was completed in June 1995.

The findings, published in the VA Guide to Long-Term Care Programs and Services, Volume 3, identified the following problems with the provision of services:

- Eleven percent of veterans expressed dissatisfaction with the continuity of care (frequent changes in CHA care providers).
- The external regulation of contracted H/HHA vendors and their internal procedures for quality control and staff training varied.
- Lack of allotted staffing to administer the program was perceived by employees to adversely affect its implementation and management.

Additionally, a 1996 OIG audit found that $10.4 million was spent for 186,000 visits from aides or non-nursing personnel, at an average cost of $56 per visit.[4] The period reviewed for the 1996 report was April 1, 1994, through March 31, 1995.

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[2] General Accounting Office (GAO) letter report, VA Long-term Care: Implementation of Certain Millennium Act Provisions is Incomplete, and Availability of Noninstitutional Services is Uneven, (FAO-02-51OR; GAO File #4055F).

[3] Data taken from the KLF Menu Financial Management Service Reports.

[4] OIG Report entitled, "Internal Controls Over the Fee-Basis Program," Report Number 7R3-A05-099, dated June 20, 1997.

The OIG recommended that the Under Secretary for Health improve the cost effectiveness of home health services by:

- Establishing guidelines for contracting for the services.
- Providing contracting officers with benchmark rates for determining the reasonableness of charges.

The OIG's September 30, 2002 semiannual report points out that VHA has yet to implement these recommendations.[5] VHA provided a draft directive to the OIG, in January 2001, to specifically address these recommendations. However, there was a lack of consensus from VHA field reviewers, and the OIG nonconcurred with the draft document. VHA withdrew the directive from concurrence in August 2001, to begin a complete revision. At the time of our evaluation, the VHA geriatrics and extended care staff was formulating a policy, and a directive may be issued later in FY 2004. We are concerned that these 7-year-old recommendations have not been implemented and VHA is losing opportunities to save valuable resources that could be used to care for veterans.

Scope and Methodology

As part of the OIG's CAP reviews, we inspected H/HHA programs at 17 VA medical facilities between October 2001 and September 2002. We sampled 142 patients, at 16 sites, who were receiving H/HHA services at the times of the CAP review visits, or who had received H/HHA services during the first quarter of FY 2002. All sampled patients had received services for at least 6 months at the times of our visits. We also consulted with OIG auditors who assisted us on the financial aspects of the review. Although the VHA Directive related to H/HHA Program operations expired in December 1997,[6] continued compliance is expected until a new policy is issued.

One of the 17 facilities we visited had no patients who met the selection criteria of receiving H/HHA services for at least 6 months. This facility limited contracts to 3 months to serve as many patients as possible. No data from the medical record reviews or the satisfaction survey of patients from this facility were included in this report; however, other program information was included.

We evaluated a larger sample of 667 patients (all patients receiving H/HHA services) from the 16 medical facilities to determine the SMC/P status of veterans receiving H/HHA services.

[5] OIG Semiannual Report to Congress, April 1, 2002 to September 30, 2002.
[6] VHA Directive 96-031.

We conducted the following reviews to determine whether the H/HHA programs were in compliance with VHA policy and if the services provided to veterans were clinically appropriate, cost effective, and met customer expectations:

- We reviewed local policies and interviewed H/HHA Program coordinators and team members from contracting, billing, nursing, and social work to assess their compliance with VHA directives.

- We reviewed CHAs' documentation regarding supervision and patient satisfaction, and performance improvement data to assess the quality of the H/HHA services provided to veteran patients.

- We reviewed the medical records of 142 patients receiving care at 16 medical facilities to evaluate initial interdisciplinary assessments, clinical eligibility, and re-certifications for continued services.

- We contacted 70 of the 142 patients in our sample, or their caregivers, to assess their satisfaction with H/HHA services. We recorded the perceptions of the patients or their caregivers regarding the timeliness of H/HHA services, the courtesy shown by homemakers or home health aides, and the levels of satisfaction with the program.

- We reviewed contractual agreements between the VA medical facilities and CHAs and examined the invoices for patients receiving services during the first quarter FY 2002, to determine whether the CHAs complied with authorized rates and hours, and whether VA medical facility managers appropriately monitored the billings. We also compared the authorized rates to the local State Medicaid rates and the Department of Labor's Bureau of Labor Statistics Wage Rates to determine the reasonableness of the charges. We examined invoices for 142 patients.

- We utilized the Benefits Delivery Network (BDN) to determine whether veterans receiving H/HHA services were also receiving SMC/P benefits because of the need for basic aid and attendance (A&A).[7] We obtained copies of the rating decisions for 32 patients who were receiving SMC/P benefits to determine whether the SMC/P was provided for the same reasons for which the patients were receiving H/HHA services. We also determined whether H/HHA Program managers were aware of their veterans' SMC/P status. We verified the SMC/P status of 667 veterans.

We conducted the evaluation in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[7] In determining whether a veteran is in need of A&A, Veterans Benefits Administration adjudicators consider if the veteran's disabilities make it impossible to perform such basic functions of daily living as bathing, dressing, and eating without the assistance of another person.

RESULTS AND CONCLUSIONS

While we found deficiencies with patient selection and program management at some facilities we visited, patients generally told us they were satisfied with H/HHA services. We interviewed 70 patients or their caregivers from 16 facilities. All 70 respondents told us that their homemakers or home health aides came on the correct days and as often as scheduled. All 70 respondents said that their homemakers or home health aides treated them with courtesy. We found that 67 (96 percent) of the 70 respondents told us they would recommend the program to their family members. Of the 70 respondents interviewed, 68 (97 percent) rated their H/HHA services as good or very good.

We followed-up on three issues identified during the 1995 VHA evaluation project. We found that patient satisfaction with the continuity of care was unchanged from 1995. Our patient satisfaction survey revealed that 8 (11 percent) of 70 patients reported not getting the same homemakers or home health aides each visit. Program managers told us that the CHAs made every effort to provide patients with the same caregivers. This factor did not cause a significant negative impact on overall patient satisfaction.

Interviews conducted with 98 employees from 13 VA medical facilities during the 1995 VHA pilot program evaluation revealed that staff were concerned that CHAs' internal procedures for quality control and staff training varied. They also had concerns about the lack of program staffing. We found that 87.5 percent of the facility staff members we surveyed felt that there was consistency in quality control and staff training among the various CHAs that served their veterans. In addition, we asked program managers in 17 facilities if they felt that they had sufficient staff to effectively manage their programs. We found that 13 (76 percent) of 17 facilities' program managers believed the H/HHA programs were sufficiently staffed.

Issue 1: Clinical Eligibility and Waiting List Management

We found that 20 (14 percent) of the 142 patients whose medical records we reviewed did not meet clinical eligibility requirements to receive H/HHA services. Five additional patients' medical records contained insufficient information to ascertain their clinical eligibility. According to VHA Directive 96-031,[8] veterans eligible for H/HHA services are those who are in need of nursing home care. The phrase "...in need of nursing home care..." means that the patient's interdisciplinary team needs to make a clinical judgment as to whether such care is needed as defined by the following indicators:

- One or more activities of daily living (ADL) dependencies (bathing, dressing, toileting, transferring, or feeding); and
- Two or more of the following conditions:
    - Three or more instrumental activities of daily living (IADL) dependencies (shopping, meal preparation, light housekeeping, medication

[8] Purchase of Homemaker/Home Health Aide Services, April 16, 1996.

management, financial management, mobility [ability to leave home], using a telephone, and laundry);

- Current residence in (or recent discharge from) a nursing facility;
- 75 years old, or older;
- High use of medical services defined as 3 or more hospitalizations in the past year and/or utilization of outpatient clinics/emergency evaluation units 12 or more times in the past year;
- Clinical depression;
- Living alone in the community; or
- Significant cognitive impairment.

Clinical Eligibility

We found that 12 (8 percent) of 142 patients did not have any ADL dependencies documented in their initial assessments for H/HHA services yet were approved to receive services. In some cases, the interdisciplinary teams documented that the patients needed assistance with ADLs, but the patients were not dependent in any ADLs. In addition, we found that 7 (10 percent) of the 70 respondents interviewed said that they would not be in need of nursing home placement at this time even if they did not receive H/HHA services. The remaining 8 patients who did not meet clinical eligibility requirements had ADL dependencies, but did not have 2 or more of the other required conditions.

In one VA medical facility, three patients receiving H/HHA services did not meet clinical eligibility requirements as none of them had documented ADL dependencies. The program coordinator told us that he interpreted VHA policy to mean that patients could qualify for H/HHA services if they had either ADL or IADL dependencies.

Those patients with no ADL dependencies received homemaker services only. Although one of the patients lived alone and was advanced in age, he told us he was able to drive himself around and did not need any assistance with ADLs. He told us he had a very active social life and we did not find any documented evidence of cognitive deficits or depression. This patient stated that the homemaker cleaned his carpets and took his clothing to the laundromat. He told us that even without the H/HHA services, he would not need nursing home placement at this point in his life.

Waiting Lists

H/HHA Program managers did not always appropriately manage their H/HHA resources in relation to wait-listed patients. We found that 10 (59 percent) of 17 VA medical facilities visited had waiting lists for placements in their programs. One facility had 23

patients on its waiting list, with 1 patient waiting 6 months for services. Another facility had eight patients on a waiting list to receive H/HHA services, and one patient had been on the list for 8 months. Three ineligible patients were receiving services through this latter facility, and a fourth (eligible) patient had repeatedly requested to terminate or reduce the hours of homemaker service he was receiving as he felt he did not have enough tasks to "...keep the homemaker busy." All eight wait-listed patients met eligibility criteria and may have been in greater need than some of the patients currently enrolled in this facility's H/HHA Program.

Most facilities' managers did not consider a veteran's receipt of A&A benefits, which could defray the cost of personal care, when authorizing H/HHA services even when other patients were on waiting lists for placement in the programs. We found seven patients in programs with waiting lists who did not meet clinical eligibility criteria yet were receiving H/HHA services in addition to A&A benefits.

Issue 2: Initial Interdisciplinary Assessment for Referral

We did not find any evidence of interdisciplinary assessments for referrals in 42 (30 percent) of 142 medical records reviewed. VHA policy requires that a physician, nurse, and social worker, at a minimum, complete an interdisciplinary assessment of a patient's need for H/HHA services.

Of the 100 medical records that did contain interdisciplinary assessments, we did not find documentation of nursing participation in 29 (29 percent) initial assessments, nor did we find evidence of social work participation in 19 (19 percent) initial assessments. While physicians participated in the assessments in 74 (74 percent) of 100 assessments, we found that, for the most part, the physicians merely cosigned the referrals for services. Most in-depth documentation of patients' needs for services was left to nurses or social workers.

We concluded that VHA interdisciplinary teams and program managers needed to more thoroughly evaluate patients' clinical eligibility, considering that 14 percent of our patient sample did not meet VHA requirements.

Issue 3: Program Operations and Quality of Care

We found many areas wherein program managers did not comply with VHA policy. All but one VA medical facility had designated coordinators of the programs; however, 8 (47 percent) of 17 facilities did not have local oversight committees monitoring program operations or the quality of patient care.

VA policy requires that VHA employees reassess their patients' continued needs for services every 3 months. We found that only 8 (47 percent) of 17 VA medical facilities were performing these reassessments in the time frame prescribed. Timely reassessments are necessary to evaluate patients' continued needs for services, and to reallocate resources to wait-listed patients whenever possible.

CHAs provided quarterly documentation of performance improvement activities to VA program managers in only 3 (18 percent) of 17 facilities visited. H/HHA Program managers cannot adequately monitor quality of care without reviewing CHAs' quality assurance measures and outcome data.

Although VHA policy requires that only licensed providers be utilized, we found that in six VA medical facilities visited, some unlicensed CHAs provided services to VA patients. This occurred mostly in localities with limited home health care resources, and usually applied to homemaker services only.

Issue 4: Cost Effectiveness

VHA has not established guidelines for contracting for H/HHA services or provided contracting officers with benchmark rates for determining the reasonableness of charges as recommended in our 1997 report. Contracts we reviewed showed hourly rates ranging from $9.86 to $30. Two of the VA medical facilities established rates on a per visit basis. We found facilities in high cost of living localities contracted for lower rates than facilities where the cost of living was low. The five VAMCs that obtained the best rates typically performed wide-ranging research into the H/HHA standard rates, and often utilized State Medicaid rates or Bureau of Labor Statistics rates for their localities during negotiations for services.[9]

From a sample of billings for 142 patients at 16 sites, we compared the State Medicaid rates for personal care services and the rates the VA medical facilities authorized. We also examined the invoices and payments for H/HHA services provided to the 142 patients in our sample during the first quarter of FY 2002, to determine whether the 16 facilities monitored billings for services provided within the scopes of the authorizations.

The following table reflects the extent of the authorizations, billings, and payments for the services provided during the first quarter of FY 2002 for the 142 patients in our sample:

Activity	Hours	Amount
Authorized Services	16,735	$300,169
Billed Services	14,130	$270,205
Payments	14,081	$265,849

We compared the State Medicaid rates for personal care services and the rates the VA medical facilities authorized, and found that 5 (31 percent) of the 16 sites, through their own initiative, considered State Medicaid rates in contracting for H/HHA services. We found that the 5 sites negotiated rates below the prevailing State Medicaid rates, and saved about $6,800. Had the remaining 11 (69 percent) sites used the Medicaid rates, they could have avoided about $42,500 (16 percent) of the $265,849 in payments made for the patients in our sample, during the first quarter of FY 2002. In applying this percentage savings to projected FY 2003 payments for all H/HHA services, we

[9] Taking into consideration the localities.

estimated that the program could avoid, on average, about $10.7 million in costs annually ($67.2 million x 16 percent), if the State Medicaid rates are used to develop benchmark rates.[10]

Overall, the VA medical facilities effectively monitored the bills for H/HHA services by requiring signed back-up documentation of the visits and comparing the billed rates and hours with the authorized services.[11] There were some isolated incidents wherein the facilities paid higher billed rates than the authorized rates, resulting in overpayments of $1,770 on behalf of 12 patients. Similarly, of the $265,849 the facilities paid, only $4,165 was for services that exceeded the authorized amounts. When patients did not receive all authorized services, documentation did not always reflect the reasons for the missed visits.

Issue 5: Consideration of Basic Special Monthly Compensation or Pension

The H/HHA Program authorized services for 667 patients totaling at least $1.4 million at 16 sites we visited during the first quarter of FY 2002. Of these 667 patients, 163 patients (24 percent) also received basic SMC/P from the Veterans Benefits Administration due to their need for aid and attendance. The amount of the SMC/P for these 163 patients totaled $242,269 during the period under review. VHA program managers were unaware that 72 (44 percent) of the 163 patients were also receiving SMC/P totaling about $99,300. The program managers at these sites authorized at least $160,500 in H/HHA services for these 72 veterans during the first quarter of FY 2002. At the same time, eight of the sites had about 107 other patients on waiting lists.

We found that program managers had differing opinions, and had been provided conflicting instructions, as to whether a veteran's SMC/P should be considered in the authorization of H/HHA services. We found nothing that precluded the consideration of the veteran's receipt of SMC/P benefits, along with other personal resources, prior to and during the authorization of H/HHA services; however, a General Counsel opinion should be sought to make a final determination on the appropriateness of this consideration. These benefits could help defray the cost of personal care services and allow a greater number of patients to be served by the H/HHA program.

Conclusions

Fourteen percent of the patients receiving H/HHA services in our sample did not meet clinical eligibility requirements. Some patients were not in need of nursing home care, while others only needed supervision with, but were not dependent in ADLs. Program managers interpreted eligibility criteria for H/HHA services differently.

Initial assessments by clinicians were often no more than referrals to the H/HHA Programs. The assessments rarely included documentation of actual evaluations by all

[10] The $67.2 million projection was based upon the average annual increase of expenditures during the past six years.

[11] The patients, or their primary caregivers, typically signed documents attesting that the homemakers or home health aides performed the services at specified times.

required interdisciplinary team members and did not thoroughly document patients' disabilities, dependencies, and needs for services.

Some facilities had many patients on waiting lists and did not always consider clinical eligibility or patients' needs. Programs with scarce resources and wait-listed patients cannot afford to serve ineligible patients or patients not requiring these services.

To enhance controls, VHA managers need to issue policy for the provision and acquisition of H/HHA services to improve the quality of care and to maximize the use of resources. This policy should address assessment and monitoring of needs, including consideration of the patient's clinical eligibility and, if General Counsel determines it is appropriate, SMC/P status. VHA managers also need to establish a method of benchmarking rates for the acquisition of H/HHA services. Had benchmark rates been established as recommended, the H/HHA program could have, on average, freed about $10.7 million annually to treat additional patients.

RECOMMENDATIONS AND COMMENTS

We recommend that the USH:

a. Issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that:

   1. Patients receive thorough initial interdisciplinary assessments prior to placement in the program.

   2. Patients receiving H/HHA services meet clinical eligibility requirements.

   3. Benchmark rates for these services are established.

b. Seek a General Counsel opinion as to whether a veteran's SMC/P status can be considered when prioritizing need for services and determining frequency of authorized H/HHA visits. If General Counsel determines that this consideration is appropriate, we recommend that policy reflect this change.

Under Secretary for Health Comments

The USH agreed with the report's findings and concurred with the recommendations, but he expressed concerns about the monetary benefits that will be derived from implementing new policies and procedures. The USH stated that VHA program officials will follow-up with field staffs to ensure all assessment standards are accomplished and will send follow-up reminders. VHA officials plan to revise policies and procedures and issue written direction on benchmark rates by March 31, 2004. The USH also agreed to seek a General Counsel opinion in response to recommendation (b) in the report. The full text of his comments are shown in Appendix A.

Inspector General Comments

The USH concurred with the findings and recommendations and provided action plans that met the intent of our recommendations. While VHA program officials expressed concern that the estimated monetary benefits of $11.4 million might actually be lower, they could not provide us with an alternative approximation of the benefits that will be saved. They also acknowledged that implementing new policies and procedures and benchmark rates may actually increase economies beyond the estimate. We met with VHA program officials in September 2003 to further discuss their concerns on our calculations. Based on the discussions at this meeting, and efforts to acknowledge additional VHA factors that might influence savings, we lowered the estimate to $10.7 million. Despite these efforts, VHA officials preferred to first implement their action plans and than measure actual data to determine the extent of the funds that could be put to better use. We will continue to follow-up until all action plans are implemented and VHA completes an after action review.

UNDER SECRETARY FOR HEALTH COMMENTS

Department of Veterans Affairs **Memorandum**

Date: Sep 25, 2003

From: Under Secretary for Health (10/10B5)

Subj: OIG Draft Audit Report, *Homemaker/Home Health Aide (H/HHA) Services*, Project Number 2002-00124-HI-0041, (EDMS Folder 232193)

To: Assistant Inspector General for Healthcare Inspections (54)

1. The appropriate program offices have reviewed this draft report. We agree with the report's findings and concur with the report's recommendations with the exception of the monetary benefits. We believe the estimated savings calculated by OIG for what will be derived from the implementation of reasonable charges in this program is somewhat high ($11.4 million annually), however an alternative estimated monetary benefits cannot be provided at this time. Representatives from your office met with VHA representatives on August 27, 2003 to discuss VHA concerns related to your estimate. At that meeting, VHA representatives explained that to ensure that the program best addresses the needs of our veteran population, VHA has changed program criteria for its Homemaker/Home Health Aide programs since this review was conducted. The new criteria require that all eligible candidates for the program have at least three activities of daily living (ADL) or have significant cognitive impairment to be admitted to the program. This change in the level of services for patients admitted to the program will reduce the savings projected; however, we will not know the extent of the effect until we have sufficient actual data.

2. VHA has already initiated several actions we believe will address the majority of the cited issues. For example, VHA's Geriatrics & Extended Care (G & E) Strategic Healthcare Group used its July 2003 National Conference call on contract care to review the initial assessment standard, with follow-up reminders to be provided in writing to the networks by September 30, 2003. VHA is currently completing a project to provide written direction on H/HHA rates in response to an earlier audit and will complete this project at the end of FY 2003, with an estimated publishing date of March 31, 2004.

3. Regarding recommendation b, that indicates VHA should seek a General Counsel (GC) opinion as to whether a veteran's special monthly compensation or pension status (SMC/P) can be considered when prioritizing the need for services and frequency of authorized H/HHA visits, G &E discussed this with the GC in August 2003. At that discussion, it was determined that a

1997 General Counsel opinion does not speak directly to this recommendation. G &E therefore is now in the process of seeking General Counsel's opinion on this issue.

5. An action plan detailing our response to the recommendations is attached. Thank you for this opportunity to review the draft report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at (202) 273-8360.

/s/

Robert H. Roswell, MD

Attachment

Recommendation: #a1. The Under Secretary of Health will issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that patients receive thorough initial interdisciplinary assessments prior to placement in the program. **VHA concurs.**		**Recommendation Metrics: % of achievement of accomplishing an action within specified timeframes.** Green= 80 to 100% 1 to 30 days of specified timeframe Yellow= 60 to 79% 31 to 60 days within timeframe. Red= 59 to 0% 61 days or more within timeframe.					
GOAL	**STRATEGY**	**MEASURE**	**TARGET**	**STATUS**	**ACTUAL**	**BENCHMARK**	**PRIOR FY**
Improved Compliance with Standard for Initial Interdisciplinary Assessment of patients prior to H/HHA placement. VHA Objective 1.3*[1]	Hold a national conference call highlighting OIG findings and VHA's assessment standard. Provide written follow-up to VAMCs	Call will be held as scheduled.	30 Jul 03	Green Written information is in development	Call was held 1 Jul 03.		
Directive & Handbook VHA Objective 1.3	Complete H/HHA Directive and Handbook, available for review and comment end of FY 2003, with an estimated publishing date of 30 Sept 05. Contains policy direction including, on assessment/ reassessment and clinical admission criteria		30 Sep 03 completion date. 30 Sept 05 Publication Date.	Green			
Initial Assessment VHA Objective 1.3	Introduce new Geriatrics & Extended Care (G&EC) Referral Form, with its use to commence 1st quarter, FY 04. G&EC will compare the referral form use and H/HHA program workload to ensure H/HHA benchmark is being met.	Ratio of G&EC Referral/Reassessment Form to H/HHA workload.	31 Oct 03 Introduction Date Mar 31 04	Green			

[1] *(VHA Objective1.3. Provide high quality, reliable, accessible, timely and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost and those statutorily eligible for care).

Recommendation: #a2. The Under Secretary of Health will issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that patients receiving H/HHA services meet clinical eligibility requirements. **VHA concurs.**		**Recommendation Metrics: % of achievement of accomplishing an action within specified timeframes.** Green= 80 to 100% 1 to 30 days of specified timeframe Yellow= 60 to 79% 31 to 60 days within timeframe. Red= 59% to 0% 61 days or more within timeframe.					
GOAL	**STRATEGY**	**MEASURE**	**TARGET**	**STATUS**	**ACTUAL**	**BENCHMARK**	**PRIOR FY**
Improved Compliance with Clinical Admission Criteria. VHA Objective 1.3	Improve Compliance of patients meeting clinical admission criteria	Number of patients meeting admission criteria/number of admissions	2 quarters following publication of Handbook. 90% of admissions met admission guidelines	Green			
Recommendation 3a. Issue a policy to replace the expired VHA Directive 96-031 and provide additional guidance requiring that benchmark rates for these services are established. VHA concurs		**Recommendation Metrics: % of achievement of accomplishing an action within specified timeframes.** Green= 80 to100% 1 to 30 days of specified timeframe Yellow= 60 to 79% < 31 to 60 days within timeframe Red= 59to 0% > 61 days or more within timeframe.					
GOAL	**STRATEGY**	**MEASURE**	**TARGET**	**STATUS**	**ACTUAL**	**BENCHMARK**	**PRIOR FY**
Improve Cost Effectiveness by providing policy direction on H/HHA rates. VHA Objective 3.1	Complete Guidance on rates for H/HHA. Rates reflect a blend of Medicare & Medicaid rates; comparison of VA rates to Medicare/Medicaid rates, by State.	G & E will compare Medicare/Medicaid benchmark rates to actual rates of VAMCs on a quarterly basis VA rates will be less than Medicare rates for H/HHA Medicare eligibles by EOFY 2004	Completion date: 30 Jul 03. Publication estimate- 30 July 05 90% compliance will benchmark rates by 1 Oct 05.	Green			

Recommendation 3b. Seek a General Counsel Opinion as to whether a veteran's SMC/P status can be considered when prioritizing for services and determining frequency of authorized H/HHA visits. If General Counsel determines that this consideration is appropriate, policy will be modified to reflect this change. VHA concurs.	**Recommendation Metrics:** % of achievement of accomplishing an action within specified timeframes. Green= 60 to100% 1 to 30 days of specified timeframe Yellow= 60 to 79%< 31 to 60 days within timeframe Red= 59 to 0% > 61 days or more within timeframe.					
GOAL	**STRATEGY**	**MEASURE**	**TARGET**	**STATUS**	**ACTUAL**	**BENCHMARK**	**PRIOR FY**
Determine if a veteran's SMC/P status can be considered as recommended by OIG, in order to achieve VHA. Objective 1.3.	Seek General Counsel opinion on AID &Attendance benefits in H/HHA. Use General Counsel findings in Directive & Handbook, if appropriate.		30 Jul 03 30 July 05-target for A & A section to be added to the Handbook, if appropriate.	Green			

Appendix B

MONETARY BENEFITS IN ACCORDANCE WITH IG ACT AMENDMENTS

Report Title: Healthcare Inspection - Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program

Report Number: 02-00124-48

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Questioned Costs
1c	Establish benchmark rates	$10,700,000	
Total		**$10,700,000**[1]	

[1] Annualized estimated better use of funds based upon projected fiscal year 2003 expenditures.

Appendix C

OIG Contact and Staff Acknowledgments

David Daigle

OIG Contact	Alanson J. Schweitzer Assistant Inspector General for Healthcare Inspections (202) 565-8305
Acknowledgements	Christa Sisterhen, Project Manager Victoria H. Coates, Director, Atlanta OHI Floyd Dembo, Audit Manager, Atlanta office of Audit Ann Batson, Auditor, Atlanta Office of Audit Paula Chapman Marion Slachta Vishala Sridhar

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Appendix D

Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

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
U. S. House of Representatives
January 28, 2004

**

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the continued enhancement of VA's long-term care programs. With me today is Dr. James F. Burris, VA's Chief Consultant for the Geriatrics and Extended Care Strategic Healthcare Group.

Mr. Chairman, we have testified previously that the need for effective and accessible long-term care services for veterans cannot be overstated. The number of veterans age 75 and older is projected to increase from 4 million to 4.5 million between 2000 and 2010, and the number of those over 85 to triple to 1.3 million during the same period. 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. Typically, VA's 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. While VA remains committed to providing long-term care for eligible veterans who need it institutional long-term care is very costly and is likely to impair long-standing relationships with friends, family, spouse, and community and reduce overall quality of life. We believe that long-term care should focus on the patient and his or her needs, not on institutions or particular programs. 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.

I announced plans to establish a new Office of Care Coordination in testimony before the Subcommittee on Health last May. I am pleased to report that the office is

now fully operational. Care coordination involves the ongoing monitoring and assessment of selected patients using telehealth technologies to proactively enable prevention, investigation, and treatment that enhances the health of patients and prevents unnecessary and inappropriate utilization of resources. Care coordination uses best practices derived from scientific evidence to bring together health care resources from across the continuum of care in the most appropriate, effective, and efficient manner to care for the patient. Care coordination provides patients a continuous connection to clinical services from the convenience of their place of residence. Also, those family members and others who provide care in the home are supported in their critical and difficult roles.

Initial efforts in Care Coordination are focusing on high resource utilization patients with chronic diseases such as diabetes, congestive heart failure, chronic pulmonary disease, depression, post-traumatic stress disorder, spinal cord injury, and wound care. On the basis of a needs assessment performed in April 2002, we anticipate that each VISN should manage between 1,000 and 1,500 such patients using home telehealth and disease management to support care. The emphasis of these programs is to support the non-institutional care of veteran patients and to promote their independent living. Episodic links to care at hospitals and clinics are replaced with continuous monitoring of the veteran's health status, which permits active intervention at an earlier stage of disease progression. These services are designed to link with existing home and community-based programs, including home-based primary care, (HBPC), mental health intensive case management (MHICM), and general primary and ambulatory care services. The average daily census in Care Coordination has grown from 2,000 patients in FY 2002 to over 3,000 currently, with a goal of 7,500 by the end of this fiscal year.

VA also continues to make progress in expanding its more traditional home and community-based non-institutional extended care programs, while retaining its three nursing home programs (VA, Contract Community, and State Homes), as recommended by the Federal Advisory Committee on the Future of Long-Term Care in VA in its 1998 report, "VA Long Term Care at the Crossroads". From 1998 to 2003, the average daily census (ADC) in VA's home- and community-based non-institutional care increased from 11,706 to 18,322. VHA has a budget performance measure that calls for an ambitious 24 percent increase in the number of veterans receiving home and community-based care between FY 2003 and FY 2004. Non-institutional home and community-based care workload has also been established as a VHA Performance Measure 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 22,242 ADC in home- and community-based programs in FY 2004, exclusive of the Care Coordination census. 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 care coordination, home health care, adult day health care, respite, and homemaker/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.

VA has several additional initiatives in progress or planned in response to last year's GAO report, "VA Long Term Care -- Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care" (GAO-03-487). We have issued a new Respite Care Handbook to provide guidance to VA field facilities, and have several other handbooks and directives in concurrence or final drafts. A workgroup is refining VA's long-term care planning model and expects to have a final product later this year. Several training initiatives were completed last year and more are underway. And, of course, we are continuing the congressionally mandated pilots on Assisted Living and comprehensive long-term care for the elderly.

VA also continued to make progress during FY 2003 in restoring the VA Nursing Home Care Unit average daily census to the 1998 baseline mandated by the Millennium Act. However, as recommended by the "Crossroads Report", most of the growth in nursing home beds occurred in the State Veterans Home program. We believe that nursing home care should be reserved as a last resort for situations in which a veteran can no longer safely be cared for in home and community-based settings and when appropriate to provide post-acute care. We again urge the Committee to allow VA to count the census in all of our extended care programs toward meeting the capacity requirements of the Millennium Act.

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 as well as a commitment to institutional long-term care when this best serves the needs of veterans. VA is leveraging 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

NON-INSTITUTIONAL LONG-TERM CARE, AVERAGE DAILY CENSUS 1998-2004

	ACTUAL						EST.
	1998	1999	2000	2001	2002	2003	2004
Home Based Primary Care	6348	6828	7312	7803	8081	8370	9877
Purchased Skilled Home Care	1916	2167	2569	3273	3845	4336	5116
VA Adult Day Health Care	442	462	453	446	427	320	378
Contract Adult Day Health Care	615	809	697	804	932	901	1063
Homemaker/Home Health Aide Services	2385	3141	3080	3824	4180	4316	5093
Home Respite						2	300
Home Hospice						77	415
Non-Institutional Care Total	11706	13407	14111	16150	17465	18322	22242

Statement of Jade Gong
Principal, Health Strategy Associates
Member, Geriatrics and Gerontology Advisory Committee
Before the Committee on Veterans' Affairs
U.S. House of Representatives

January 28, 2004

Dear Mr. Chairman and Members of the Committee:

Thank you for inviting me to present my views on how to meet the long term care needs of aging Veteran's over the next 10 years. Although I currently serve on the Geriatrics and Gerontology Advisory Committee to the Secretary of Veterans Affairs, the views I am expressing today are my own and do not reflect official positions of the GGAC.

First, I would like to thank the Committee for its role in ensuring the passage of the Veterans Health Care, Capital Asset and Business Improvement Act of 2003, Public Law 108-170, Section 105. Prior to the passage of this Act, the Service Contract Act was often cited as a burden and a reason for not contracting with the VA. Under this new law, providers that serve Veterans can now enter into "agreements" with the VA, and will no longer be subject to the detailed reporting requirements of the Service Contract Act. Without access to community providers, the VA would be unable to meet its objectives of providing a continuum of long term care. Thus the availability of these agreements will help to ensure that needed long term care services will be more readily available to Veterans in the communities where they live.

As a member of the Federal Advisory Committee on the Future of VA Long Term Care, I have strongly supported the need for policies that will shift the VA's approach to geriatrics and extended care from one that is institution focused to one that is patient-centered, and offers home and community based options. I believe the VA's policies should offer care to Veterans in their homes for as long as possible, and provide viable options in addition to nursing home placement. Indeed, the Centers for Medicare and Medicaid Services and Medicaid Programs across the country have achieved a dramatic reduction in spending on institutional care through the funding of home and community based "waiver" programs as well as other innovative programs, such as Programs of All Inclusive Care for the Elderly (PACE), an integrated service delivery model that utilizes an adult day health center as the hub of care.

One of the central recommendations of the Federal Advisory Committee was to make home and community based care options the preferred placement when clinically appropriate. As a target, the Committee sought to double the proportion of VA long term care spending from about 18 percent (in 1997) to 35 percent by 2010 (the planning

horizon). The following snapshot illustrates the current mix of services and reveals that the VA has not yet achieved this target:

- The VA spent $3.262 billion on long term care programs in FY 2002, with 91% of spending on institutional care and 9% of spending on non institutional care (GAO-03-487, May 2003).

- By comparison, Medicaid spent $75.288 billion on long term care in 2001, with 71% of spending on nursing homes and ICF/MR and 29% of spending on home and community based care (GAO-03-576, June 2003).

While the comparison with Medicaid program spending shifts is not entirely comparable because of the differences in the benefits and populations served, it does illustrate the responsiveness of the Medicaid programs to meet the desires of the elderly in a cost effective manner.

I would also like to draw your attention to the growth of assisted living in the private sector. Over the past decade, assisted living has emerged as a long term care alternative for seniors who need more assistance than is available in independent living, but who do not require the heavy medical and nursing care provided in nursing homes. Assisted living facilities are designed to be operated, staffed and maintained to meet the needs and desires of its residents. Between 1995 and 2000, the National Academy of State Health Policy (NASHP) reports that the number of assisted living facilities has doubled from about 16,000 facilities to about 33,000 facilities with almost 800,000 beds nationwide. While most assisted living services are paid for privately, Medicaid funding for assisted living is growing. The NASHP reports that 41 states serve 102,000 residents in assisted living or residential care settings. During this same time, the number of nursing home beds has remained approximately flat at approximately 1.8 million beds, and median occupancy has declined to 82 percent. The assisted living sector of the long term care industry has been growing, with assisted living substituting for some nursing home services.

Veterans, however, have limited access to assisted living services through the VA. At present, the VA provides assisted living services on a pilot basis in one VISN, but anticipates the start-up of eight assisted living developments through the enhanced use lease program. However, Veterans residing in non VA operated assisted living facilities in the community can access VA long term care services, such as home based primary care.

The VA has made progress in developing a wider array of home and community based programs, including respite care, home based primary care, geriatric evaluation, adult day health care, homemaker/home health aide programs and skilled home health care. The VA has also introduced a performance measure to encourage the networks to provide these long term care services at the local level. Nevertheless, it is clear that additional progress needs to be made in ensuring greater availability of these programs across VISNs.

The Medicaid statistics that I have highlighted illustrate how policies can successfully impact shifts in the utilization of services. Medicaid has achieved much of this shift in spending from institutional care to home and community based care through comprehensive "waiver" programs that target beneficiaries who meet nursing home admission requirements. However, I believe that it is difficult if not impossible for the VA to achieve a shift of this magnitude within the current policy constraints. Therefore, I offer the following recommendations for discussion about how the VA can achieve its goals of "rebalancing" the institutional and non institutional long term care delivery system.

1. Currently, the VA has a requirement that the nursing home services provided in VA facilities are no less than the level provided in the 1998 base year. This requirement is particularly stringent because it does not take into account nursing home care provided in state homes and contract community nursing homes. This requirement forces the VA to continue its emphasis on nursing home care rather than shift its emphasis to home and community based care services. **Instead, I recommend that the VA be given the flexibility of providing the most appropriate total long term care services that are clinically appropriate. In order to maintain accountability for the provision of long term care services, the VA could be required to maintain a specified level of long term care funding as a baseline, but then have the flexibility to shift that funding towards home and community based services when clinically appropriate. Performance measures should also be applied to ensure that quantity and quality of services are satisfactory.**

2. As authorized by the Veterans Millennium Healthcare and Benefits Act (PL 106-117), has initiated PACE pilots in 3 sites, each implementing a variation on the PACE model. The Denver, Colorado site uses the VAMC as its partner. The Columbia, South Carolina site utilizes VAMC oversight of the community PACE provider. Finally, the Dayton, Ohio site utilizes the VA as the sole provider of PACE services rather than a community PACE provider. I have attached a description of the VA PACE Program operated with Palmetto Senior Care in

Columbia, South Carolina, which illustrates the comprehensive services that are provided and coordinated through the Program.

In the first year of operation, the three sites enrolled a total of 222 veterans with an average age of 75. An interim evaluation of the first year of operation has shown that Veterans and their caregivers are highly satisfied with the program, and reduced rates of nursing home and hospital use have occurred. The final evaluation of the PACE pilot is due to Congress in early 2005. Unfortunately, funding for the pilot is expected to terminate as of July 2004, prior to the completion of the evaluation. Should the pilot projects be terminated, these VA specific PACE programs will be dismantled before they can serve as models for other VISNs.

By the time that the VA began its pilot program, the PACE program had already moved from demonstration status to provider status for the Medicare and Medicaid programs over a 20 year period. The Balanced Budget Act of 1997 Congress recognized the success of the demonstration and PACE became a permanent provider. At present, 31 Medicare and Medicaid certified programs serve almost 10,000 participants on a daily basis. Independent evaluations of the PACE program by the Centers for Medicare and Medicaid Services (CMS) have found the PACE programs to offer high quality, cost effective care that is desired by seniors and their families. With this track record of success, CMS is actively encouraging states to develop and expand PACE programs as a cost-effective alternative to nursing home placement.

Given the CMS experience with PACE over two decades, it is highly likely that the PACE program will also meet the needs of Veterans. **Therefore, I recommend the following:**

- **Congress should authorize the VA to continue funding and continue new enrollment in the existing PACE pilot programs until the evaluations are complete and an informed decision can be made about whether to make these programs a permanent part of the VA long term care continuum.**

- **Should the final evaluation be positive, the VA should expand access to PACE programs where viable using the most appropriate model. In some rural communities, PACE programs can be developed in partnership with other agencies, such as the Indian Health Service.**

3. Similarly, the Millennium Healthcare and Benefits Act also authorized one Assisted Living Pilot. This pilot has operated in VISN 20 (Washington, Alaska, Oregon and Idaho). The evaluation of the assisted living pilot is due to Congress in late 2004, with funding for the pilot expected to terminate before the evaluation is complete. Anecdotal reports indicate that the assisted living pilot is serving Veterans with more chronic impairments in daily living than those who are currently served at the domiciliary level of care, and thus providing a level of support that is not now available within the VA long term care continuum. **Again, I recommend that Congress authorize the VA to continue funding the Assisted Living Pilot until the evaluation is complete and an informed decision can be made about whether or not to continue and/or expand this program to other VISNs.**

4. The State Home Program has been highly successful in meeting the long term care needs of Veterans. Currently, the state home construction program and the per diem program provide construction funding and on-going funding through the VA for nursing home level of care, domicillary care and now adult day health care (in planning). While the State Home Program continues to meet the needs of aging Veterans for nursing home care and domiciliary care, it does not fund the construction or operation of assisting living facilities, a level of care that should be more available to Veterans. **Therefore, consideration should be given to utilizing the VA State Home Construction Grant Program and Per Diem Program to spur development of assisted living facilities, with a higher priority given to assisted living projects.**

Finally, I would like to note the accomplishments of the VA's Geriatric Research, Education and Clinical Center Program. There are now 21 GRECCs nationwide that are translating their research into programs that improve the lives of older Veterans. In several research projects, including the evaluation of Geriatric Evaluation and Management Units and the development of the Resident Assessment Instrument, GRECCs have developed tools and models of care that have been adopted by the broader aging community. We look forward to the continued success of GRECCs towards the benefit of Veterans and all seniors.

In conclusion, I hope that these recommendations will spur discussion among Congress, Veterans and the VA about how to best utilize the limited resources available to meet the long term care needs of aging Veterans. Thank you again Chairman Smith and members of the Committee for the opportunity to present my views about how to provide Veterans with access to the entire continuum of long term care programs and services.

The PACE Centers of
Palmetto Senior Care

Veterans accepted into the PACE Program will be assigned to one of these Palmetto SeniorCare PACE Centers.

PSC-Eau Claire
5110 Fairfield Road

PSC-Laurel
1308 Laurel Street

PSC- Lexington
700 Knox Abbott Drive

PSC- Shandon
1100 Shirley Street

PSC– White Rock
109 Wartburg Road

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Department of Veterans Affairs

VA PACE

A Pilot Partnership
of
W.J.B. Dorn VA Medical Center
&
Palmetto Senior Care

Q: What does PACE stand for?

A: **P**rogram for **A**ll-Inclusive **C**are for the **E**lderly. Palmetto SeniorCare is the PACE program for South Carolina, started 1988 by Palmetto Health (formerly Richland Memorial) as a special health plan for senior citizens.

Q: How did WJB Dorn VAMC get involved with PACE?

A: Desiring to offer veterans a community-based option, the VA has joined with Palmetto Health in a partnership to expand health services to frail elderly veterans. This partnership between WJB Dorn VAMC and Palmetto SeniorCare is called VA-PACE.

Q: How can a veteran benefit from VA-PACE?

A: Here are just a few of the many ways that veterans can benefit from the VA-PACE program:

- VA-PACE offers a complete program of medical and support services to help frail senior citizens remain in their homes. and communities as long as possible.
- VA-PACE expands the choices for long term health care available to eligible veterans.
- Veterans receive monitoring by the VA-PACE Registered Nurse Coordinator and Program Analyst.

Services are provided through Adult Day Health, and include:

- Hospitalization
- Support Services for Caregivers
- End of Life Care
- Primary Medical & Nursing Services
- Occupational, Physical, & Speech therapy
- Medical Specialist Services
- Transportation
- Skilled Home Care & Personal Care Services
- Medications
- Nursing Home
- Alzheimer's and Dementia Care

Q: Who Can Participate?

- Veterans aged 55 and older.
- Veterans who live in Lexington or Richland County.
- Veterans who meet nursing home criteria, but who prefer to live in their own homes and communities for as long as possible.

All VA applicants will be screened by the VA PACE team. They will help you in deciding if VA PACE is the best option for you.

Q: What if I qualify but don't live in Richland/Lexington Counties?

A: Veterans who live outside the service area can help us determine the degree of success for VA PACE. These veterans will continue to receive traditional VA services in addition to having their health/health care monitored by a VA PACE program analyst.

Alzheimer's Association

STATEMENT OF

Linda Sabo, MS
on behalf of the

ALZHEIMER'S ASSOCIATION

presented to

Committee on Veterans Affairs
United States House of Representatives
January 28, 2004

10:00 a.m.

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION, INC.

Washington Office; 1319 F St., NW, Suite 710 • Washington, DC 20004 • Phone: (202) 393-7737 • Fax: (202) 393-2109 www.alz.org

Mr. Chairman and members of the committee, thank you for giving me the opportunity to testify at this important hearing. I am Linda Sabo, executive director of the Western New York Chapter of the Alzheimer's Association. The chapter serves Buffalo and eight surrounding counties in the western part of New York State.

Since 1997, my chapter and three other Alzheimer's Association chapters in upstate New York have been working with VA staff from the Veterans Integrated Services Network (VISN) 2 to create a coordinated system of care for veterans with Alzheimer's disease and other dementias. This initiative, called Partners in Dementia Care, is important for two reasons.

One, there is a large number of veterans suffering from Alzheimer's disease and other dementias. A recently completed study using VA data shows that 7.3% of veterans age 65 and over who received VA services between 1997 and 2001 had a documented diagnosis of Alzheimer's disease or another dementia.[1] Our experience in Partners in Dementia Care indicates that many veterans with these conditions have not received a diagnosis. Thus, the true prevalence of Alzheimer's disease and other dementias in veterans who use VA services is undoubtedly much higher. Moreover, VA data show that, on average, these veterans use substantial amounts of VA services, including hospital, urgent care, primary care, and institutional and non-institutional long-term care.

Many veterans who are not currently using VA services also have Alzheimer's disease and other dementias. Recent data for the U. S. population as a whole indicate that in 2000, 13% of people age 65 and over had Alzheimer's disease, with the proportion increasing from 2% of those age 65-74 to 42% of those age 85+,[2] and these figures do not include people with other dementias. Thus, the number of veterans with Alzheimer's disease and other dementias who are not now using VA services is undoubtedly also large. Given the predicted 3-fold increase by 2010 in the number of veterans age 85+, the total number of veterans with Alzheimer's disease and other dementias can be expected to increase rapidly, both among current users and non-users of VA services. We must be prepared to meet the needs of these veterans.

A second reason the Partners in Dementia Care initiative is important is that the VA must find innovative ways to ensure appropriate services and support are provided to veterans with Alzheimer's disease and other dementias. This initiative provides a best practice model for ensuring such services and support.

The Partners in Dementia Care initiative is groundbreaking because of the extent of ongoing cooperation and joint activity between the VA and Alzheimer's Association chapters. The working partnership we have developed goes far beyond the usual referrals that Alzheimer's Association chapters might make to a VA medical center or, conversely, that VA staff might make to an Alzheimer's Association chapter. VA physicians, nurses, and other VISN 2 staff worked with our chapters to plan the Partners in Dementia Care initiative. We identified the

[1] Kunik ME, Krishnan LL, Petersen NJ, et al., Prevalence of Dementia Among VA Medical Care System Users, poster presentation to the VA QUERI conference, "Enhancing Impact Through Integration and Collaboration," Alexandria, VA, Dec. 10-12, 2003.
[2] Hebert LE, Scherr PA, Bienias JL, et al., "Alzheimer disease in the US population: prevalence estimates using the 2000 Census," Archives of Neurology, 60:1119-1122, 2003.

health care, long-term care, and supportive services that each of our organizations can provide for veterans with Alzheimer's disease and other dementias and their families, and we participated in joint training for staff of both of our organizations.

Coordination of care has been a problem, both within the VA and between the VA and community agencies. Even if needed services are available, including the important non-institutional services mandated by the Millenium Act, veterans with Alzheimer's disease and other dementias may not know about or receive the services. The Partners in Dementia Care initiative is intended to make sure that these veterans and their families are connected to VA and non-VA services that can help them.

Our previous experience has been that families who receive a referral to the Alzheimer's Association from the VA or any other health care system usually wait an average of more than 2 years before contacting us. By that time, their problems have reached a crisis point. Moreover, many families never contact us. In Partners in Dementia Care, we developed an effective way of addressing this issue. With informed consent from the veteran (if capable) and the veteran's family, contact information for the family was provided to the chapter. As a result, the chapter was able to call the family to offer information and supportive services, instead of waiting for the family to contact the chapter.

The four Alzheimer's Association chapters that are participating in the Partners in Dementia Care initiative value the Partners in Dementia Care initiative because it helps us ensure that veterans and their families who contact us are quickly and effectively connected to the VA for health care and long-term care services they are eligible for, while also having access to the information, education and training programs, support groups, and other services provided by the Alzheimer's Association. For the VA, the initiative creates a way to improve the care available to veterans and ensure that VA and non-VA community services are coordinated.

Results of the Partners in Dementia Care initiative show that this best practice model of care can increase early identification and diagnosis of Alzheimer's disease and other dementias and improve quality of care, access to needed information and services, and satisfaction for veterans with these conditions and their families.

- More than 500 veterans with Alzheimer's disease and other dementias were enrolled in Partners in Dementia Care. Many of these veterans had not been previously identified or diagnosed. Although most of the enrollees were not capable of participating in evaluation interviews, 85 veterans were capable of responding. On average, these veterans reported receiving the information and support they needed, including information about available treatments and support in obtaining needed help. They also reported high satisfaction with the VA and non-VA services they received.

- Almost all of the veterans enrolled in Partners in Dementia Care had a family caregiver, and 270 of these family caregivers participated in interviews about the initiative. They reported receiving extensive information and support, especially information about how to manage daily care for the veteran and help with accessing needed VA and non-VA services.

- VISN 2 was the only VA site among the six health care systems that participated in a larger national demonstration of coordinated Alzheimer's and dementia care. Among these sites, reported satisfaction with care was higher for family caregivers of the enrolled veterans in the VISN 2 site than for family caregivers of enrollees in any of the other five, non-VA sites.

- VA physicians, nurses, and other VA and chapter staff who responded to interviews about the Partners in Dementia Care initiative (n = 209) had strongly positive attitudes about its impact on quality of care and outcomes for veterans. More than 80% of these care providers said, for example, that the initiative improved their own ability to care for their patients with dementia, increased their confidence that the and services needed by these patients and their families were available, and improved ongoing care management for the veterans and their families.

We do not have comparable information for veterans with Alzheimer's disease and other dementias who did not participate in the Partners in Dementia Care initiative in VISN 2 or veterans, families, and care providers in other VISNs. Interestingly, a GAO study of Millenium Act services provided for veterans in all VISNs in 2001 found that VISN 2 provided non-institutional Alzheimer's care for three times more veterans than the average for all other VISNs (689 vs. 191 veterans receiving services on the day of the survey).[3] VISN 2 also provided non-institutional adult day services for almost three times more veterans than the average for all other VISNs (349 vs. 133 veterans receiving adult day services on the day of the survey).[3]

The Alzheimer's Association, VA staff from VISN 2 and VA headquarters, and other VA and non-VA researchers are currently working together on proposals to implement and evaluate the Partners in Dementia Care best practice model in other VISNs. We are aware that all the non-institutional services mandated by the Millenium Act are not uniformly available to all veterans. We encourage the VA to increase the availability of these services. We do not believe, however, that the VA can provide all the services needed by veterans with Alzheimer's disease and other dementias. The services provided by Alzheimer's Association chapters are also needed. Chapter services are especially important in helping families cope with caregiving tasks and maintain their relative with dementia at home for as long as possible.

Although this hearing is focused on non-institutional services we also want to stress the need for adequate nursing home beds for veterans with Alzheimer's disease and other dementias who need nursing home care and have no family at all or no family that is able to provide this level of care.

We hope and expect to continue working with the VA to increase the availability of high-quality institutional and non-institutional care and the coordination of VA and non-VA services in order to improve outcomes for veterans with Alzheimer's disease and other dementias.

[3] General Accounting Office, testimony submitted to the U.S. Senate Committee on Veterans' Affairs, Washington DC, April 25, 2003, pps. 17-33.

Prepared Testimony of

Philip Jean, President

National Association of State Veterans Homes (NASVH)

Issues Affecting Long-Term Care for Veterans

Committee on Veterans' Affairs

U.S. House of Representatives

January 28, 2004

Mr. Chairman and members of the committee, thank you for the opportunity to testify today on behalf of the National Association of State Veterans Homes ("NASVH") on the issue of long-term care for veterans. I am pleased to serve as the 2003–2004 President of NASVH. Since 1999, I have been the administrator of the Scarborough Maine Veterans' Home. In that role, I oversee a 150-bed facility which provides skilled nursing care, skilled rehabilitation, long-term care, Alzheimer's care, respite care, residential care, and end of life care to veterans, their spouses, widows, widowers, and gold star parents.

I am joined today by two of my colleagues from across the country. Robert L. Shaw is the Administrator of the Colorado State Veterans Nursing Home at Rifle and the Legislative Officer of NASVH. John M. King is the Director of the Washington State Department of Veterans Affairs and Vice President of the National Association of State Directors of Veterans Affairs.

As the largest deliverers of long-term care to our nation's veterans, the State Veterans Homes system plays a substantial role in ensuring that eligible veterans receive the benefits, services, long-term health care, and respect that they have rightfully earned by their service and sacrifice to our country. We greatly appreciate this Committee's commitment to the long-term care needs of veterans, your understanding of the role that State Veterans Homes play, and your strong support for our programs.

NASVH is made up of the administrators and staff of State-operated veterans homes throughout the United States. We currently operate 117 veterans homes in 48 States and territories. Nursing home care is provided in 111 homes, domiciliary care in 52 homes, and hospital-type care in 5 homes. These homes presently have over 27,500 beds and in the most recent fiscal year provided nearly 6 million days of care. Attachment A to my testimony lists the homes and number of beds in each State.

We work closely with the Department of Veterans Affairs ("VA"), State governments, the National Association of State Directors of Veterans Affairs, veterans service organizations, and all other entities dedicated to the long-term care of our veterans. Our goal is to ensure that the level of care and services provided by State Veterans Homes meets or exceeds the highest standards available.

Role of the State Veterans Homes

State Veterans Homes first began serving veterans in the wake of the Civil War. Faced with a staggering number of soldiers and sailors in critical need of long-term medical care, and with the capacity of the Federal veterans home system unable to meet the demand, several States established veterans homes to provide for those residents who had served honorably in the military.

In 1888, Congress authorized Federal aid to States which maintained homes in which certain disabled American soldiers and sailors received long-term care. At the time, the payments amounted to about 30 cents per resident per day. In the years since, Congress has made several major revisions to the State Veterans Homes program to expand the base of payments to include specialized hospital, nursing home, and domiciliary care.

Today, State Veterans Homes operate under a program administered by the Federal Department of Veterans Affairs ("VA"), which offers construction grants and per diem payments to support State Veterans Homes. Both the VA construction grants and the VA per diem payments are essential components of support. Each State Veterans Home meets stringent VA-prescribed standards of care, which exceed standards prescribed for other long-term care facilities. The VA conducts annual inspections to ensure that these standards are met and to certify the proper disbursement of funds. Together, the VA and the State Homes represent a very effective and financially-efficient Federal-State collaboration in the service of our veterans.

Construction grants are authorized by 38 U.S.C. §§ 8131–8137. The objective of such grants is to assist the States in constructing or acquiring State Home facilities. Construction grants also can be utilized to renovate existing facilities, and this recently has become a more important activity. Construction grants made by the VA may not exceed 65 percent of the estimated cost of construction or renovation of facilities, including the provision of initial equipment for any such project.

The per diem payments to State Homes are authorized by 38 U.S.C. §§ 1741–1743. They are intended to assist the States in providing for the higher level of care and treatment for eligible veterans in recognized State Veterans Homes which meet standards prescribed by the Secretary of Veterans Affairs. As you know, the per diem rates are established annually by Congress. They are currently $56.24 per day for nursing home care and $26.95 per day for domiciliary care.

State Veterans Homes are in a period of sustained managed growth – the result of increasing numbers of elderly veterans who have reached that time in life when long-term care is needed. In fact, we face the largest aging veterans population in our nation's history, with our veteran population growing substantially each year, and creating a growing demand for service to long-term care veterans. The State Veterans Homes program must continue to grow in a managed fashion to fill the existing unmet need for long-term care beds for veterans in certain States, and to meet generally the annual absolute increase in the number of veterans eligible for such long-term care nationally.

Specifically, the VA has identified six States as having either a "great" or "significant" need to build new State Veterans Homes beds immediately. These six States are Florida, Texas, California, Pennsylvania, Ohio, and New York. In response to this need, Florida has five new homes in the planning stages, and Texas has five additional homes in the planning stages and a sixth new home under construction. California has three new homes approved. Pennsylvania has one new facility under construction, Ohio has two new facilities underway, and New York has one new facility pending construction.

The VA State Veterans Homes construction program is working well. According to priorities set by the VA, 37 construction projects that will add needed new beds to the State Veterans Homes system are either underway or planned in 20 States, including Florida, New York, Louisiana, Connecticut, Arkansas, Pennsylvania, California, Texas, Maine, and Ohio. In addition, numerous other renovation projects within the State Veterans Homes system are either underway or planned in several other States, including Illinois, Kansas, South Carolina, and Colorado. Attachment B to my testimony lists the projects in progress.

Most importantly, the State Veterans Homes system can construct and operate these long-term care facilities for veterans at less cost to taxpayers than can the Federal government. For example, the average daily cost of care for a veteran at a long-term care facility run directly by the VA is estimated nationally to be $376.55 per day. The same average daily cost of care at a State Veterans long-term care facility is estimated to be far less. For example, the average daily cost for long-term nursing care at Maine Veterans' Homes is only $185.51. The same cost of care at a Washington State Veterans Home is $231 per day, while Florida's cost of care is estimated to be in the range of $200–243 per day.

These total costs per day for long-term veterans nursing care are all significantly less than what it costs the VA to deliver a similar service. This, in part, prompted the VA Office of Inspector General to conclude in a 1999 report: "the SVH [State Veterans Home] program provides an economical alternative to Contract Nursing Home (CNH) placements, and VAMC [VA Medical Center] Nursing Home Care Unit (NHCU) care" (emphasis added). In this same report, the VA Office of Inspector General went on to say:

> A growing portion of the aging and infirm veteran population requires domiciliary and nursing home care. The SVH [State Veterans Home] option has become increasingly necessary in the era of VAMC [VA Medical Center] downsizing and the increasing need to discharge long-term care patients to community based facilities. VA's contribution to SVH per diem rates, which does not exceed 50 percent of the cost to treat patients, is significantly less than the cost of care in VA and community facilities.

Threat to State Veterans Homes Program

Unfortunately, there now exists an immediate and severe threat to the State Veterans Homes program that we hope the Members of this committee will consider and address this year. The use of VA per diem payments by many States is threatened by interpretations of Medicaid rules by the Centers for Medicare & Medicaid Services ("CMS"). This threat is applicable to States that have elected to fund their State Veterans Homes in part through Medicaid.

The State Veterans Homes are financed in many different ways, but in recent years, a growing number of State Veterans Homes have decided to become Medicaid-certified nursing homes. This provides the opportunity for those homes to use Medicaid funds to help defray costs. There are approximately 20 States where the State Veterans Homes are Medicaid-certified.

For those States, there is some ambiguity regarding the treatment of the VA per diem. Under the interpretation of its Medicaid rules being advanced by CMS, VA per diem payments would be considered a third party payment in the Medicaid-certified States. This would require that the entire amount of the VA per diem be offset against Medicaid payments, thereby denying veterans who receive Medicaid in these States any benefit whatsoever of the VA per diem payments.

This result obviously frustrates the intent of Congress in establishing the VA per diem payment system in the first place. For more than 100 years, the Federal government has provided support for the State Veterans Homes. Since 1960, this support largely has been in form of the VA per diem payment. State Veterans Homes are required to meet very stringent and very costly VA standards for veterans care as a condition for receiving these per diem payments. The CMS interpretation, however, would deny the State Veterans Homes system and the veterans residing in it any benefit whatsoever from such VA per diem payments, thus effectively treating veterans no differently than non-veterans, conflicting directly with the intent of Congress to provide our veterans with a stricter standard of care.

In my own State of Maine, this interpretation is also contrary to State law, which provides that "the Maine Veterans' Homes retain as direct income revenue any stipend funds they may receive from the Federal Veterans' Administration for the homes' entire

eligible resident population." Other States have also determined to treat the per diem stipend in this same manner, while still other States have chosen to offset the payments against their Medicaid funding.

The result of the CMS interpretation would be to force the State Veterans Homes that do not currently offset the VA per diem payments against Medicaid funding to look for alternative funding sources, reduce their standard of care, and possibly to close certain State Veterans Homes. At the Maine Veterans' Homes, the VA per diem payments are the difference between our Veterans' Homes system operating in the black or operating in the red. We simply could not provide the level of service we currently provide to our veterans if Medicaid funding were to be offset against the VA per diem amount.

Many costs of care are not covered by Medicaid or other Federal programs and must nonetheless be paid for by the State Veterans Homes. Our fear is that an insistence by CMS on the current CMS interpretation would jeopardize the funding balance for many Medicaid-certified State Veterans Homes across the country, particularly during a period when States face severe fiscal crises. In other States, the per diem offset issue is a looming financial threat that will severely limit funding choices for State Veterans Homes in those States until the problem is solved.

Proposed Legislative Solution

A clarification to the law to solve this problem would make clear that VA per diem payments would not be required to be treated as a third party payment under Medicaid. Federal law already includes exceptions for similar payments, including those made under the Indian Health, Community Health, and Migrant Health programs. Clarifying that the VA per diem similarly should not be treated automatically as a third party payment would eliminate the threat to States that are Medicaid-certified. For the majority of States, which are not Medicaid-certified, there would be no effect. And because such proposed legislation would clarify the law as it is currently being implemented and applied, there would be no new costs to the Federal government.

Legislation to clarify this issue was considered previously by Congress, in 1986. The legislation was approved in the Senate but not enacted. In the intervening years, the number of affected States has increased and the confusion surrounding the treatment of per diem payments within the Medicaid system has grown. It is essential and urgent that Congress clarify the matter now and ensure that the long-term care promises that we have made to our veterans are kept. If this issue is not dealt with promptly, many States will face serious financial crises in the funding for State Veterans Homes. Mr. Chairman, we look forward to working with you and Members of the Committee on this important matter, and I thank you for the opportunity to testify today.

Attachments

Attachment A

VISN	State Home Program (Authorized Bed Capacity) as of January 2004						
				DOM	NHC	HOSP	ADHC
	State Homes (117/48)*	City		(49/33)	(111/46)	(5/4)	(1/1)
	Total State Homes	117	TOTAL STATE BEDS	6066	21000	454	40
7	1. Alabama	Alexander City		0	150	0	
7		Bay Minette		0	150	0	
7		Huntsville		0	150	0	
			Total Beds	0	450	0	
18	2. Arizona	Phoenix		0	200	0	40
16	3. Arkansas	Little Rock	Total Beds	55	61	0	
22	4. California	Barstow		220	58	0	
22		Chula Vista		220	180	0	
21		Yountville		817	570	46	
			Total Beds	1257	808	46	
19	5. Colorado	Florence		0	120	0	
19		Homelake		50	60	0	
19		Rifle		0	100	0	
19		Walsenburg		0	120	0	
19		Fitzsimons			180		
			Total Beds	50	580	0	
1	6. Connecticut	Rocky Hill	Total Beds	650	0	350	
8	7. Florida	Daytona Beach		0	120	0	
8		Lake City		150	0	0	
8		Land O'Lakes		0	120	0	
8		Pembroke Pines		0	120	0	
			Total Beds	150	360	0	
7	8. Georgia	Augusta		0	192	0	
7		Milledgeville		175	375	0	
			Total Beds	175	567	0	
20	9. Idaho	Boise		46	136	0	
20		Lewiston		0	66	0	
19		Pocatello		0	66	0	
			Total Beds	46	268	0	
15	10. Illinois	Anna		12	50	0	
12		LaSalle		0	120	0	
12		Manteno		12	340	0	
23		Quincy		150	629	0	
			Total Beds	174	1139	0	
11	11.Indiana	Lafayette		115	465	0	
23	12. Iowa	Marshalltown		113	691	26	
15	13. Kansas	Fort Dodge		165	86	0	
15		Winfield		80	104	0	
			Total Beds	245	190	0	

	State	State Home		DOM	NHC	HOSP	ADHC
23	24. Nebraska	Grand Island		2	414	0	
23		Norfolk		0	149	0	
23		Omaha		9	179	0	
19		Scottsbluff		90	50	0	
			Total Beds	101	792	0	
22	25. Nevada	Boulder City	Total Beds	0	180	0	
1	26. New Hampshire	Tilton	Total Beds	0	150	0	
3	27. New Jersey	Menlo Park		0	332	0	
3		Paramus		0	336	0	
4		Vineland		0	300	0	
			Total Beds	0	968	0	
18	28. New Mexico	Fort Bayard		0	47	0	
18		Truth or Conseq.		20	164	0	
			Total Beds	20	211	0	
2	29. New York	Batavia		0	126	0	
2		Oxford		0	242	0	
3		Saint Albans		0	250	0	
3		Stony Brook		0	350	0	
3		Montrose		0	252	0	
			Total Beds	0	1220	0	
6	30. North Carolina	Fayetteville	Total Beds	0	150	0	
23	31. North Dakota	Lisbon	Total Beds	112	38	0	
10	32. Ohio	Sandusky	Total Beds	300	427	0	
16	33. Oklahoma	Ardmore		10	175	0	
16		Claremore		0	302	0	
16		Clinton		0	145	0	
16		Norman		0	301	0	
16		Sulphur		30	132	0	
16		Talihina		0	184	0	
			Total Beds	40	1239	0	
20	34. Oregon	The Dalles	Total Beds	0	151	0	
4	35. Pennsylvania	Erie		100	75	0	
4		Hollidaysburg		167	348	0	
4		Pittsburgh		32	204	0	
4		Scranton		16	184	0	
4		Spring City		150	192	0	
4		Delaware Valley			171		
			Total Beds	465	1174	0	
8	36. Puerto Rico	Juana Diaz		180	60	0	

	State	State Home		DOM	NHC	HOSP	ADHC
1	37. Rhode Island	Bristol		79	260	0	
7	38. South Carolina	Anderson		0	220	0	
7		Columbia		0	115	0	
			Total Beds	0	335	0	
23	39. South Dakota	Hot Springs		128	52	0	
9	40. Tennessee	Humboldt		0	120	0	
9		Murfreesboro		0	120	0	
			Total Beds	0	240	0	
18	41. Texas	Big Springs		0	160	0	
17		Bonham		0	160	0	
17		Floresville		0	160	0	
17		Temple		0	160	0	
			Total Beds	0	640	0	
19	42. Utah	Salt Lake City		0	80	0	
1	43. Vermont	Bennington		31	185	0	
6	44. Virginia	Roanoke		60	180	0	
20	45. Washington	Orting		41	161	0	
20		Retsil		8	259	0	
20		Spokane		0	100	0	
			Total Beds	49	520	0	
9	46. West Virginia	Barboursville	Total Beds	195	0	0	
12	47. Wisconsin	King		84	665	0	
12		Union Grove		86	0	0	
			Total Beds	170	665	0	
19	48. Wyoming	Buffalo	Total Beds	123	0	0	
	Total State Homes	117	TOTAL STATE BEDS	6,066	21,000	454	40

Attachment B

Priority List of Pending State Home Construction Grant Applications for FY 2004

FY 2000 List Rank	FY 2004 List Rank	FAI No.	State (Locality)	Description	Priority Group (PG) Ranking	Est. VA Grant Cost (000)
				FY 2000 Transition Applications Subject to Previous Regulations (38 CFR 17.190 - 17.222)		
24	1	55-020	WI (King)	Renovate Food Service Facility - NHC	PG-1	2,470
51	2	54-005	WV (Barboursville) *	General Renovations - Dom	PG-1	1,474
56	3	45-003	SC (Walterboro) **	220-Bed NHC; 60-Bed Dom	PG-1	18,572
				Subtotal All Transition Phase Applications:		22,516

	FY 2004 List Rank	FAI No.	State (Locality)	Description	PG, Subpriority, Further Priority, Ranking	Est. VA Grant Cost (000)
				FY 2004 Applications Subject to Revised Regulations (38 CFR 59) - Priority Group 1		
	4	31-014	NE (Omaha)	120-Bed NHC/DOM (Repl.)	PG - 1,1,2	9,540
	5	25-050	MA (Chelsea) **	Life Safety- Fire Alarm Sys	PG - 1,1,5	6,068
	6	39-019	OH (Sandusky)	Fire Alarm, Emergency Generator and Security	PG - 1,1,5	2,269
	7	56-005	WY (Buffalo) *	Life/Safety Systems Renovations	PG - 1,1,5	616
	8	33-005	NH (Tilton)	Upgrade Fire/Safety & General Renovations	PG - 1,1,5	1,671
	9	25-050	MA (Holyoke)	Life Safety - Air Conditioning	PG - 1,1,7	8,055
	10	21-005	KY (Wilmore) *	Renovate Special Care Unit	PG - 1,1,7	1,863
	11	06-048	CA (Yountville) **	Renovate Water Storage/Transmission Lines	PG - 1,1,7	1,370
	12	21-006	KY (Hanson)	Life/SafetyHVAC Renovation	PG - 1,1,7	309
	13	54-008	WV (Clarksburg) **	120-Bed NHC (New)	PG - 1,2	14,857
	14	15-001	HI (Hilo)	96-Bed NHC (New)	PG - 1,2	15,229
	15	06-044	CA (Greater LA County	620-bed NHC/Dom (New)	PG - 1,3	54,804
	16	55-025	WI (Union Grove) **	Adult Day Healthcare (Renv)	PG - 1,4,1	588
	17	06-049	CA (Yountville) **	Annex 1 Renovations	PG - 1,4,2	10,063
	18	25-059	MA (Holyoke)	Care Center Compliance Renov.	PG - 1,4,2	695
	19	36-007	NY (Stony Brook) *	ADA Compliance	PG - 1,4,3	301
	20	36-008	NY (Stony Brook)	ADA Compliance - Phase II	PG - 1,4,3	421
	21	08-012	CO (Homelake) *	Upgrade Heating Plant,Mechanical/Electrical Systems	PG - 1,4,4	473
	22	25-055	MA (Chelsea) **	Roof Replacement	PG - 1,4,4	589
	23	55-026	WI (King)	Upgrade Nurse Call System	PG - 1,4,4	520
	24	55-027	WI (King) *	Upgrade Boiler Control System	PG - 1,4,4	391
	25	08-013	CO (Rifle)	Upgrade Fire/Safety Renovations	PG - 1,4,4	1,662
	26	06-050	CA (Yountville) **	Electrical System Renovation	PG - 1,4,4	2,217
	27	06-051	CA (Yountville)	Steam Dist. System Renov.	PG - 1,4,4	1,729
	28	20-003	KS (Fort Dodge) **	HVAC Upgrade	PG - 1,4,4	1,141
	29	31-013	NE (Grand Island)	Generator/Water System	PG - 1,4,4	1,378
	30	55-029	WI (Union Grove)	Chilled Water Plant Renov	PG - 1,4,4	1,002
	31	55-030	WI (King)	Install Freight Elevator - MacArthur Hall	PG - 1,4,4	272
	32	55-031	WI (King)	Water Supply Well System	PG - 1,4,4	1,389
	33	29-013	MO (St. Louis)	Roof Replacement	PG - 1,4,4	966
	34	29-014	MO (Cape Girardeau)	HVAC Upgrade, Gen. Renov., & Construct	PG - 1,4,4	3,489
	35	37-003	NC (Salisbury)	Dietary Project	PG - 1,4,5	695
	36	06-045	CA (Yountville)	Laundry Building Renovation	PG - 1,4,5	1,202
	37	06-047	CA (Yountville)	Chapel Renovation	PG - 1,4,5	1,013
	38	06-049	CA (Yountville)	Recreation Building Renovation	PG - 1,4,5	4,885
	39	25-057	MA (Holyoke)	Auditorium Modification	PG - 1,4,5	591
	40	55-028	WI (Union Grove)	Dietary Renovation	PG - 1,4,5	2,145

Priority List of Pending State Home Construction Grant Applications for FY 2004

FY 2004 List Rank	FAI No.	State (Locality)	Description	PG, Subpriority, Further Priority, Ranking	Est. VA Grant Cost (000)
			FY 2004 Applications Subject to Revised Regulations (38 CFR 59) - Priority Group 1		
41	25-059	MA (Holyoke)	Kitchen Renovation	PG - 1,4,5	975
42	53-032	WA (Spokane)	Kitchen Addition	PG - 1,4,5	937
43	08-011	CO (Florence) *	General Renovation	PG - 1,4,6	4,056
44	25-054	MA (Chelsea)	General Renovations	PG - 1,4,6	3,250
45	46-011	SD (Hot Spring)	General Renovations	PG - 1,4,6	1,233
46	20-002	KS (Winfield) **	General Renovations	PG - 1,4,6	2,829
47	17-026	IL (LaSalle)	New Storage Building	PG - 1,4,6	500
48	17-027	IL (Quincy)	Bus & Ambulance Garage	PG - 1,4,6	585
49	12-012	FL (Lake City)	General Renovations	PG - 1,4,6	925
50	28-005	MS (Jackson)	General Renovations	PG - 1,4,6	1,800
51	51-004	VA (Roanoke)	General Renovations	PG - 1,4,6	404
52	48-007	TX (Amarillo)	160-Bed NHC (New)	PG - 1,5	8,881
53	42-019	PA (Erie)	50-Bed Alzheimer's/NHC (Add.)	PG - 1,5	4,275
54	47-005	TN (Knox County)	120-bed NHC (New)	PG - 1,6	10,660
55	22-004	LA (Reserve)	156-Bed HNC/Dom (New)	PG - 1,6	11,248
56	51-002	VA (Richmond)	220-Bed NHC; 60-Bed Dom (New)	PG - 1,6	14,750
57	55-023	WI (Union Grove)	120-Bed NHC (New) & Commons Bldg	PG - 1,6	12,025
58	23-010	ME (Machias)	30-Bed Domiciliary (New)	PG - 1,6	4,306
59	05-003	AR (Fayetteville)	108-Bed NHC (New)	PG - 1,6	4,456
60	17-025	IL (Quincy)	106-Bed NHC (New)	PG - 1,6	3,213
61	47-006	TN (Murfreesboro)	20-Bed Alzheimer's Unit Addition & General	PG - 1,6	2,275
62	47-007	TN (Humbolt)	20-Bed Alzheimer's Unit Addition & General	PG - 1,6	1,996
63	22-005	LA (Bossier City)	156-Bed NHC (New)	PG - 1,6	11,248
64	05-052	CA (Redding) **2	150-Bed NHC/DOM (New)	PG - 1,3	17,572
65	05-053	CA (Fresno) **2	300-Bed NHC/DOM (New)	PG - 1,3	25,864
66	48-008	TX (Pending) **3	160-Bed NHC (New)	PG - 1,5	8,881
67	48-009	TX (Pending) **3	160-Bed NHC (New)	PG - 1,5	8,881
68	48-010	TX (Pending) **3	160-Bed NHC (New)	PG - 1,5	8,881
69	48-011	TX (Pending) **3	160-Bed NHC (New)	PG - 1,5	8,881
70	55-032	WI (Union Grove) **4	24-Bed DOM Addition (New)	PG - 1,6	1,825
			Subtotal All Transition & New Priority Group 1 (Has State Matching Funds) Applications:		**367,009**

FY 2004 List Rank	FAI No.	State (Locality)	FY 2004 Applications Subject to Revised Regulations (38 CFR 59) - Priority Groups 2-7	PG, Subpriority, Further Priority, Ranking	Est. VA Grant Cost (000)
71	09-012	CT (Rocky Hill)	Life Safety General Renovations - DOM	PG - 2,7	7,800
72	02-001	AK (Palmer)	General Renovations to Establish SVH (79-Beds)	PG - 3	1,785
73	09-011	CT (Rocky Hill)	250-Bed NHC (New)	PG - 3	20,040
74	12-007	FL (Pending)	120-Bed NHC (New)	PG - 4	9,207
75	12-008	FL (Pending)	120-Bed NHC (New)	PG - 4	9,418
76	12-009	FL (Pending)	240-Bed NHC (New)	PG - 4	16,980
77	12-010	FL (Pending)	120-Bed NHC (New)	PG - 4	9,857
78	12-011	FL (Pending)	240-Bed NHC (New)	PG - 4	17,780
79	27-018	MN (Minneapolis)	Adult Day Health Care Renovation - 35 Participants	PG - 5,1	1,838
80	35-003	NY (Oxford)	New Wing & Renovations - No Beds	PG - 5,2	1,217
81	19-028	IA (Marshalltown)	General Renovations NHC	PG - 5,2	2,731
82	27-019	MN (Luverne)	Dementia Unit	PG - 5,2	498

Priority List of Pending State Home Construction Grant Applications for FY 2004

FY 2004 List Rank	FAI No.	State (Locality)	FY 2004 Applications Subject to Revised Regulations (38 CFR 59) - Priority Groups 2-7	PG, Subpriority, Further Priority, Ranking	Est. VA Grant Cost (000)
82	44-009	RI (Bristol)	Nursing Unit Renovations	PG - 5,2	2,218
84	13-006	GA (Milledgeville/Augusta)	Elevator Renovations (5 Buildings)	PG - 5,4	656
85	13-007	GA (Milledgeville)	HVAC Renov. - Wheeler Bldg.	PG - 5,4	480
86	27-020	MN (Minneapolis)	Kitchen/Dining Room Renov.	PG - 5,5	2,844
87	27-021	MN (Silver Bay)	Nursing Care Space	PG - 5,5	499
88	13-005	GA (Milledgeville)	Dietary Facility	PG - 5,5	715
89	34-025	NJ (Paramus)	Multipurpose Room	PG - 5,6	1,415
90	36-010	NY (St. Albans)	General Renovations	PG - 5,6	3,247
91	08-014	CO (Homelake)	Upgrade Resident Support and Activity Areas	PG - 5,8	844
92	39-017	OH (Pending)	168-bed NHC (New)	PG - 6	7,800
93	39-018	OH (Pending)	168-bed NHC (New)	PG - 6	7,800
94	36-009	NY (Oxford)	252-Bed NHC (242 Repl. + 10 Addit.)	PG - 6	39,215
95	37-004	NC (Eastern)	120-Bed NHC (New)	PG - 6	5,358
96	55-021	WI (King)	45-Bed Dom (New)	PG - 7	2,294
97	24-005	MD (Western)	120-Bed NHC (New)	PG - 7	7,684
98	53-030	WA (Orting)	120-Bed NHC (97 Repl. 23 new)	PG - 7	8,316
99	27-022	MN (Fergus Falls)	Dementia - Special Care Unit	PG - 7	4,799
100	37-005	NC (Western)	120-Bed NHC (New)	PG - 7	5,358
		Subtotal All Priority Groups 2 - 7 Applications (No State Matching Funds):			**192,691**
			Total All Pending Applications:		**559,700**

* These projects were awarded after August 15, 2003.

** These projects were conditionally approved after August 15, 2003. This is a 180 day time extension authorized in 38 UCS 8135.

**2 The State of California has requested that funding for the construction of one of its bed-producing project (06-044) be considered for funding on this priority list. Projects 06-052 and 06-053 have PG-1 certification of 35% State matching

**3 The State of Texas has requested funding for the construction of one of its bed-producing projects (48-007) be consid for funding on this priority list. Projects 48-009 through 48-011 have PG-1 certification of 35% State matching funds.

**4 The State of Wisconsin has requested that funding for the construction of one of its bed-producing project (55-023) be considered for funding on this priority list. Project 55-032 has PG-1 certification of 35% State matching funds.

This Priority List is established in accordance with 38 USC 8135 and 38 CFR 59

These applications will be funded in FY 2004 in the order which they appear on this list, subject to the availability of Federal funds and compliance with all Federal requirements.

Approved.

Anthony J. Principi
Secretary, Department of Veterans Affairs

1/28/04
Date

National Association of State Veterans Homes
"Caring for America's Heroes"

Return Address:
Philip D. Jean
President, NASVH
Maine Veterans' Home-Scarborough
290 US Route One
Scarborough, ME 04074
(207) 883-7184

March 8, 2004

The Honorable Christopher H. Smith
Chairman
House Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, D.C. 20510

The Honorable Lane Evans
Ranking Member
House Committee on Veterans' Affairs
U.S. House of Representatives
333 Cannon House Office Building
Washington, D.C. 20510

Re: Supplement to January 28, 2004 Testimony

Dear Chairman Smith and Congressman Evans:

It was a pleasure to appear before the Committee on Veterans' Affairs on behalf of the National Association of State Veterans Homes ("NASVH") at the January 28, 2004 hearing on issues affecting long-term care for veterans. Following the hearing, I was asked by Committee staff for additional information on the issue I described related to the VA per diem available to State Veterans Homes. I ask that this letter, in response to that request, be included in the hearing record.

In my testimony, I described a threat to the VA per diem stipend provided for in 38 U.S.C. §§ 1741–1743. The Centers for Medicare & Medicaid Services ("CMS") is advancing an interpretation of Medicaid rules that would treat the VA per diem as a third-party payment and require the entire amount of the per diem to be offset. I explained that in states with Medicaid-certified Veterans Homes, the per diem allows homes to satisfy the higher standard of care required by the VA.

The Committee staff asked for an example of how the funding currently works in a State Veterans Home system and what the shortfall would be if the VA per diem is offset. I asked the State of Washington to provide NASVH with detailed information as an illustration.

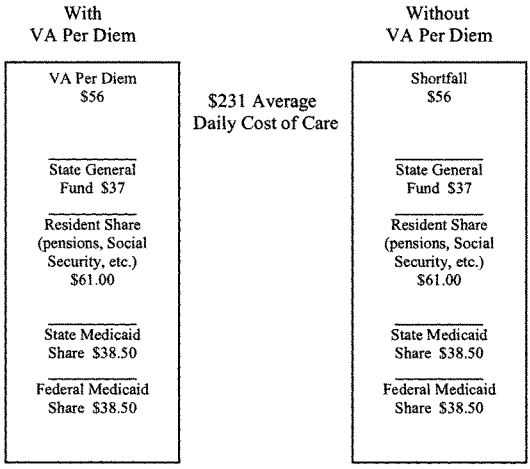
In Washington, the average daily cost of care in 2003 was $231. Of that amount, $138 is reimbursed by Medicaid, which is shared evenly by the State and by CMS. Of the

$138 Medicaid amount, individual residents contribute $61 through third party payments such as pensions or Social Security. The portion not covered by Medicaid is $93. Of that total, the State of Washington general fund pays $37, and the $56 VA per diem makes up the rest.

The Washington data, which is also presented below and in an attached chart, demonstrates that the per diem, along with the additional State contribution, makes it possible for the Homes to meet the higher standard of care required by the VA.

The following bar graphs simply illustrate the situation, both with and without the per diem stipend:

State of Washington
State Veterans Homes System
Average Daily Funding



Unless something is done to clarify that the State Veterans Homes may continue to retain the VA per diem without offsetting it against Medicaid payments, an additional $56 must be found to maintain solvency. The State of Washington already contributes to the funding of its State Veterans Homes through its share of Medicaid funding and again from the general fund.

While there are differences state-to-state in the Medicaid share ratios, the total cost of care, and the number of residents that are Medicaid-qualified, other States with

Medicaid-certified State Veterans Homes face the same problem. Medicaid-certified State Veterans Home systems that retain the VA per diem payments will continue to operate, while those that are denied those payments and that have a large number of Medicaid residents will be forced to make difficult choices about the quality of care, available programs and services, and even continued operations.

I hope that this letter and the financial information presented herein prove helpful to the Committee. If you have any questions, please do not hesitate to contact me, my colleague John E. Larouche (at 207-883-7184), or John M. King, Director of the Department of Veterans Affairs, State of Washington (at 360-725-2151).

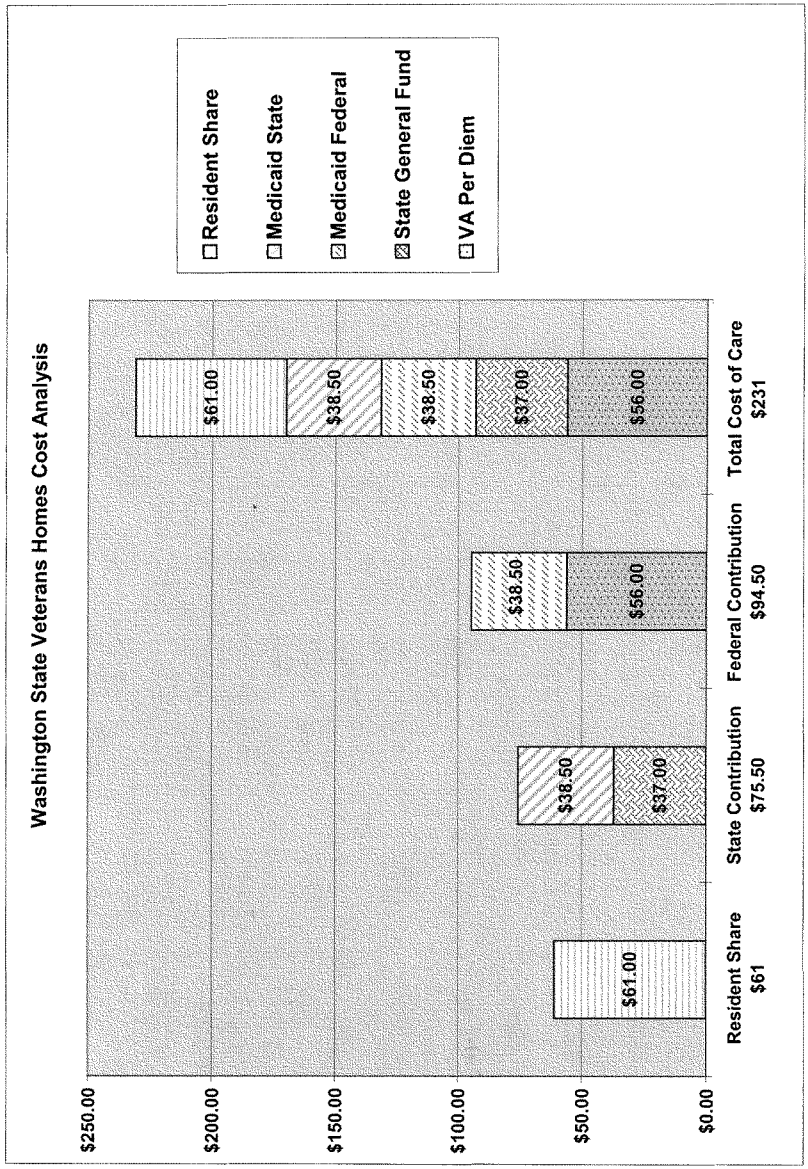
NASVH looks forward to working with you and the Committee on this important issue.

Sincerely,

Philip J. Jean

Philip Jean, MBA, CNHA
President

Attachment


Washington State Veterans Homes Cost Analysis
$250.00
$200.00
$150.00
$100.00
$50.00
$0.00
Resident Share
State General Fund
Medicaid Federal
Medicaid State
VA Per Diem
$61.00
$38.50
$37.00
$56.00
Resident Share $61
State Contribution $75.50
Federal Contribution $94.50
Total Cost of Care $231

STATEMENT OF
CAROL RUTHERFORD, DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
TO THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE LONG TERM CARE POLICIES OF
THE DEPARTMENT OF VETERANS AFFAIRS

JANUARY 28, 2004

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to share The American Legion's views on the Long Term Care policies of the Department of Veterans Affairs. We commend the Committee for holding this hearing to discuss these important issues.

BACKGROUND AND DEMOGRAPHICS

Department of Veterans Affairs' (VA) Long Term Care (LTC) has been the subject of discussion and legislation for nearly twenty years. In a landmark July 1984 study, ***Caring for the Older Veteran***, it was predicted that a 445 percent increase over 1980 in the numbers of veterans aged 75 and older would occur by the year 2000 and that 21.3 percent of all veterans in 2010 would be 75 or over compared to 3 percent in 1980. The study projected the Average Daily Census (ADC) in VA institutional LTC as 80,000 in 1990 with peak demand occurring in 2010 at between 110,000 and 140,000. In 1980, approximately 28 percent of all males 65 and over were veterans and the study projected that would increase to 62 percent by 2000. It was further estimated that demand for non-institutional care, not widely available in America at that time, could approach 790,000 veterans. This "wave" of elderly World War II and Korean Conflict veterans would occur some 20 years ahead of the general patient population and had the potential to overwhelm the VA LTC system if not properly planned for.

The most recent available data from VA, 2000 Census-based VETPOP 2001 Adjusted, shows there were 25.6 million veterans in 2002. Of that number, 9.76 million, or 37 percent, are age 65 or older. According to the 2001 National Survey of Veterans, the average age of all veterans was 58 years. More specifically, just 21.1 percent of the veteran population was under the age of 45, 41.2 percent were between the ages of 45 and 64, and 37.1 percent of the population was 65 years or older. The percentage of veterans 65 and older is significantly lower than the 62 percent projected by the 1984 study.

These findings do reflect the continuing trend of the aging veteran population; however, in comparison to the 1992 veteran population, the percentage of veterans in the youngest age cohort decreased (21 percent vs. 32 percent), the age percentage of the oldest age cohort increased (38 percent vs. 26 percent), and the middle cohort remained virtually unchanged (42 percent vs. 41 percent). Gender comparisons show that almost 4 in 5 male veterans are 45 years and older. This percentage of male veterans over 45 reflects their participation in the major wars of the last century. In contrast, female veterans tend to be younger. More than half of female veterans are under the age of 45. This gender difference between male and female veterans is due in part to the fact that females did not enter into the armed forces in great numbers until 1975. However, there is also a smaller peak in the female veteran age distribution at the older ages, reflecting their participation in WWII. Approximately 12 percent of female veterans are 75 years or older.

Veterans with service-connected disabilities rated 70 percent or higher have priority for VA institutional LTC under current law. In 2000, there were 328,363 such veterans. VETPOP2001 Adjusted projects this number to increase to 462,581 by 2010 and 533,695 by 2020, representing 29.1 percent and 39.5 percent increases over 2000, respectively.

VHA'S LONG TERM CARE PLAN

In April 1999, then Undersecretary of Veterans Affairs for Health, Dr. Kenneth Kizer and others issued ***A Strategic Plan for Long Term Care Provided by the Veterans Health Administration***. In the introduction, the Plan implied that the "wave" forecast in the 1984 study had arrived and that VHA was now confronted with a " 'demographic imperative' that the rest of American society will confront in another 15 or 20 years (i.e., a burgeoning population of elderly persons needing both acute and long-term healthcare services)...." and that the "imminent need to provide a coherent and comprehensive approach to long-term care for veterans will severely strain the VA health care system and will require significant increased funding."

In the Plan, VHA defined LTC as the continuing care needs of the person, as determined by their functional status. A number of Strategic Actions were outlined in the Plan including:

- Financial incentives and performance measures for Veterans Integrated Service Networks (VISN). The refinement of the VA LTC Planning Model, Planning for VA LTC should be based on Priority Groups 1-6 veterans and modeling for Priority Group 7 veterans (*prior to creation of Priority Group 8 veterans*) should include analysis of co-payments, coinsurance and insurance. This coverage was to have been initiated by VA, if deemed feasible.
- Retention of core in-house LTC services with most new demand for LTC being met through non-institutional services, contracting and State Veterans Homes (SVHs),
- Preference was to have been given to Home and Community-Based Care (HCBC), as defined in the basic benefits package, when clinically appropriate.
- VA was to have increased its investment in HCBC from 2.5 percent to 7.5 percent of the VA medical care budget, increased the FY 2000 – FY 2003 budgets for HCBC by $106 million per fiscal year and $30 million per FY for four years for new and innovative HCBC models with emphasis on community provider partnerships.
- Within VA LTC spending, HCBC was to double to 35 percent of LTC expenditures and legislative authority was to be sought for budget initiatives for new Facilitated Residential Living programs.
- VA was tasked to develop a policy on contract Community Nursing Homes (CNH) based on patient needs rather than one-size-fits-all contract lengths based on fiscal goals.
- Veterans with continuing needs and whose VA NHUs stays exceed 1000 days should be allowed to remain if they so desire, the current limitation being arbitrary.
- VA should not seek funding for new NHUs, except where justified by objective measures and national policy. A redesigned SVH construction grant prioritization methodology was to be advanced.
- VA was to have developed a standardized core patient assessment model using Resident Assessment Instrument/Minimum Data Set (RAI/MDS) input by Geriatric Evaluation Management (GEM) Teams.

The Plan also called for VA to seek legislative authority for broadened respite care, payment of Assisted Living/Residential Care and a new Medicare-like 100 days/patient/year nursing home benefit following a period of VA hospitalization. Additional ideas called for enhanced LTC/mental health staff collaboration, research and geriatrics education initiatives, and incentives to VISNs for lowering costs and increasing services offered and the development of a LTC Quality Index.

EXPANSION OF LONG TERM CARE ELIGIBILITY

On November 30, 1999, the President signed into law the Veterans Millennium Health Care and Benefits Act of 1999, P.L. 106-117, 113 Stat. 1545 (1999), (Millennium Act) which provided VA authority to implement some aspects of VHA's Long Term Care Plan.

Section 101 of the Act mandates VA to provide nursing home care to any veteran who requires it due to a service-connected disability and any vet with a disability rating 70 percent or higher. Certain other veterans are also eligible for VA NHU care. It also provides that any veteran currently in a VA NHU who continues to need care cannot be transferred to a SVH or contract nursing home without his or her consent. It further redefined "medical services" to include non-institutional Extended Care Services (ECS) provided either directly by VA, contract or third party providers/payers.

The Millennium Act directs VA to operate and maintain a program to provide ECS subject to 38 U.S.C. § 1710(a)(4): "effective in any fiscal year only to the extent and in the amounts provided in advance in appropriations Acts for such purposes." For ECS for the general, non-service connected veteran population, copayments may be required except where the veteran meets certain annual income limitation criteria (means testing) or is receiving a non-service connected VA pension based on wartime service, limited assets and permanent and total disability. The Millennium Act directs VA to develop a methodology for determining the amounts of copayments and establishes VA's Extended Care Fund, a Treasury revolving fund, into which copayments are to be deposited. Copayments for Extended Care Service were published October 4, 2001. Final regulations were published May 17, 2002, and became effective June 17, 2002. Implementation began at the end of July 2002. No deposits to the fund are shown either in the FY 2002 actual VA healthcare business-line budget or in the FY 2003 or FY 2004 estimated budgets. VHA Directive 2002-008, Extended Care Fund, was published in February 2002 and provides financial policy and procedures for VA's Extended Care Fund.

Statutory entitlement to VA's ECS under the Millennium Act does not necessarily mean that a veteran will be automatically admitted to a VA NHU, SVH or CNH. VHA Directive 2000-044, November 14, 2000, requires that VA facilities determine the need for nursing home care based on a comprehensive interdisciplinary clinical assessment. Where it is clinically appropriate, eligible patients are placed initially in the least restrictive, lowest cost environment; Home and Community Based Care (HCBC). Patients admitted to VA NCUs or CHNs on or after the Millennium Act date of enactment may be transferred to HCBC or assisted living facilities only when it is clinically determined that the patient no longer needs inpatient care at any level. An attachment to the Directive, **Policy Guidelines for Continuity of Care Planning for VA Long Term Care Inpatient Units**, states as a principle that while fiscal constraints and competing priorities exist, transfer decisions should not be based solely on cost considerations.

INSTITUTIONAL CARE

Nursing Homes

Except for the occasional congressional initiative to build nursing homes in individual states or congressional districts and some CARES planning initiatives, VA has no plans to expand its own nursing home capacity. On the contrary, it is apparent that VA intends to get out of the nursing homes business to the extent possible. It was charged in the House Veterans' Affairs Committee's (HVAC) FY 2004 Budget *Views and Estimates* that VA plans to do away with a large part of its existing LTC beds, to wit:

> The Committee has been in regular communication with the Secretary concerning a noted decline in VA nursing home beds (approximately 2,000 beds). On May 8, 2002 the Secretary made a commitment to restore these beds to their prior level, provided that Congress appropriates an increase in VA's medical care appropriation for fiscal year 2003. In the omnibus appropriation approved by Congress on February 13, 2003, VA received $1.1 billion more than what was requested by the President for the period.
>
> The Committee is disappointed by the Secretary's proposal in this budget to close thousands of additional VA nursing home beds. VA's own long-term care model, based on the medical needs of its users, indicated a need for 17,000 new nursing home beds by 2020. The Committee does not believe that VA can replace 5,000 nursing home beds with outpatient programs for elderly, chronically ill veterans.
>
> VA has failed to fulfill the promise of its landmark mid-1980's study, ***Caring for the Older Veteran***. That study recommended large increases in both inpatient and alternative programs, such as respite, hospice, adult-day and home-based care, so that VA could approach the needs of World War II veterans with meaningful, health and end-of-life care programs, on both institutional and non-institutional bases. This has not been achieved.
>
> In order to aid the Department in maintaining its current nursing home bed level, the Committee recommended VA's budget request be augmented by an additional $297 million. Furthermore, VA should fund effective alternatives to long-term care and reopen long-term care nursing beds that have been closed.

The Millennium Act required VA to maintain its in-house NHU bed capacity at the 1998 level of 13,391. This capacity has significantly eroded rather than been maintained. In 1999 there were 12,653 VA NHU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimates it will have only 9,900 beds in 2003 and 8,500 in 2004. VA has claimed that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act.

In a February 2002 letter to HVAC Ranking Democratic Member Lane Evans, VA Secretary Anthony Principi stated:

> "I have come to the conclusion that as long as we continue to use VA inpatient average daily census (ADC) as the singular measure for long-term care capacity, it will not be possible for VA to meet the requirements of P.L. 106-117 without adversely affecting our ability to provide other essential health care services to veterans on a timely basis."

On March 20, 2002, VA Secretary Principi forwarded a plan to HVAC to restore VA NHU bed capacity to the 1998 level including "substantial implications" for doing so. The cost was to be offset by forgoing planned expansion of contract community nursing care, decreasing education and research programs, reprogramming technology infrastructure requirements, transferring a portion of the SVH construction budget and converting intermediate medicine beds to NHU beds. Following these "threats", HVAC replied on March 26 that it was prepared to recommend appropriation of additional funds to enable VA to comply with the law.

An examination of the **VA Long Term Care Fact Sheet** from June 2003 shows that State Veterans Homes ADCs will have risen between 1999 and 2004 (estimated) by approximately the same number of veterans as the decline in VA's NHU ADC. The Fact Sheet came out more than a full year after the HVAC-SecVA exchanges began and the additional funding promised by HVAC has not materialized.

VA has historically had strong LTC programs and capability, and should be required to maintain its nursing home capacity as intended by Congress. VA must create incentives and receive appropriate funding to maintain its NHCU beds rather than abandon them to alternative sources. These beds are a vital component of the VA LTC continuum of care, and they are essential in addressing the LTC needs of the aging veteran population.

According to VA's FY 2002 Annual Accountability Report Statistical Appendix, in September 2002, there were 93,071 World War II and Korean War era veterans receiving compensation for service-connected disabilities rated seventy percent or higher. The American Legion believes that VA should comply with the intent of Congress to maintain an adequate LTC nursing home capacity for those disabled veterans who are in the most resource intensive groups; clinically complex, special care, extensive care and special rehabilitation case mix groups. The nation has a special obligation to these veterans. They are entitled to the best care that the VA has to offer.

Assisted Living Pilot Program

Section 103 of The Millennium Act authorizes VA to establish a three-year assisted living pilot program by allowing VA to enter into six-month contracts with Assisted Living Facilities (ALFs) for eligible veterans who require assistance with ADLs and would otherwise require ongoing VA nursing home care. The Assisted Living Pilot was awarded to VISN 20 (Oregon, Washington, Idaho, and Alaska), which began implementation of the clinical demonstration in early 2002. Evaluation will be by VA's Health Services Research Centers of Excellence and a report will be submitted October 2004. Legislation (S.1572) is currently pending in the 108th Congress that would expand these pilots to an additional three VISNs.

State Veterans Homes

Per diems

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans Homes and contracts with public and private Nursing Homes. The reason for this is obvious; VA pays a per diem of only $59.48 (FY 2004 estimate) for each veteran it places in SVHs, compared to the $354.00 VA says it cost in FY 2002 to maintain a veteran for one day in

its own NHUs. In the same letter in which HVAC promised more funding, this figure was questioned. VA confirmed that the amount was correct. In his reply, Secretary Principi explained that VA NHUs employ experienced nursing staff with paid salaries comparable to state or regional locality pay rates and that VA tends to fill vacancies with registered nurses rather than less skilled workers. These staffing decisions "have been supported by the patient assessment data. In FY 2001, 79 percent of veterans served in [VA NHUs] were in the clinically complex, special care, extensive care and special rehabilitation case mix groups. These groups are the four highest resource intensive categories, resulting in a higher cost of care." SVHs, on the other hand, are required to provide the same levels of care to an increasing Average Daily Census of veterans for the VA per diem, plus whatever Medicaid, private insurance and veteran copayments are available. Any shortfall in SVH operating revenue must come from private donations and state treasuries.

Currently, VA pays 70 percent of charges when it places a veteran in a contract nursing home. VA should consider utilizing State Veterans Homes and reimbursing them the same 70 percent that is charged by contracted facilities.

Many states require that per diems paid to SVHs be offset to the state's Medicaid fund. The American Legion believes that this practice defeats the purpose of providing the per diem and has the effect of lowering the quality of care afforded veterans. This issue has been the subject of congressional effort in the past. In 1986, identical bills were introduced in the House and Senate that would have precluded SVH per diem from being considered third-party liabilities. The Senate bill passed; the House bill did not. In its report, the Senate Veterans' Affairs Committee stated that, "VA per diem payments should increase the resources available to eligible veterans – not simply reduce the amount of Medicaid payments to the Homes." The American Legion believes that, in light of escalating health care costs to SVHs, it is time to revisit this issue.

Pharmaceutical benefits

Currently, veterans with service-connected disabilities rated 50 percent or greater receive VA pharmaceutical benefits at no cost. Veterans in SVHs also receive this benefit but are required to travel to VA facilities to obtain their medications. This practice places an unnecessary burden on many frail, elderly SVH residents. It is the position of The American Legion that these veterans should receive their prescription and over-the- counter medications at their places of residence.

Construction grant program

The Millennium Act required VA to develop a methodology for determining the greatest levels of need when prioritizing SVH construction grants based on a 10-year projection of veterans over 65 in each State. Those need levels were to be classified as "great", "significant" or "limited", depending on the existing SVH bed inventory, eligible veteran population and prior grants for each State. A priority scale was then mandated by the Act, designating in which order grant applications were to be granted:

1. A SVH requiring life safety, utility or structural upgrades
2. Applications from States that have never applied in the past.
3. Applications from a State having great need.
4. A SVH requiring other renovations.
5. Applications from a State having significant need.
6. Applications meeting other criteria as determined appropriate by VA.
7. Applications from a State having limited need.

The **State Home Construction Grants 2003 Priority List** prioritizes 81 projects to be funded at 65 percent of cost to build for a total VA outlay of $379 million. Of those, 25 add 3529 new beds to SVH capacity and the remainders are renovations or the outright replacement of existing facilities. If this activity continues at the current level for the next five years, over 17,000 new SVH beds will be available. **The FY 2003 VHA Baseline Health Care Demand Model** projects total VA nursing home ADC of approximately 53,000 in FY 2012, including SVHs, VA NHUs and contract homes. Currently, there are 42,329 veterans in VA institutional care of all types.

Interestingly, the Skilled Nursing Facility (SNF) industry has already begun to complain that SVHs are lowering their occupancy rates. Many states have Certificate of Public Need (COPN)

laws requiring needs-based justification for the construction of new medical infrastructure. In Texas, a recipient of numerous new SVH grants, a moratorium is in effect on the construction of new SNF Medicaid beds. State governments may or may not be subject to their own COPN laws. According to a LTC trade publication, ***Provider Magazine*** (June 2002), there are 22,000 empty SNF beds in Texas for an occupancy rate of 74 percent. The article calls the situation in Texas a microcosm for the rest of the country where SNF occupancy rates are dropping (88 percent in March 2002 according to Centers for Medicare and Medicaid Services).

Community Nursing Home Providers

In 2001, VA contracted with approximately 2,500 private SNFs for the long term care of 3,960 veterans, an increase over 2000, but a marked decline from 1998 and 1999. This number is expected to increase, as veterans more often want to be close to family, something that is not always possible with VA NHUs and SVHs. VA currently pays 70 percent of contract NH charges. Contracts are entered into by local VA medical centers (VAMCs) or regionally at the VISN level. Regional level contracts appear to offer the most flexibility for the veteran because they are usually entered into with larger LTC firms that guarantee care to veterans at any facility nationwide.

NON-INSTITUTIONAL CARE

VA provides a wide range of services as alternatives to inpatient nursing home care for all enrolled veterans.

Home-Based Primary Care
This program (formerly Hospital Based Home Care) began in 1970 and provides long-term primary medical care to chronically ill veterans in their own homes under the coordinated care of an interdisciplinary treatment team. This program has led to guidelines for medical education in home care, use of emerging technology in home care and improved care for veterans with dementia and their families who support them. In 2002, home-based primary care programs were located in 76 VA medical centers.

Contract Home Health Care
Professional home care services, mostly nursing services, are purchased from private-sector providers at many VA medical centers. The program is commonly called "fee basis" home care.

Adult Day Health Care (ADHC)
Adult Day Health Care programs provide health maintenance and rehabilitative services to veterans in a group setting during daytime hours. VA introduced this program in 1985. In 2002, VA operated 21 programs directly and provided contract ADHC services at 80 VA medical centers. Two state homes have requested VA recognition to provide ADHC, which has recently been authorized under the State Home Per Diem Program.

Homemaker and Home Health Aide (H/HHA)
In 1993, VA began a program of health-related services for service-connected veterans needing nursing home care. These services are provided in the community by public and private agencies under a system of case management provided directly by VA staff. VA purchased H/HHA services at 120 medical centers in 2002.

Community Residential Care
The community residential care program provides room, board, limited personal care and supervision to veterans who do not require hospital or nursing home care but are not able to live independently because of medical or psychiatric conditions, and who have no family to provide care. The veteran pays for the cost of this living arrangement. VA's contribution is limited to the cost of administration and clinical services, which include inspection of the home and periodic visits to the veteran by VA health care professionals. Medical care is provided to the veteran primarily on an outpatient basis at VA facilities. Primarily focused on psychiatric patients in the past, this program will be increasingly focused on older veterans with multiple chronic illnesses that can be managed in the home under proper care and supervision.

Respite Care
Respite care temporarily relieves the spouse or other caregiver from the burden of caring for a chronically ill or disabled veteran at home. In the past, respite care admission was limited to an institutional setting, typically a VA nursing home. The Millennium Act expanded respite care to home and other community settings. Currently, respite care programs are operating in 136 VA medical centers, with each program typically providing care to approximately five veterans on any given day. Respite care is usually limited to 30 days per year.

Domiciliary Care
Domiciliary care is a residential rehabilitation program that provides short-term rehabilitation and long-term health maintenance to veterans who require minimal medical care as they recover from medical, psychiatric or psychosocial problems. Most domiciliary patients return to the community after a period of rehabilitation. Domiciliary care is provided by VA and state homes. VA currently operates 43 facilities. State homes operate 51 domiciliaries in 33 states. VA also provides a number of psychiatric residential rehabilitation programs, including ones for veterans coping with post-traumatic stress disorder and substance abuse, and compensated work therapy or transitional residences for homeless chronically mentally ill veterans and veterans recovering from substance abuse.

Telehealth
For most of VA's non-institutional care, telehealth communication technology can play a major role in coordinating veterans' total care with the goal of maintaining independence. Telehealth offers the possibility of treating chronic illnesses cost-effectively while contributing to the patient satisfaction generally found with care available at home.

Subacute Care
This care is provided to veterans who require a level of care between acute and long-term care. These veterans are provided care in VA hospital intermediate bed sections.

Geriatric Evaluation and Management (GEM)
Older veterans with multiple medical, functional or psychosocial problems and those with particular geriatric problems receive assessment and treatment from an interdisciplinary team of VA health professionals. GEM services can be found on inpatient units, in outpatient clinics and in geriatric primary care clinics. In 2002, there were 57 inpatient GEM programs and more than 164,000 visits to GEM and geriatric primary care clinics.

Geriatric Research, Education and Clinical Centers (GRECC)
These centers increase the basic knowledge of aging for health care providers and improve the quality of care through the development of improved models of clinical services. Each GRECC has an identified focus of research in the basic biomedical, clinical and health services areas, such as the geriatric evaluation and management program. Medical and associated health students and staff in geriatrics and gerontology are trained at these centers. Begun in 1975, there are now 21 GRECCs in all but two of VA's health care networks. Congress authorized VA to establish up to 25 of these centers.

All-Inclusive Care Pilot Program

Section 102 of the Millennium Act mandates that VA carry out three pilot programs to determine the effectiveness of different models of LTC for frail elderly veterans. The objective of the mandate is to reduce VA's reliance on hospital and nursing home LTC. The Millennium Act describes three different models to be used; directly by VA, direct VA and contract providers and direct VA and cooperative agreement with public and private providers. In-kind assistance to providers is authorized to reduce the cost to the government. The pilot programs include the full spectrum of non-institutional LTC including Adult Day Health Care (ADHC) eight hours per day, five days per week, medical services, coordination of care, transportation, home care and respite care. All-Inclusive Care Pilot sites were awarded to Denver, Columbia, SC, and Dayton VA facilities, which began implementing the clinical demonstrations in mid 2001. Evaluations will be done by VA Health Services Research Centers of Excellence, with a report to be submitted in March 2005. Current legislation (S. 836), pending in the 108th Congress, would extend these pilots an additional five years.

VA IMPLEMENATION OF NON-INSTITUTIONAL CARE PROGRAMS

On March 29, 2002, the General Accounting Office (GAO) issued a report that stated that nearly two years after The Millennium Act's passage, VA had not implemented its response to the Act's requirements that all eligible veterans be offered adult day health care, respite care and geriatric evaluation. At the time of GAO's inquiry access to these services was "far from universal." While VA served about one-third of its 3rd Quarter 2001 LTC workload (23,205 out of an ADC of 68,238) in non-institutional settings, it only spent 8 percent of its LTC budget on these services. Additionally, at the time of the report, VA had not even issued final regulations for non-institutional care, but was implementing the services by issuing internal policy directives, according to GAO. Of 140 VAMCs, only 100 or 71 percent were offering adult day health care in non-institutional settings. Almost all VAMCs provided respite care, but less than 40 offered it in a non-institutional setting. That is, the veteran was required to be admitted to a VA hospital in order to give home caregivers a break, rather than VA sending workers out to the veteran. Less than 90 VAMCs conducted geriatric evaluations and the venue was mixed; some offered evaluations only in hospitals, some in a non-institutional setting and some both.

By May 22, 2003, over one year later, GAO testified before the HVAC Subcommittee on Health that things had not improved and that veterans access to non-institutional LTC was still limited by service gaps and facility restrictions. The services offered now included home-based primary care, homemaker/home health aide services and skilled home health care. GAO's assessment now included the degree to which services were offered within the geographical region encompassed by the VAMCs, and services were found to be spotty within regions. For four of the six services, the majority of facilities either did not offer the service or did not provide access to all veterans living in the geographic service area. Veterans had the least access to respite care that was actually offered by fewer VAMCs than in 2001. GAO found that at least 9 VAMCs were illegally limiting veterans' eligibility to receive non-institutional LTC based on their service-connected disability. 59 VAMCs had developed waiting lists for services based on eligibility restrictions. GAO summed up the problem nicely when it testified that " [f] aced with competing priorities and little guidance from headquarters, field officials have chosen to use available resources to address other priorities."

At the same hearing, VA Undersecretary for Health Dr. Robert Roswell acknowledged the GAO study was correct in its conclusion that implementation of non-institutional LTC services is incomplete and access is uneven over the system. He disagreed, however, with GAO's contention that VA has failed to emphasize access, citing the rise in non-institutional LTC ADC from 13, 407 in 1999 to an estimated 25,873 in 2004. Dr. Roswell further stated that GAO's position that every enrolled veteran should have equal access to every non-institutional care program regardless of location or circumstances is "unrealistic." He cited the availability of local providers, cost-effectiveness, implementation of care coordination on a broader scale and "reasons over which VA has no control." The American Legion believes that the intent of Congress in authorizing these programs to was to provide a continuum of care that matches the veteran with the least costly, most clinically appropriate services in the least restrictive environment. The key to compliance with congressional intent lies in mandatory funding of e VHA

MANDATORY FUNDING OF VETERANS HEALTH CARE

The American Legion believes that the solution to VHA's recurring fiscal difficulties will only be achieved when it's funding becomes a mandatory spending item. Funding for VA health care currently falls under discretionary spending within the Federal budget. VA health care budget competes with other agencies and programs for Federal dollars each year. The funding requirements of health care for service-disabled veterans are not guaranteed under discretionary spending. VA's ability to treat eligible veterans is dependent upon discretionary funding approval from Congress each year.

Under mandatory spending; however, VA health care would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care entitlement of veterans.

The American Legion believes it is disingenuous for the government to promise long term care to its aging veterans and then make it unattainable because of inadequate funding. Rationed

health care is no way to honor America's obligation to the brave men and women who have, and continue to, unselfishly put our nation's priorities in front of their own needs. Mandatory funding for VA health care will help ensure timely access to quality health care for America's veterans.

Mr. Chairman, this concludes my submission for the record. I again thank the Committee for this opportunity to express the views of The American Legion on VA's Long Term Care Policies and I look forward to working with you on these important issues.

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WITH
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STATEMENT for the RECORD

of

Richard "Rick" Jones
AMVETS National Legislative Director

presented to the

Committee on Veterans' Affairs
U.S. House of Representatives

on

Long-Term Care Policies, Department of Veterans Affairs

Friday January 23, 2004
10:00 am, Room 334
Cannon House Office Building

AMVETS

NATIONAL
HEADQUARTERS
4647 Forbes Boulevard
Lanham, Maryland
20706-4380
TELEPHONE: 301-459-9600
FAX: 301-459-7924
E-MAIL: amvets@amvets.org

Chairman Smith, Ranking Member Evans, and Members of the Committee:

On behalf of National Commander S. John Sisler and the nationwide membership of AMVETS (American Veterans), I thank you for the opportunity to present a statement for the record to the Committee on VA's long-term care programs and issues that affect an aging veterans population.

Mr. Chairman, AMVETS has been a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces. Today, our organization continues its proud tradition providing not only support for veterans and the active military in procuring their earned entitlements but also an array of community services that enhance the quality of life for this nation's citizens.

AMVETS strongly supports VA's effort to provide extended care services to enrolled veterans and legislation to improve VA's response to the care needs of an aging veterans population.

Under Public Law 106-117, the Veterans Millennium Health Care and Benefits Act, enacted in November 1999, VA is required to provide extended care in its facilities, including nursing home care, domiciliary, home-based primary care and adult day health care.

Section 101 of P.L. 106-117 directs VA to provide nursing home care to any veteran who is in need of such care or who is 70 percent or greater service-connected disabled.

In addition, the Veterans Millennium Act required VA to maintain staffing and care at levels no less than that provided in 1998. Unfortunately, it is clear that both the staffing for nursing home care and the average number of veterans in such care has decreased. And, VA recognizes it is not in compliance with the Act, citing the inadequate provision of resources.

As the Committee is aware, there is a growing need for long-term care in VA. While the veterans population is projected to decline from 24.3 million to 20 million over the present decade, those aged 75 and older will increase from 4 million to 4.5 million and those over 85 will more than double, from about 640,000 currently to nearly 1.3 million in 2012.

Moreover, VA estimates that more than half of those veterans who receive health care through VA are over age 65. And VA further informs us that veterans living with disabilities needing long-term care are the most frail, most vulnerable, least able to advocate for themselves, and most in need of VA services.

Clearly, the need for veterans long-term care is growing. According to current projections, the number of elderly veterans will reach its peak over the next 5 years and occur approximately 20 years before that of the general population. While this particular veterans demographic offers geriatric health care a valuable opportunity in learning lessons on health care delivery, it also highlights the urgent need to make progress in serving the long-term care needs of veterans.

With demand clearly increasing, AMVETS is concerned that VA is both reducing its inpatient long-term care capacity and failing its statutory obligation to maintain capacity at the same level as provided

in fiscal year 1998. VA's data demonstrates that the long-term care average daily census for 1998 to 2003 has decreased 35 percent, to 9,900 in 2003 from 13,391 in 1998.

We agree that most patients would prefer to live at home in their own communities for as long as possible. However, we are concerned that the institutional inpatient long-term care program is being dismantled at the same time as long-term care needs are growing.

Mr. Chairman, AMVETS believes that the question on the need for veterans long-term care services is settled. With the sharp increase in the number of elderly veterans, VA's extended care services have become indispensable to VA's overall mission in providing veterans health care.

The challenge ahead for Congress and the administration is to provide access for enrolled veterans to a continuum of extended care services that include nursing home care, domiciliary care, as well as home and community-based extended care services. To achieve an integrated care system, VA must be provided the necessary resources that will assure improved delivery and will enhance the measure of care for elderly veteran patients.

AMVETS supports advances in community-based care and home care solutions to assist aging veterans. And, we encourage Congress to design a general agenda that offers a solution to the long-term care crisis facing all Americans. Such actions would likely include policies to encourage income tax credits for private health insurance, enhance catastrophic health insurance coverage, promote the use of medical IRAs designed to pay health care costs in retirement and establish responsible assistance to families with pre-existing and expensive medical needs that cannot be covered by private health insurance.

We applaud the Chairman and the members of the House Veterans' Affairs Committee for their continued work to improve and strengthen programs and services that enhance the lives of veterans. While we recognize that these programs and services are costly, we also know that the price we pay as a nation will never equal the value we received from their sacrifices as American veterans.

Mr. Chairman, thank you again for the opportunity to present a statement for the record on these issues of critical importance to all veterans. We sincerely appreciate your vigilance in efforts to improve veterans earned healthcare benefits and services.

Richard "Rick" Jones
National Legislative Director

Richard "Rick" Jones joined AMVETS as the National Legislative Director on January 4, 2001. As legislative director, he is the primary individual responsible for promoting AMVETS legislative, national security, and foreign affairs goals before the Departments of State, Defense, and Veterans Affairs, and the Congress of the United States.

Rick is an Army veteran who served as a medical specialist during the Vietnam War era. His assignments included duty at Brooke General Hospital in San Antonio, Texas; Fitzsimons General Hospital in Denver, Colorado; and Moncrief Community Hospital in Columbia, South Carolina. At Moncrief Hospital, Rick was selected to assist in processing the first members of the all-volunteer Army.

Rick completed undergraduate work at Brown University prior to his Army draft and earned a Master Degree in Public Administration from East Carolina University in Greenville, North Carolina, following military service.

Prior to assuming his current position, Rick worked nearly twenty years as a legislative staff aide in the offices of Senator Paul Coverdell, Senator Lauch Faircloth, and Senator John P. East. He also worked in the House of Representatives as committee staff for Representative Larry J. Hopkins and Representative Bob Stump.

In working for Rep. Stump on the House Committee on Veterans' Affairs, he served two years as Republican minority staff director for the subcommittee on housing and memorial affairs and two years as Republican majority professional staff on funding issues related to veterans affairs' budget and appropriations.

Rick and his wife Nancy have three children, Sarah, Katherine, and David, and reside in Springfield, Virginia.

AMVETS National Headquarters
4647 Forbes Blvd., Lanham, MD 20706
Telephone: 301-459-9600 ext. 3016
Fax: 301-459-7924
Email: rjones@amvets.org

SERVING
WITH
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January 28, 2004

The Honorable Christopher Smith, Chairman
House Veterans' Affairs Committee
Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Smith:

Neither AMVETS nor I have received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the January 28, 2004, Committee hearing to discuss the Department of Veterans Affairs policies on long-term care.

Sincerely,

Richard Jones
National Legislative Director

AMVETS

NATIONAL
HEADQUARTERS
4647 Forbes Boulevard
Lanham, Maryland
20706-4380
TELEPHONE: 301-459-9600
FAX: 301-459-7924
E-MAIL: amvets@amvets.org

STATEMENT OF
ADRIAN M. ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
JANUARY 28, 2004

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) on the Department of Veterans Affairs (VA) policies affecting veterans who will need long-term care in the next ten years. As an organization of more than one million service-connected disabled veterans, DAV is concerned about VA's ability to meet the needs of an aging veteran population and availability of specialized long-term care services.

According to VA, the veteran population today is projected to decline to 20 million by 2010, but over the same time period those age 75 and older will increase from 4.5 to 4.7 million and those 85 and older will nearly triple from 510,000 to over 1.3 million. Older veterans, particularly those over 85, are especially likely to have multiple, complex chronic diseases requiring comprehensive health care including long-term care services. Of equal importance is the fact that current VA patients are not only older in comparison to the general population, but they are much more likely to be disabled and unable to work, generally have lower incomes, and lack health insurance.

VA has indicated that the current demographics of the veteran population are one of the major driving forces in the design of the VA health care system. Thus, in redefining the VA health care system from a predominantly inpatient-based system to an outpatient-based comprehensive health care provider, VA changed its long-term health care package to one that includes alternative health care delivery options. VA now offers a continuum of institutional and noninstitutional long-term care services. The long-term care program, which includes VA-operated nursing home care units, contract community nursing homes and state veteran homes, also includes noninstitutional care such as respite care, domiciliary care, contract home health care, home-based primary care, adult day health care, homemaker and home health aide services, home respite care, home hospice care and community residential care. As part of these extended care services, VA also provides programs for subacute care such as Geriatric Evaluation and Management and Geriatric Research, Education and Clinical Centers.

According to Public Law 106-117, the Veterans Millennium Health Care and Benefits Act, commonly known as the Millennium Act, VA is required to provide enrolled veterans access to a continuum of noninstitutional extended care services including geriatric evaluation, adult day health care, and respite care. Moreover, VA is required to 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. Nursing home care may be provided on a discretionary basis to other enrolled veterans. 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 VA facilities during fiscal year 1998.

With a constrained budget, an increasing and aging veteran population, and the high cost of providing inpatient long-term care, VA is struggling with the issue of long-term care. An attempt was made to address long-term care through the Capital Asset Realignment for Enhanced Services (CARES) initiative. Despite VA's own projections, which forecast that by 2022 the VA will need to have more than 17,000 additional nursing home care beds to meet the needs of elderly and frail veterans, VA has chosen to treat the long-term care issues neutrally; that is, there will be no major changes or negative impact on care or capacity in long-term care. In addition, VA is isolating long-term care from the CARES process to provide projections consistent with its perspective on long-term care as stated in VHA VISION 2020, "Nursing home care will become an option of last resort, where it is medically infeasible or inadvisable for a veteran to receive care at home or in an assisted living facility."

On May 22, 2003, DAV provided testimony before the House Veterans' Affairs Subcommittee on Health on VA's noninstitutional long-term care programs. We voiced our concerns over uneven access and provision of VA's noninstitutional extended care services and noted our anticipation of a General Accounting Office (GAO) report on this issue. GAO's May 2003 report, "VA LONG-TERM CARE: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care" (GAO-03-487), confirmed veterans' access to noninstitutional long-term care services is limited and highly variable across the nation.

Extensive gaps in service exist due in part to restrictions based on veterans' levels of service-connected disability that are inconsistent with existing eligibility standards. GAO cites VA headquarters as the source of such disparity as a result of not providing clear and adequate guidance on making noninstitutional long-term care services available. Furthermore, VA headquarters has failed to emphasize noninstitutional long-term care as a priority, and has failed to develop a performance measure to ensure the provision of these services consistently across VA facilities.

In response to the GAO report, VA indicates it would add eligibility sections in each new directive and handbook concerning home and community-based care programs. An information letter (IL 10-2003-012) was issued on October 1, 2003, which includes the eligibility criteria for geriatric evaluation, and home and community-based care programs. Additionally, VA proposed to develop measures to underscore the importance of its noninstitutional long-term care programs. One such measure is a strategic objective to provide care in the least restrictive setting through alternatives such as adult day and home health care, respite care and home-maker/home health aide services. A long-term care initiative in VA's Strategic Plan for 2003 through 2008 proposes a performance measure to increase non-institutional long-term care. VA also issued VHA Handbook 1140.2 on respite care to offer the most appropriate services in the least restrictive settings ranging from home or community-based respite care to respite care in a nursing home. We look forward to an update on the progress of "VHA's Response Action Plan for GAO 03-487," provided by VA Under Secretary for Health to the House Veterans' Affairs Subcommittee on Health on May 22, 2003, as well as the evaluation of VA's assisted living pilot project.

Despite these efforts, demand for long-term care services has been increasing while VA has been reducing its inpatient long-term care capacity. According to VA, the average daily census in VA nursing home beds decreased from 13,426 in 1998 to 11,766 in 2002, and is estimated to further decrease to 8,500 in fiscal year 2004. VA has indicated it cannot meet the staffing level of the 1998 capacity requirement while using VA's average daily census as intended by Congress. VA believes the requirement that only VA-operated and VA-staffed extended care programs be included to meet capacity levels is too restrictive. Instead, VA proposes all types of care including noninstitutional and contracted care be included to meet capacity requirements as this reflects the change in modality of providing long-term care services to veterans.

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. As part of *The Independent Budget*, DAV supports increasing a variety of alternative noninstitutional extended care services; however, we are opposed to VA's proposal to include all noninstutional long-term care services in addition to institutional long-term care in order to meet the 1998 capacity requirements.

We recognize the fact that patients are living longer, often with chronic conditions, and some veterans will undoubtedly require care in an institutional setting. In addition, the aging veteran population is projected to peak 20 years ahead of the general U.S. population. As a world leader in providing health care, VA is in a unique position to lead our nation toward providing high quality comprehensive long-term health care. We are cognizant of VA's limited resources, however, VA must ask for adequate funding to adhere to the capacity requirements for long term care mandated by law and other essential health care services. DAV strongly supports mandatory funding for VA health care to ensure VA can meet the growing needs of veterans seeking care.

In light of VA's inability to meet mandated capacity requirements, coupled with its commitment to invest in alternative extended care services, our concern is the delicate balance VA must achieve between institutional and noninstitutional long-term care services to provide for veterans' health care needs. DAV strongly supports VA providing comprehensive health care to include long-term care services to meet the needs of our service-connected veterans and rapidly aging veteran population. Under DAV Resolution No. 096, we support legislation to establish a comprehensive program of extended care service to veterans with a service-connected disability rated 50 percent or more, or veterans in need of such care for a service-connected disability.

In closing, DAV sincerely appreciates the Committee for holding this hearing and for its interest in improving benefits and services for our Nation's veterans. The DAV deeply values the advocacy this Committee has always demonstrated on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on this important issue.

DISABLED AMERICAN VETERANS
P.O. Box 14301 ★ Cincinnati, Ohio 45250-0301 ★ Phone (606) 441-7300 ★ Fax (606) 442-2090

FACT SHEET

BIOGRAPHICAL INFORMATION

ADRIAN M. ATIZADO
Assistant National Legislative Director
Disabled American Veterans

Adrian M. Atizado, a service-connected disabled veteran of the Persian Gulf War Era, was appointed Assistant National Legislative Director of the million-member-plus Disabled American Veterans (DAV) in August 2002. He is employed at DAV National Service and Legislative Headquarters in Washington, D.C.

As a member of the DAV's legislative team, Mr. Atizado works to support and advance federal legislative goals and policies of the DAV to assist disabled veterans and their families, and to guard current benefits and services for veterans from legislative erosion.

Mr. Atizado joined the DAV's professional National Service Officer (NSO) staff as an NSO Trainee at the DAV NSO Training Academy in Denver, Colorado in January 2000. He graduated as a member of Academy Class IX in May 2000 and was assigned as an NSO trainee to the DAV National Service Office in Chicago, where he served until his current appointment.

Mr. Atizado was born in Mountain View, Calif., and moved to Chicago at an early age where he was raised and attended public schools. He enlisted in the U.S. Navy in 1989. Following his initial training as a Navy Corpsman, Mr. Atizado's service included Company B and Battalion Aid Station Corpsman for the 1st Battalion, 1st Marine Regiment, 1st Marine Division at Camp Pendleton, Calif., as well as duties at the San Diego Naval Hospital.

In March 1993, while preparing for a second six-month deployment to the Western Pacific, Mr. Atizado sustained injuries in a vehicle accident that resulted in his disability. He was medically discharged from the Navy in December 1993, and spent an additional six months recuperating from his injuries after leaving the military.

Following his Navy enlistment, Mr. Atizado attended the University of Illinois in Chicago, where he earned his bachelor's degree in secondary education mathematics in 1999.

Mr. Atizado is a life member of DAV Chapter 36 in Chicago. He resides in Arlington, Va.

11/02

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

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STATEMENT FOR THE RECORD OF FRED COWELL

HEALTH POLICY ANALYST

PARALYZED VETERANS OF AMERICA

FOR THE HOUSE COMMITTEE ON VETERANS' AFFAIRS,

CONCERNING THE

DEPARTMENT OF VETERANS AFFAIRS'

LONG-TERM CARE POLICIES

JANUARY 28, 2004

Chairman Smith, Ranking Member Evans, members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit a statement for the record concerning the Department of Veterans Affairs' (VA) long-term care policies.

Despite an aging veteran population and Congressional passage of P.L. 106-117, the "Veterans Millennium Health Care and Benefits Act" (Mill Bill), the VA has, once again, failed to maintain its capacity to provide extended (long-term) care services to America's aging veterans as mandated by 38 U.S.C. Section 1710B. Since 1998, VA's average daily census (ADC) for VA nursing homes has continued to decline. Additionally, as highlighted in a recent General Accounting Office report (GAO), VA has failed to ensure that all VA facilities are providing the full range of mandated non-institutional services as required by law.

VA's Assisted Living Pilot Project (ALPP) is well underway and holds promise to be an effective alternative to nursing home care for America's aging veteran population. However, VA must work to remove any existing state regulatory barriers that may discriminate against veterans with severe disabilities by restricting their access and choice of Assisted Living as an alternative to nursing home care. PVA also believes that veteran (ALPP) consumer satisfaction information must be collected to fully appreciate the program's successes or failures.

Current VA long-term care services for veterans with spinal cord injury are inadequate to meet the increasing demand and interest for non-institutional, assisted living and nursing home accommodations. VA must move to increase its capacity to meet the specialized long term care needs of this population.

VA Nursing Home Care

VA's Veteran Population (VetPop) data adjusted to the Census of 2000 reveals aging trends that will certainly increase veteran demand for both VA's institutional and non-institutional long-term care services. For example, the number of veterans in the 85–89 age group is projected to increase from 547,735 in 2002 to 966,669 by 2010. Additionally, veterans in the 90-94 age group are projected to increase from 107,695 in 2002 to 314,167 in 2010. These aging demographics will most certainly increase demand

for VA long-term care services and place a tremendous strain on existing VA long-term care resources within the next 10 years.

Despite an aging veteran population and aging trends that will increase demand for VA nursing home care, the daily census for VA nursing homes continues to decline from the baseline number of 13,391 as required by the Mill Bill. According to VA's workload data included in its 2004 budget submission, the ADC for VA nursing homes was 11,969 in 2002, 9,900 in 2003, and is projected to be 8,500 for 2004. Also, VA's ADC for Community Nursing Homes was 3,834 in 2002 and is projected to drop to 3,072 in 2004.

Yet despite this clear picture of increasing long-term care demand VA has failed to meet its statutory obligations as mandated in 38 U.S.C. Section 1710B to maintain its nursing home capacity at 1998 levels. Section 1710B states, "The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during fiscal year 1998."

VA Non-institutional Care (Home and Community-Based Services)

In addition to a decline in VA nursing home capacity, VA has done a poor job of correcting service gaps and facility restrictions that limit veterans' access to non-institutional long-term care services provided under the Mill Bill.

In May of 2003, the GAO issued a report (GAO-03-487) entitled "Service Gaps and Facility Restrictions Limit Veterans' Access to Non-institutional Care." The report addresses service gaps for six non-institutional VA services mandated by the Mill Bill. GAO found that of the 139 VA facilities it reviewed, 126 do not offer all six of these services. The services were: adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care. Of these six services, veterans have the least access to respite care.

GAO also reported that veterans access to non-institutional services is even more limited than the numbers suggest because even when facilities offer these services they often do so in only part of the geographic area they serve. The report also states that at least 9 facilities limit veterans' eligibility to receive these services based on their level of disability related to military service, which conflicts with VA's own eligibility standards. These restrictions have resulted in waiting lists at 57 of VA's 139 facilities.

GAO said, "VA's lack of emphasis on increasing access to non-institutional long-term care services has contributed to service gaps and individual facility restrictions that limit access to care." GAO added, "Without emphasis from VA headquarters on the provision of non-institutional services, field officials faced with competing priorities have chosen to use available resources to address other priorities."

PVA supports the two GAO recommendations issued to correct VA's access barriers to non-institutional care:

- VA ensure that facilities follow VA's eligibility standards when determining veteran eligibility for non-institutional long-term care services.

- VA refine current performance measures to help ensure that all facilities provide veterans with access to required non-institutional services.

VA Long-Term Care Workload

The following data is taken from VA's FY 2004 budget submission and is expressed in Average Daily Census (ADC) numbers.

Institutional Care:	2002	2003	2004	Increase/Decrease
VA Domiciliary	5,484	5,577	5,672	+ 95
State Home Dom.	3,772	4,323	4,389	+ 66
VA Nursing	11,969	9,900	8,500	- 1400
Community Nursing Home	3,384	4,929	3,072	- 1,857
State Home Nursing	15,833	17,600	18,409	+ 809
Subacute Care	1,122	956	860	- 96
Psych. Residential Rehab.	1,349	1,429	1,508	+ 79
Institutional Total	43,363	44,714	42,410	- 2,304

Non-Institutional Care	2002	2003	2004	Increase/Decrease
Home-based primary care	8,081	10,024	13,024	+ 3,000
Contract home health care	3,845	3,959	4,070	+ 111
VA adult day care	427	442	458	+ 16
Contract adult day care	932	1,352	1,962	+ 610
Homemaker/home health aide	4,180	4,247	4,315	+ 68
Community residential care	6,661	6,821	6,821	0
Home respite	0	1,284	1,552	+ 268
Home Hospice	0	0	492	+ 492
Non-institutional care total	24,126	28,129	32,694	+ 4,565

Long-term care total	67,489	72,843	75,104	+ 2,261

These VA workload numbers show a clear decline in VA nursing home care and contract community nursing home care and an overall decline in capacity for VA institutional care services. While VA non-institutional care reflects a modest increase in ADC the projected increase in 2004 services remains to be seen.

Recommendations:

- Congress must provide the necessary resources to enable VA to meet its legislative mandate to maintain its long-term care services at the 1998 levels and meet increasing demand for these services. In accordance with the recommendations of *The Independent Budget* for FY 2005, PVA calls for an additional $600 million to enable VA to provide comprehensive high quality long-term care services.

- VA must meet its statutory obligation to provide long-term care services in its facilities.

- VA must work to identify and incorporate additional non-institutional services and programs that can improve and bolster VA's ability to meet increasing demand as required by law.

Paralyzed Veterans of America also supports the following GAO recommendations regarding VA non-institutional care:

- VA must ensure that its facilities follow VA's eligibility standards when determining veteran eligibility for non-institutional long-term care services.

- VA must refine current performance measures to help ensure that all facilities provide veterans with access to required non-institutional services.

SCI Long-Term Care

Thousands of veterans with spinal cord injury (SCI) are at a disadvantage when it comes to the availability of specialized VA long-term care in their geographical area. Currently, VA operates four designated SCI long-term care facilities for persons with spinal cord injury. These are located at Castle Point, NY, Hampton, VA, Brockton, MA and at the VA residential care facility (RCF) at the Hines VAMC in Chicago, IL. PVA documentation and experience shows high demand and long waiting lists for these VA specialized long-term care programs. The December 2003 VA SCI Center and Staff Survey report shows 23.9 staffed SCI long-term care beds with a 23 patient census at Brockton; 15.4 staffed SCI long-term care beds with a 13 patient census at Castle Point; 47.1 staffed SCI long-term care beds at Hampton with a patient census of 51; and 26.7 staffed SCI long-term cared beds at the Hines RCF with a patient census of 27.

Veterans with SCI, who are eligible for VA nursing home care and who live west of the Mississippi River, have no local access, let alone a choice, of VA facilities for VA specialized SCI long-term care. To its credit, the VA's Draft National CARES Plan (DNCP) calls for the addition of SCI long-term care beds at several VA locations. The DNCP calls for 30 SCI long-term care beds in Tampa, FL, 20 SCI long-term care beds in Cleveland, OH, 20 SCI LTC beds in Memphis, TN and 30 SCI long-term beds in Long Beach, CA. While this is a step in the right direction, additional SCI specialized long-term care capacity must me made available to west-coast veterans.

During the recent work of the CARES Commission, PVA has become increasingly concerned with Commission dialog that blurs the distinction between SCI acute and long-term care. The CARES Commission seems to be under the opinion that there is no difference between an SCI acute care bed and an SCI long-term care bed.

PVA must draw attention to this misconception. An SCI Center acute bed is designed to treat the rehabilitation needs and serious secondary medical conditions associated with SCI. An SCI long-term care bed is a residential environment designed to maximize the independence and dignity of the SCI veteran and is a spoke in the SCI hub and spoke design. When a medical condition becomes a serious treatment issue the SCI long-term care resident is referred to the appropriate SCI Center for medical treatment.

PVA supports the DNCP plan for additional SCI long-term care beds to be added to the SCI system but feels additional SCI long-term care capacity must be soon developed and implemented to meet the growing demand for these VA specialized long-term care programs.

Recommendations:

- VA must expand its specialized SCI long-term care capacity.

- PVA is hopeful that the CARES Commission will support the additional VA SCI long-term care capacity as outlined in the DNCP and that VA will move quickly to implement these recommendations.

- Congress and the VA must not allow the CARES Commission to blur the distinction between an SCI acute bed and an SCI long-term care bed. These are distinctly different environments and must not be confused.

Assisted Living

Assisted Living (AL) is a special combination of individualized services that include housing, meals, healthcare, recreation, and personal assistance designed to respond to the individual needs of those who require assistance with the activities of daily living (ADLs)

or the instrumental activities of daily living (IADLs). A key feature of AL is the delivery of services in a home-like setting. Assisted Living can range from renovated homes serving 10 to 15 individuals or high-rise apartment complexes accommodating 100 people or more. The philosophy of AL emphasizes independence, dignity, and individual rights.

Therefore, AL can be a viable alternative to nursing home care for many of America's aging veterans who require ADL or IADL assistance and can no longer live at home. However, there are some AL regulatory barriers that must be overcome before it will be open to many disabled veterans. Currently, AL is an industry that is regulated by state law, and many states have regulations that do not support the needs of disabled veterans or other people with disabilities. Before VA becomes an AL provider or establishes relationships with private providers, solutions to these regulatory barriers must be found to enable full participation in any VA or private AL program.

VA has argued that it should not become an AL provider because it is not in the business of providing housing to its veterans. However, PVA would point out that VA has long been in the business of providing housing for veterans who use VA domiciliary programs, VA nursing homes and VA contract nursing homes. VA could easily harness its vast long-term care expertise and building resources to become an efficient provider of AL services. These services could be provided through an expanded VA domiciliary care program if modifications were made to serve this population.

VA medical centers have already looked into public-private partnerships to provide AL on VA property through VA's enhanced-use leasing authority. Under this program, VA leases unused land to private AL providers in exchange for services to veterans at a negotiated rate. Additionally, VA's Capital Asset Realignment for Enhanced Services (CARES) initiative has called for the broad use of AL in its Draft National Cares Plan.

Public Law 106-117 authorized VA to establish a pilot program to determine the "feasibility and practicability of enabling eligible veterans to secure needed assisted living services as an alternative to nursing home care." VA's Northwest Veterans Integrated Service Network, VISN 20, is implementing the Assisted Living Pilot Program (ALPP) in 7 medical centers in 4 states: Anchorage, AK; Boise, ID; Portland, OR; Roseburg, OR; Spokane WA; Puget Sound Health Care System (Seattle and American Lake, WA); and White City, OR.

The following highlights reflect a preliminary review of the implementation of the program and the first year of program operation, through December 2002. The Final Report, as mandated by law, will be provided to Congress in October of 2004. VA finding thus far include:

- The implementation of the ALPP has been successful: Despite significant challenges, ALPP has negotiated contracts with a total of 89 vendors. All sites are actively recruiting and enrolling veterans for the program. From January 29, 2002, through December 31, 2002, a total of 181 veterans were placed in ALPP facilities.

- A new computerized database is allowing efficient recruitment, processing of payments, high quality data collection, and data analysis for ongoing management feedback and evaluation.

- The average ALPP veteran is a 69 year-old unmarried white male who is not service connected, was referred from an inpatient hospital setting, and was living in a private home at referral.

- ALPP veterans show significant functional impairment and a wide variety of physical and mental health conditions.

- 36 Adult Family Homes, 39 Assisted Living Facilities, and 14 Residential Care Facilities have been contracted with to date. The average vendor has 25 rooms or apartments.

- Preliminary data on the cost of ALPP placements are available. Initial findings suggest that the mean cost per-day for the first 160 enrolled veterans (not including bed hold days) is $75.10.

- ALPP's implementation will allow VA to obtain an accurate picture of the feasibility of these services in VA based on the high quality managerial and clinical staff with commitment to the goals of evaluation, the new data base, and a wide variety of important issue arising from a multi-site demonstration.

PVA believes that based on the highlights of VA's ALPP that Assisted Living can be a cost effective alternative to nursing home care for many of America's veterans. PVA also believes that an expansion of the Pilot Project to additional VISN's will benefit veterans and provide useful information to VA regarding other AL markets. However, additional information is needed to better understand how the ALPP is accommodating veterans with severe disabilities. PVA also recommends that VA develop, collect and disseminate ALPP consumer satisfaction information before its final report is submitted to Congress in October of 2004.

Recommendations:

- VA must expand and broaden the ALPP authorized by P.L. 106-117.

- VA must investigate and eliminate state regulatory barriers that prevent disabled veterans from enrollment and full participation in any VA ALPP, VA Assisted Living program, or any other AL arrangement or contract for private services utilizing VA property.

- VA should aggressively pursue development of AL capacity within existing VA programs that are adaptable to AL and through enhanced-use lease opportunities with private sector providers and partnerships.

- Congress must pass permanent legislation and provide funding to allow VA to provide AL.

- VA should develop, collect, and disseminate AALP consumer satisfaction information for inclusion in their final report due to Congress in October of 2004.

Summary

Over the next ten years an aging veteran population will have an increased demand for VA long-term care services. Despite mandating legislation, VA has failed to meet requirements to maintain long-term care capacity at 1998 levels and to provide the full complement of non-institutional long-term care services system wide. VA's capacity to provide VA nursing home care continues to decline despite increased appropriations from Congress. In 2003, the GAO reported that VA has failed to provide mandated non-institutional long-term care services in a comprehensive manner. It is clear that VA must do more to meet the increasing demand for VA long-term care services.

VA has attempted to amend Congressional language mandating VA long-term care capacity at 1998 levels by allowing VA to count nursing home care furnished by private providers and state veterans nursing homes. PVA is adamantly opposed to this suggestion and continues to believe that the only true measure of VA capacity is one that counts only the services provided directly by VA.

Sadly, it appears that VA would prefer to offload America's aging veterans who require nursing home care to the private sector or other federal payers. It also appears that VA is allowing its facilities to provide non-institutional long-term care as they see fit instead of providing these services as mandated by Congress. Non-institutional long-term care services can be a great benefit to America's veterans and in some cases can reduce the

timing and need for nursing home care. But the availability of these services must be nationwide and unrestricted by the manipulation of eligibility standards.

Regarding Assisted Living, The VA ALPP holds a promise of an environment that fosters increased independence and dignity for Americ a's aging veterans, but VA must pay attention to discriminatory state regulations and collect consumer satisfaction information before its final report is submitted to Congress.

PVA must emphasize the importance for VA to expand its SCI long-term care capacity to meet existing and growing demand for these services. An aging veteran with SCI has specific long-term needs that must be met by specially trained staff in a properly designed VA SCI long-term care facility.

PVA believes that VA must move to embrace its aging veteran population by improving its mindset and current culture which seems to see these men and women as a financial burden rather than a national treasure.

Paralyzed Veterans of America appreciates the opportunity to express our views on these important programs. We look forward to working with the Committee to ensure that the VA is providing adequate long-term care as required by law.

Fred Cowell
Health Policy Analyst
Paralyzed Veterans of America
801 18th Street, N.W.
Washington, D.C. 20006
(202) 416-7602

Fred is a Health Policy Analyst in PVA's Department. His responsibilities include real time health care issues related to the Department of Veterans Affairs Health Care System, Medicare and Medicaid. PVA is directly involved in influencing the managed care industry to become more responsive to the needs of persons with disabilities.

Fred is a graduate of Southern Illinois University with degrees in Marketing and Anthropology. Fred has an extensive background in advocacy for health care, personal assistance services, transportation, housing, and employment issues for persons with disabilities.

Fred is a veteran of the United States Navy. He served two tours of duty in Vietnam while attached to the Naval Security Group.

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.

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $220,000 (estimated).

Fiscal Year 2002

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $179,000.

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $242,000.

STATEMENT OF

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

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS' LONG-TERM CARE POLICIES

WASHINGTON, DC JANUARY 28, 2004

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

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 take part in today's hearing on Department of Veterans Affairs' (VA) long-term health care policies.

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 (long-term) 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 (5) respite care." According to 38 U.S.C. § 1710B, "The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during fiscal year 1998."

Unfortunately, VA has failed to meet its statutory obligation to provide extended care services at the 1998 levels. The nursing home average daily census (ADC) provided by VA in FY 1998 was 13,391. By 2003, VA's ADC was 9,900 and it is projected to be 8,500 in 2004. Further, just last year, in the FY04 budget proposal the VA proposed closing 5,000 VA nursing home care beds and the Capital Assets Realignment for Enhanced Services (CARES) process initially failed to even mention long-term care. This decreased emphasis on providing long-term care services is striking when compared to VA's veteran population (VetPop) data.

After analyzing the VetPop data, the Government Accounting Office (GAO) concluded that 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." Further, veterans 90-94 years old will triple by 2010. These projections illustrate that long-term care demand is about to be at an all time high.

Decreasing long-term care services utilization in direct violation of a Congressional mandate when faced with what appears to be an increasing demand for long-term care services is not a sound policy for the VA or for this nation's veterans.
In the past five years, the VFW has been witness to a VA system that 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 Act, 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 $97 a day co-payment reimbursement program available to recover a portion of VA's expense.

This Committee rightly denied VA's request last year to circumvent their statutory responsibility by "substituting 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 supports the policy of expanding, not substituting, state and community nursing home beds just as we support the policy of expanding, not substituting, more non-institutional solutions to long-term health care. I have attached a copy of VFW National Resolution 619 that calls for adequate funding for state veterans homes programs.

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. 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. The VA provides quality care and they should adopt policies that promote and expand access to that care, not restrict it. 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. This is the soundest policy that VA can adopt. I have attached a copy of VFW National Resolution 605 that urges Congress to mandate and provide funding for the provision of nursing home care for *all* veterans.

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

ahca
American Health Care Association

SUBMITTED WRITTEN TESTIMONY OF CHARLES H. ROADMAN II, MD, CNA PRESIDENT AND CEO AMERICAN HEALTH CARE ASSOCIATION (AHCA)

BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
JANUARY 28, 2004

On behalf of the 12,000 long term care facilities represented by the American Health Care Association (AHCA), I applaud the Veterans' Affairs Committee for not only recognizing the needs of America's frail, elderly, and disabled veterans, but for also continually seeking to optimize the quality of their care in the face of substantial challenges – both budgetary and demographic in nature.

As the former Surgeon General of the U.S. Air Force, I have a special interest in veterans' health care needs, and ensuring they receive the highest quality long term care our nation has to offer.

That's why I was thrilled to see that President Bush recently signed into law S 1156—enabling community nursing homes that are Medicare- and Medicaid-certified to form "agreements" with the VA in a manner already done with CMS. Under these new arrangements, certain barriers that have historically prevented community nursing homes (CNHs) from entering into contracts with the VA will be eliminated, thus S 1156 ensures that veterans will have access to a wider selection of quality facilities.

AHCA and our member facilities are proud to provide quality care to our veterans. CNHs provide the option of living closer to their families while receiving health benefits from the VA. As we all know, proximity to loved ones is critical in maintaining quality of life for any nursing home resident.

CNHs are a vital component of the VA long term care system. Whereas VA medical facilities tend to provide care to residents with high acuity levels, CNHs are an excellent choice for veterans who either have acuity levels that do not warrant placement in a VA facility, but are too high for home health care -- or for veterans who would be too far from their families if placed in one of their state's VA Medical Facilities or State Veterans Nursing Homes.

But as we now go about our mission to provide an increasing number of America's veterans with the quality care they need and deserve, further programmatic, structural and procedural obstacles must be addressed.

First, as we all seek to maintain the two core principles of VA long term care, choice and balance, we must reevaluate how we go about achieving these objectives. In an effort to care for one population, we must be cautious not to jeopardize the care for another.

Texas provides a stark example. With approximately 20,000 empty beds in skilled nursing facilities and a median occupancy rate of 74 percent, according to recent data, the state of Texas is in a position to respond to the needs of veterans. Yet, in the past several years, the state in conjunction with the VA, has built four new 160-bed nursing facilities and is now building two more.

These new state homes are exempt from state bed laws, and are designed expressly to serve veterans' needs. But given Texas facilities' capacity to house veterans – in conjunction with the fact the VA's other primary long term care program involves placement in CNHs—the Texas long term care community is correct to wonder why the VA would elect to build new homes when the existing under-capacity in some facilities can easily accommodate greater demand.

Under this scenario, quality of care is threatened, especially when considering reimbursement and staffing. Facilities with low census have fewer dollars to spend on patients. In times of fiscal uncertainty, we must carefully weigh the efficacy of constructing new State Veterans Homes when the possibility already exists for quality care within the community.

Mr. Chairman, now is the time to evaluate the extent to which the VA is enforcing statutes included in the Veteran's Millennium Health Care and Benefits Act– which established standards for evaluating a state's need for constructing new facilities for veterans. The Texas example is but a microcosm of what is occurring nationwide, and this dilemma must be resolved if we are to maintain our commitment to providing quality long term care.

We laud Congress for passing the Millennium Act that specified in statute that the methodology for establishing the need for new veterans' beds must take into account the number of available community nursing facility beds in each state. We believe that failure to include availability of community nursing home beds has the potential to discriminate against long term care providers nursing home care and services to veterans through contracts.

Another problem that exists under the current situation is that, with staffing shortages at an all time high, facilities are competing for a smaller and smaller pool of caregivers. This is as problematic and unsustainable.

With record numbers of retirees in general and retiring veterans in particular requiring long term care, competing against ourselves for staff is damaging to every facet of our long term care system, and detrimental to the well being and livelihoods of all our patients.

A recent AHCA study examining the vacancy rates in the nation's nursing homes finds almost 100,000 health care professionals are immediately needed simply to fill key nursing jobs across the United States. The majority of the nursing home staffing vacancies -- nearly 52,000 -- were for CNA positions, who perform as much as 80 percent of direct patient care, and who help make the difference in care outcomes.

By 2012, there are expected to be approximately 1.3 million veterans over 85 years of age, and it is imperative that we work together to insure that both the veteran and civilian populations receive the best possible care, and that one population should not receive care at the expense of another.

For the record, Mr. Chairman, AHCA neither discourages in any way funding necessary improvements to veterans' homes nor disagrees with the need to provide alternatives such as State Veterans Nursing Homes. As a veteran myself, I am keenly aware of the need for choice in the long term care continuum. But we ask that prior to appropriating millions in construction costs, we work to determine whether there are quality facilities in proximity to the proposed new homes that could otherwise provide quality care and do it closer to a patient's family and friends.

Thank you again Mr. Chairman, and members of this Committee, for holding this important hearing. With our nation's soldiers and veterans in both the national and international spotlight, our concern for their care and safety today as well as tomorrow has never been more important to the soul and conscience of the American people. They deserve the best we have to offer.

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TESTIMONY OF THE
AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY
Before The
Committee on Veterans' Affairs
U. S. House of Representatives
On the Department of Veterans Affairs Long-Term Care Policies
January 28, 2004

Mr. Chairman and members of the Committee, I am Joel Streim, M.D., a practicing geriatric psychiatrist and President of the American Association for Geriatric Psychiatry (AAGP). In addition to my practice and academic appointment at the University of Pennsylvania, I would note that, while I am not speaking on behalf of the Veterans Administration, I do serve as Co-Associate Director for Clinical Programs at the VA Mental Illness Research Education Clinical Center (MIRECC) in Philadelphia.

I thank you for this opportunity to present AAGP's views on the Department of Veterans Affairs (VA) policies affecting the millions of veterans who will need long-term care in the next ten years. AAGP is a professional organization dedicated to promoting the mental health and well being of older Americans and improving the care of those with late-life mental disorders. Our membership consists of approximately 2,000 geriatric psychiatrists as well as other health professionals who focus on the mental health problems faced by senior citizens.

Mr. Chairman, AAGP greatly appreciates the Committee's willingness to hear our comments on the issue of long-term care needs of our nation's veterans and the need for the VA to address those needs. AAGP brings a unique perspective to these issues because our members serve the older adult patient population, many of whom require substantial long-term care for disabling psychiatric and neurological illnesses.Nine million of our nation's 25.5 million veterans are seniors who served in World War II or the Korean War. Veterans of the war in Viet Nam – the post World War II baby boom generation – are on the cusp of joining their ranks as aging adults. More than half a million veterans are 85 years of age or older, and the VA predicts that this oldest group will grow to 1.2 million by 2010. We currently do not have adequate long-term care services for those who need them, and there is great danger that the coming swell in the number of elderly veterans will overwhelm existing services.

Planning for the mental health needs of aging veterans who need long-term care requires consideration of many factors. Among these are:

- the aging of the veteran population, including the longevity of those with mental illness;
- the prevalence of mental illness among veterans served by the VA, and the high concentration of veterans with psychiatric disorders in the current cohort of nursing home residents;
- the complexity of caring for elderly veterans with co-morbidity from concurrent medical and psychiatric disorders, in both institutional and non-institutional settings;
- the limited psychiatric training of most long-term care staff; and,
- the limited availability and access to psychiatrists, psychologists, and other mental health professionals with subspecialty training in geriatrics.

It is also important to understand the nature of the illnesses and disabilities that require long term care, in order to properly identify the circumstances under which non-institutional long-term care will adequately meet a patient's needs, and to define those situations in which institutional care is unavoidable.

Epidemiological studies over the past decade and a half have consistently reported that the prevalence rate of diagnosable psychiatric disorders among residents of community

nursing homes is between 80 and 90 percent. We call them nursing homes, but the numbers indicate that these facilities are *de facto* institutions for the care of patients with mental illness. Across studies, approximately two-thirds of patients have dementia due to Alzheimer's or vascular disease, and more than half of these residents have psychosis and/or behavioral disturbances. In many cases, psychiatric and behavioral symptoms of dementia are the reason for nursing home admission. Approximately one-fourth of residents have clinically significant depression.

In a survey of the Philadelphia VA Nursing Home Care Unit, the findings were similar: 86% of residents have a psychiatric diagnosis. A total of 61 percent of residents have cognitive impairment and 31 percent have symptoms of depression. The notable difference is that the prevalence of schizophrenia and substance abuse is higher in the VA nursing home than in most community facilities. Of the 29 percent in the Philadelphia sample who had a lifetime history of alcohol abuse, 9 percent were still drinking during the year prior to their nursing home placement. A VA national nursing home survey in 1994 reported lower rates of cognitive impairment and depression, but found 12 percent of residents with a diagnosis of schizophrenia, and 4 percent with other psychotic disorders. Any model that is used to plan for institutional long term care services must therefore take into account the astonishingly high prevalence of mental illness among those aging veterans who currently reside in nursing homes.

The high prevalence of mental illness in nursing homes defines the need for extensive mental health services in these facilities. Unfortunately, like community nursing facilities, most VA nursing homes are not staffed by psychiatric nurses, and the majority of long-term care nurses and primary care physicians do not have the skills required for proper assessment and management of the psychiatric and behavioral disorders commonly encountered in their work. While a few VA nursing home facilities have access to consultation from geriatric psychiatrists, these subspecialists are in short supply, and the projected number of trainees in geriatrics falls far short of the projected needs. Unfortunately, there is no systematic plan to ensure the provision of mental health services in long-term care settings by clinicians with appropriate training in geriatrics and psychiatry. We urgently need to develop alternative models for delivery of quality mental health care to aging veterans with long term care needs.

Recognizing the preference of many elderly individuals to remain in the community, AAGP applauds the efforts of the Veterans Health Administration to expand the availability of non-institutional long-term care options. The doubling of the census of veterans who received home-based primary care, contract home health care, and contract adult day health care suggests improved access to these alternatives to nursing home placement. However, it is not clear whether these programs are providing adequate mental health services for these veterans. Similar to nursing homes, staff in these programs often do not have psychiatric expertise, or access to geriatric mental health consultation. Although we could not find any reports describing the mental health needs of recipients of non-institutional long-term care services, we do know that, historically, as many as one-third of all veterans seeking care at VA facilities have received mental health treatment, and research indicates that serious mental illnesses affect at least one-fifth of the veterans who use the VA healthcare system. Based on the much higher rates of mental illness found in nursing home residents, we would expect that the rates are higher in those who receive non-institutional long-term care than in the general veteran patient population. In this context, lack of system-wide plans to provide mental health services to non-institutionalized long-term care recipients is troubling. As a first step in assessing care needs and evaluating quality of care delivered, AAGP recommends that the VA conduct epidemiological research on psychiatric disorders and access to mental health services among veterans receiving care in these programs. Based on the findings from these studies, the VA should then define processes for delivery of quality mental health care and develop age-appropriate mental health services in these settings.

Psychiatric care of elderly long-term care patients is rendered more complex because of the frequent co-occurrence of medical illness, which usually requires treatment with multiple medications. Older long-term care patients commonly suffer from co-existing medical conditions such as diabetes, hypertension, heart disease, stroke, lung disease, osteoarthritis, or other conditions. For these patients, diagnosis and treatment of their

medical illnesses is often complicated by psychiatric disorders. Conversely, the assessment and management of their psychiatric illness is more difficult because of concurrent medical conditions. Diagnosis may be confounded because of medical symptoms that mimic psychiatric disorders, or psychiatric symptoms that mimic medical illnesses. Disease-disease interactions, disease-drug interactions, and drug-drug interactions can challenge even the most experienced health care professionals. Thus, for older veterans with long-term care needs—whether institutionalized, or receiving long-term care services in non-institutional programs in the VA or the community—psychiatric treatment must be an integral component of their health care, must be informed by sufficient geriatric training, and must be well-coordinated with the medical, rehabilitative, and nursing care they receive for other medical conditions.

As veterans with mental illness are living longer, they are at increased risk for developing the illnesses and disabilities that are common in late-life. For example, the World War II veteran with chronic schizophrenia, now grown old, may suffer from a stroke or debilitating arthritis. These chronic conditions may limit independent ambulation and overall mobility, and the resulting disability and frailty leads to a need for long-term care. While some veterans with strokes or arthritis may be able to remain in the community if provided with non-institutional long-term care services, those with severe chronic mental illness often have life-long deficits in independent living skills. Some of them have spent much of their early adulthood and middle-age living in institutional settings, and have never acquired the skills necessary to live in the community. Those veterans with chronic mental illness who develop cognitive impairment in late-life are even more disabled, and incapable of learning the skills that might enable them to adapt and accept services from non-institutional long term care programs. Many of them also have disruptive behaviors that have persisted into the later stages of life, and that cannot be adequately managed in non-institutional long-term care settings. This is because typical home-based primary care and adult day health care programs do not have sufficient access to age-appropriate mental health services. Thus, most non-institutional programs are designed to manage physical frailty and disability, but not mental disorders. Until access to geriatric mental health services is integrated in these programs, it will be difficult, if not impossible, for them to accommodate older adults with serious mental illnesses such as schizophrenia, or severe behavioral disturbances such as those associated with dementia.

While the VA does provide community residential care and psychiatric residential rehabilitation programs in some locations, these are limited in their ability to care for frail older adults with multiple chronic, debilitating medical conditions. To illustrate, many Viet Nam veterans suffer from post-traumatic stress disorder, and some have severe, disabling anxiety and behavioral disturbances that require psychiatric rehabilitation. But many of these baby-boomers have also begun to experience the complications of diabetes, and to develop heart disease and arthritis and other infirmities associated with later stages of life. Community residential care is primarily designed to deal with psychiatric and behavioral problems and the associated disability; but these programs are not equipped to take care of them when their medical problems become complex, or as they grow old and frail. For those without family supports, frailty may therefore eventually lead to a need for nursing home care.

It is important to note that, between the years 1990 and 2000, the number of veterans in the 45-54 year old age group who received mental health services from the VA more than tripled. However, the most rapid growth in demand during the last decade was among the oldest veterans. During that time, there was a four-fold increase in the number of veterans aged 75-84 who received VA mental health services. This substantial increase in utilization is even more striking when one considers that research has revealed an ongoing problem with under-diagnosis of mental disorders in older age groups. As the most rapid population growth is expected to continue among the oldest old veterans, the extent of physical frailty, combined with the high prevalence and complexity of interacting medical and psychiatric illnesses, is likely to increase the demand for nursing home care, even as non-institutional long-term care options are expanded.

In conclusion, the projected aging of the veteran population will require the VA to increase its capacity to provide long-term health care and to continue its efforts to expand

non-institutional options while preserving and enlarging its network of nursing homes. Although the Veterans Millennium Health Care and Benefits Act (November 1999, P.L. 106-117) requires the VA to provide extended care services at 1998 levels, this will not be sufficient to meet the demands of the wave of baby boomer veterans who are about to enter old age. Congress should not only support the VA's commitment to non-institutional options, but must also ensure the continued availability of nursing homes for the oldest, most frail patients who cannot be maintained in home or community settings. Moreover, the current models of extended care are sorely deficient in the provision of age-appropriate mental health care. Quality of care for elderly veterans with long-term care needs will require substantial attention to the epidemiology of mental illness in this population, and the provision of geriatric mental health services that are integrated into both institutional and non-institutional programs.

Thank you for the opportunity to testify here today. On behalf of the American Association for Geriatric Psychiatry, we look forward to working with you to ensure that the long-term care needs of all veterans are met in the coming years. I will be happy to answer any questions.

UNIVERSITY OF PENNSYLVANIA - SCHOOL OF MEDICINE
Curriculum Vitae

July 1, 2003

Joel E. Streim, M.D.

Home Address: 631 Revere Road
Merion, PA 19066-1007

Office Address: Section on Geriatric Psychiatry
University of Pennsylvania
3535 Market Street, Room 3053
Philadelphia, PA 19104-3309

Citizenship: U.S.

Education:

Sept 1969-May 1973	B.A. Haverford College (Philosophy)
Sept 1973-May 1978	M.D. University of Rochester

Postgraduate Training and Fellowship Appointments:

July 1978-June 1981	Resident in Internal Medicine University of Rochester at Rochester General Hospital Rochester, NY
July 1981-June 1982	Chief Resident in Internal Medicine University of Rochester at Rochester General Hospital; Medical-Psychiatric Liaison Fellow University of Rochester at Strong Memorial Hospital Rochester, NY
July 1982-June 1985	Resident in Psychiatry University of Wisconsin Hospital & Clinics Madison, WI
July 1985-June 1987	Fellow in Geriatric Psychiatry VA Medical Center Madison, WI
July 1987-June 1988	Research Fellow in Geriatric Psychiatry VA Medical Center Madison, WI

Military Service: none

Faculty Appointments:

July 1981-June 1982	Instructor in Medicine and Psychiatry University of Rochester School of Medicine & Dentistry
July 1985-June 1988	Clinical Instructor in Psychiatry University of Wisconsin School of Medicine
July 1988-June 1994	Assistant Professor of Psychiatry Department of Psychiatry University of Pennsylvania School of Medicine
July 1988-June 1991	Assistant Professor of Psychiatry in Physical Medicine and Rehabilitation (secondary) Department of Rehabilitation Medicine University of Pennsylvania School of Medicine

July 1994-June 1997	Assistant Professor of Psychiatry at HUP Department of Psychiatry University of Pennsylvania School of Medicine
July 1991-June 1997	Assistant Professor of Psychiatry in Rehabilitation Medicine at HUP (secondary) Department of Rehabilitation Medicine University of Pennsylvania School of Medicine
July 1997-	Associate Professor of Psychiatry at HUP Department of Psychiatry University of Pennsylvania School of Medicine
July 1997-	Associate Professor of Psychiatry in Rehabilitation Medicine at HUP (secondary) Department of Rehabilitation Medicine University of Pennsylvania School of Medicine

Hospital and Administrative Appointments:

July 1982-June 1986	Medical Consultant to Forensic Programs Mendota Mental Health Institute Madison, WI
July 1985-June 1988	Senior Staff Physician VA Medical Center Madison, WI
July 1988-June 1990	Acting Chief of Service Piersol Rehabilitation Center Hospital of the University of Pennsylvania
July 1988-June 1991	Liaison Psychiatrist Piersol Rehabilitation Service Hospital of the University of Pennsylvania
July 1988-April 1994	Director, Geriatric Psychiatry Consultation Service Hospital of the University of Pennsylvania
July 1988-June 2000	Fellow, The Institute on Aging University of Pennsylvania School of Medicine
July 1990-June 1993	Co-Director, Geriatric Psychiatry Fellowship Program Hospital of the University of Pennsylvania
July 1993-	Director, Geriatric Psychiatry Fellowship Program Hospital of the University of Pennsylvania
Dec 1991-	Staff Physician VA Medical Center and Nursing Home Care Unit Philadelphia, PA
Apr 1994-June 2000	Consulting Psychiatrist Philadelphia Geriatric Center Philadephia, PA
July 1995-June 1996	Consulting Psychiatrist Bryn Mawr Rehabilitation Hospital Malvern, PA
Oct 1990-Sept 1993	Faculty, Delaware Valley Mid-Atlantic Geriatric Education Center, Institute on Aging University of Pennsylvania School of Medicine
Oct 1995-	Faculty, Delaware Valley Geriatric Education Center Institute on Aging University of Pennsylvania School of Medicine
Oct 1997-Oct 1998	Medical Director, Nursing Home and Partial Hospital Programs Section of Geriatric Psychiatry Department of Psychiatry and Behavioral Health System University of Pennsylvania Health System
July 2000-	Senior Fellow, The Institute on Aging University of Pennsylvania School of Medicine

April 2000-	Co-Associate Director for Clinical Programs Mental Illness Research Education Clinical Center (MIRECC) on Comorbid Medical, Psychiatric, & Substance Use Disorders Department of Veterans Affairs, VISN 4

Specialty Certification:

1988-	American Board of Psychiatry and Neurology Certification in Psychiatry #30389
1991-2001	American Board of Psychiatry and Neurology Added Qualification in Geriatric Psychiatry #438
2000-2010	American Board of Psychiatry and Neurology Recertified in Geriatric Psychiatry (through 2010)

Licensure:

1982-	New York 149637
1988-	Pennsylvania MD-041519-E

Awards, Honors, and Membership in Honorary Societies:

1973	Elected to Phi Beta Kappa
1973	BA degree from Haverford College conferred Magna Cum Laude, with Honors in Philosophy
1981	Appointed Chief Resident in Internal Medicine University of Rochester at Rochester General Hospital
1993	Annual Passmore Endowed Lectureship (invited) Presbyterian Medical Center
1993	John A. Musser Award for outstanding patient care Presented by Department of Social Work & Community Health Services, Hospital of the University of Pennsylvania
1995	Clinical Mental Health Academic Award National Institute of Mental Health
1996	Philadelphia Magazine—Top Doctors in Philadelphia Listed in Geriatric Psychiatry
1996	Class of '99 Excellence in Teaching Award University of Pennsylvania School of Medicine
1998	Philadelphia Magazine—Top Doctors for the Aging Listed in Psychiatry
1999	Outstanding Physician Award Philadelphia Corporation for Aging Emergency Fund Coalition for Older Philadelphians
2002	Philadelphia Magazine—Top Doctors Listed in Geriatric Psychiatry
2002	Appointed to Committee for Subspecialty Certification in Geriatric Psychiatry American Board of Psychiatry and Neurology
2003	Exemplary Psychiatrist Award—Honorable Mention National Alliance for the Mentally Ill
2003	Elected President American Association for Geriatric Psychiatry

Memberships in Professional and Scientific Societies:

National Societies:

American Psychiatric Association
(Member, Work Group on Practice Guidelines for Psychiatric Care of Geriatric Patients in Long-Term Care Settings, 1992-1993
Member, Council on Aging, 2002-present
Member, Assembly Allied Organization Liaison Committee, 2002-present)

American Association for Geriatric Psychiatry

(Chair, Committee on Long Term Care, 1992-1996
Secretary, 1995-1996
Member, Strategic Planning Task Force, 1995-1996
Chair, Public Policy Committee, 1996-2003
Treasurer-elect, 1999-2000
Treasurer, 2000-2001
President-elect, 2002-2003
President, 2003-2004)
International Psychogeriatric Association
Gerontological Society of America
American Geriatrics Society
(Advisor, Public Policy Committee 1999-
Member, Program Committee 2003-)
Physicians for Social Responsibility

Local Societies:
Pennsylvania Psychiatric Society
Philadelphia Psychiatric Society
Philadelphia Mental Health and Aging Advocacy Group

National Scientific Committees:
none

Local Scientific Committees:
Data Safety Monitoring Unit
NIMH Advanced Center for Intervention and Services Research, Department of Psychiatry, University of Pennsylvania, member 2002-present

Editorial Positions:

1996-99	Editorial Board, Journals of Gerontology, Medical Sciences

Academic Committees at the University of Pennsylvania and Affiliated Hospitals:

1988-1991	Member, Piersol Rehabilitation Commission
	Member, Piersol Executive Committee
	Chair, Quality Assurance Committtee
	Department of Physical Medicine and Rehabilitation
1988-1994	Member, Psychiatry Residency Recruitment Committee
1989	Member, Dean's Work Group on Rehabilitation Services
1991-present	Member, Psychiatry Residency Steering Committee
1993-1994	Member, Ethics Committee
	Hospital of the University of Pennsylvania
1994-present	Chair, Geriatric Psychiatry Fellowship Training Committee
1996-1997	Member, Dept. of Ophthalmology Review Committee
2000-2002	Member, VA VISN-4 MIRECC Steering Committee
2000-present	Member, Institute on Aging Senior Fellows Advisory Board
2002-present	Member, Strategic Planning Committee
	Education Subcommittee, Dept of Psychiatry

Major Teaching and Clinical Responsibilities at the University of Pennsylvania and Affiliated Hospitals

1. Lecturer and preceptor for Brain and Behavior course for medical students, Module 2 (spring semester)
2. Preceptor for Doctoring I and II course for medical students (12 sessions/year)
3. Geriatric lectures in core curriculum and case conferences for PS 200 and PGY2 psychiatry residents at HUP and VAH (monthly)
4. Director, Dementia Module, Clinical Neuroscience and Psychpharmacology

course for PGY3 psychiatry residents (3 sessions/year)
5. Program director, general supervision, and tutorials for geriatric psychiatry fellows (4 hours/week)
6. Clinical preceptor for nursing home rotation for geriatric psychiatry fellows (2 hours/week throughout the year)
7. Clinical supervision of home care rotation for geriatric psychiatry fellows (1 hour/week throughout the year)
8. Clinical preceptor for fellows and nurse practitioner in Living Independently for Elders (LIFE) program (2 hours biweekly, throughout the year)
9. Geriatric psychiatry consultation outreach to local nursing homes (8 hours/week throughout the year)
10. Geriatric psychiatry home care consultation to area agency on aging (4 hours/week throughout the year)
11. Geriatric psychiatry clinic at city district health center (4 hours/week throughout the year)
12. Advisor and lecturer for graduate students in gerontological and geropsychiatric nursing, School of Nursing

Lectures by Invitation (past 5 years):

March 11, 1998	"Clinical Utility of Assessment Instruments for Measuring Morbidity and Disability in Alzheimer's Disease" Annual Meeting of the American Association for Geriatric Psychiatry San Diego, California
April 8, 1998	"Identifying and Treating Depression in Older Adults: Pennsylvania Governor's Conference on Aging Hershey, Pennsylvania
May 21, 1998	"Treatment of Psychosis and Agitated Behavior in Medically Ill Geriatric Patients with Dementia" Psychiatry Grand Rounds, New York Medical College Valhalla, New York
August 11, 1998	"Alzheimer's Disease: Progress and Perspectives on Intervention and Care" Regional Symposium Boston, Massachusetts
December 17, 1998	"Current Approaches to the Treatment of Alzheimer's Disease" Medical Grand Rounds, Jersey City Medical Center Jersey City, New Jersey
February 10, 1999	"Current Approaches to the Treatment of Alzheimer's Disease" Medical Grand Rounds, Hunterdon Medical Center Flemington, New Jersey
May 21, 1999	"Mental Health Problems in Older Adults: Comorbidity, Disability Treatability," keynote address for regional symposium of the Northwest Louisiana Coalition for the Mentally Ill Shreveport, Louisiana
June 1, 1999	"Current Approaches to the Treatment of Alzheimer's Disease" Medical Grand Rounds, Lehigh Valley Hospital Allentown, Pennsylvania
September 16, 1999	"Drug Treatment of Depression in the Nursing Home Elderly" Research Colloquium, Center on Aging, University of Minnesota Minneapolis, Minnesota

September 16, 1999	"Effects of Cognitive Impairment on Recovery from Illness and Disability in Geriatric Patients" Research Colloquium, Center on Aging, University of Minnesota Minneapolis, Minnesota
June 1, 2000	"Agitated Depression in Older Adults" Regional Symposium on Geriatric Psychiatry St. Barnabas Behavior Health Center Toms River, New Jersey
June 24, 2000	"LTC Policy Implications from the Payment System Perspective" National Consensus Conference on Improving the Quality of Long Term Care Washington, DC
October 5, 2000	"Treatment of Psychiatric Symptoms in Geriatric Patients with Medical Comorbidity: Depression Associated with Medical Illness" Grand Rounds, Carrier Foundation Belle Mead, New Jersey
January 31, 2001	"Ethics of Behavioral Treatment in Nursing Homes" Regional Symposium, Coalition of Advocates for the Rights of the Infirm Elderly Philadelphia, Pennsylvania
November 14, 2001	"Integrating Mental Health, Medical Care, and Aging Services: What Have We Learned?" Keynote address, Regional Aging & Advocacy Symposium Philadelphia, Pennsylvania
February 24, 2002	"Medical-legal and Ethical Issues in Geriatric Psychiatry" Review and Update Course, Annual Meeting of the American Association for Geriatric Psychiatry Orlando, Florida
February 26, 2002	"Depressive Symptoms in the Nursing Home: Evolving Ideas" Annual Meeting of the American Association for Geriatric Psychiatry Orlando, Florida
May 9, 2002	"Pharmacotherapy of Depression in Late-Life" Annual Meeting of the American Geriatrics Society Washington, DC
September 29, 2002	"Research Policy Agenda for Mental Health and Aging" AAGP Research Summit on Geriatric Psychiatry Western Psychiatric Research Institute Pittsburgh, PA
November 14, 2002	"Scope of Psychotic Symptoms in the Long Term Care Setting" Annual meeting of the American Society for Consultant Pharamacists Anaheim, CA
March 1, 2003	"Quality Improvement in Geriatric Mental Health Care: Using Science to Inform Policy" Presidential Keynote Address, Annual Meeting of the American Association for Geriatric Psychiatry Honolulu, HI

April 9, 2003	"Mental Health Care for Aging Veterans in the VA Healthcare System" Invited testimony before the House of Representatives Appropriations Subcommittee on Veterans Affairs Washington, DC
May 15, 2003	"Treatment of Psychosis in Alzheimer's Disease" Grand Rounds, Spring Grove State Hospital Catonsville, MD
May 19, 2003	"Age Discrimination in the Provision of Geriatric Mental Health Care in the U.S." Invited testimony before the Senate Special Committee on Aging, Washington, DC
June 12, 2003	"Advances in the Treatment of Psychosis Across the Lifespan: Focus on Aging and Medical Co-morbidity" Grand Rounds, James Haley VA Medical Center Tampa, FL

Organizing Roles in Scientific Meetings:

March 14-17, 1999	Annual Scientific Meeting; member, Program Committee American Association for Geriatric Psychiatry, New Orleans, LA
March 12-15, 2000	Annual Scientific Meeting; member, Program Committee American Association for Geriatric Psychiatry, Miami Beach, FL
February 23-27, 2001	Annual Scientific Meeting; member, Program Committee American Association for Geriatric Psychiatry, San Francisco, CA

Bibliography:

Research Publications, peer reviewed:

Streim JE, Siebers MJ, Hill SL, Bauwens SF, Mayer M, Vincent MO. Planning in advance for critical care. Am J Nursing 89:37-41, 1989.

Drinka TJK, Streim JE. Case studies from purgatory: maladaptive behavior within geriatric health care teams. Gerontologist 34:541-547, 1994.

Katz IR, Streim JE, Parmelee P. Prevention of depression, recurrences, and complications in late life. Preventive Medicine 23:743-750, 1994.

Katz IR, Parmelee PA, Streim JE. Depression in older patients in residential care: significance of dysphoria and dimensional assessment. Am J Geriatr Psychiatry 3:161-169, 1995.

Oslin D, Streim J, Parmelee P, Boyce A, Katz I. Alcohol abuse: a source of reversible disability among residents of a VA nursing home. International J Geriatr Psychiatry 12:825-832, 1997.

Kurlowicz LH, Streim JE. Measuring depression in hospitalized, medically ill, older adults. Arch Psychiatric Nurs 12:209-218, 1998.

Colenda CC, Streim J, Greene JA, Meyers N, Beckwith E, Rabins P. The impact of OBRA '87 on psychiatric services in nursing homes. Am J Geriatr Psychiatry 7:12-17, 1999.

Oslin DW, Streim J, Katz IR, Edell WS, TenHave T. Change in disability follows inpatient treatment for late life depression. J Am Geriatr Soc 48:1-6, 2000.

Streim JE, Oslin DW, Katz IR, Smith BD, DiFilippo S, Cooper TB, TenHave T. Drug treatment of depression in frail elderly nursing home residents. Am J Geriatr Psychiatry 8:150-159, 2000.

Oslin DW, Streim JE, Katz IR, Smith BD, DiFilippo S, TenHave T, Cooper TB. A heuristic comparison of sertraline with nortriptyline for the treatment of depression in the frail elderly. Am J Geriatr Psychiatry 8:141-149, 2000.

Mago R, Bilker W, Ten Have T, Harralon T, Streim J, Parmelee P, Katz IR. Clinical laboratory measures in relation to depression, disability, and cognitive impairment in the elderly. Am J Geriatr Psychiatry 8:327-332m 2000.

Datto CJ, Oslin DW, Streim JE, Scheinthal SM, DiFilippo S, Katz IR. Pharmacological treatment of depression in nursing home residents: a mental health services perspective. J Geriatr Psychiatry and Neurology 15:141-146, 2002.

Streim JE, Beckwith EW, Arapakos D, Banta P, Dunn R, Hoyer T. Regulatory oversight, payment policy, and quality improvement in mental health care in nursing homes. Psychiatric Services 53:1414-1418,2002.

Weintraub D, Streim JE, Datto CJ, Katz IR, DiFilippo SD, Oslin DW. Effect of increasing the dose and duration of sertraline trial in the treatment of depressed nursing home residents. J Geriatr Psychiatry and Neurology, 16(2):109-11, 2003.

Oslin DW, Ten Have TR, Streim JE, Datto CJ, Weintraub D, DiFilippo S, Katz IR. Probing the safety of medications in the frail elderly: evidence from a randomized clinical trial of sertraline and venlafaxine in depressed nursing home residents. J Clin Psychiatry 64:875-82, 2003.

Contributions to peer-reviewed clinical research publications, participation cited but not by authorship: none

Research Publications, non-peer reviewed: none

Abstracts (past 3 years):

Streim JE, Ten Have TR, Zhou L, Katz IR. Effects of cognitive and affective status on the recovery trajectory of geriatric patients after discharge from medical rehabilitation. Presented at the annual meeting of the American Psychiatric Association. Chicago, May 2000.

Harralson T, Ten Have T, Regenberg A, Rider M, Kallan M, StreimJ, Forciea M. Reliability of a telephone screen for depression among elderly primary care patients. Presented at the annual meeting of the American Psychiatric Association, Chicago, IL, May 2000.

Streim JE, Gallo JJ, Coyne J, Katz IR. Antidepressant drug use in older adult primary care patients with depression. Gerontologist 40(Special Issue 1):255, 2000. Presented at the annual meeting of the Gerontological Society of America, Washington DC, November 2000.

Streim J, DeVries C, Vanderbilt M. Power and politics: shaping America's mental health policy. Am J Geriatr Psychiatry 9 (suppl. 1): 31-32, 2001. Presented at the annual meeting of the American Association for Geriatric Psychiatry, San Francisco CA, February 2001.

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Datto C, Scheinthal S, Oslin D, Streim J, DiFilippo S, Rooney D, Katz I. Treatment of depression in nursing homes: second generation issues. Presented at the annual meeting of the American Psychiatric Association, New Orleans LA, May 2001.

Streim JE, Vanderbilt MW. Policy and politics: health care priorities for the 107th Congress. Am J Geriatr Psychiatry 10(suppl 1):11-12, 2002. Presented at the annual meeting of the American Association for Geriatric Psychiatry, Orlando FL, February 2002.

Streim JE. Depressive symptoms in the nursing home setting: evolving ideas. Am J Geriatr Psychiatry 10(suppl 1):26, 2002. Presented at the annual meeting of the American Association for Geriatric Psychiatry, Orlando FL, February 2002.

Katz IR, Oslin DW, Datto CJ, Streim JE, TenHave R. Randomized clinical trial of venlafaxine versus sertraline for depressed nursing home residents. Presented at the annual meeting of the American Psychiatric Association, Philadelphia PA, May 2002.

Streim J, Sayers S, Kinosian B, Carey M, TenHave T, Katz I. Diabetic control among veterans with severe mental illness. Presented at the annual meeting of the Society of General Internal Medicine, Vancouver, BC, Canada, May 2003.

Streim J, Conigliaro J, Kinosian B, Sayers S, Carey M, TenHave T, Katz I. Quality of diabetes care for aging U.S. veterans with serious mental illness. Accepted for presentation at the 11th Congress of the International Psychogeriatric Association, Chicago IL, August 2003.

Editorials, Reviews, Chapters:

Drinka PJ, Streim JE. Dementia and depression [letter to the editor]. Am J Psychiatry 144:1368-1369, 1987.

Streim JE, Marshall JR. The dying elderly patient. Am Fam Physician 38:175-183, 1988.

Marshall JR, Streim JE. The dying elderly patient. In Reichel W (ed), Clinical Aspects of Aging, 3rd ed. Baltimore: Williams & Wilkins, 1989, pp. 566-573.

Gottlieb GL, Shtasel DL, Ruff GE, Streim JE. An NIMH geriatric training model: integration of geriatric training in a general psychiatric residency program. Hospital and Community Psychiatry 40(11):1118-1119, 1989.

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Robinson KM, Seigler EL, Streim JE. Medical emergencies in rehabilitation medicine. In DeLisa JA, Gans BM (eds), Rehabilitation Medicine: Principles and Practice, 2nd ed. Philadelphia: JB Lippincott, 1993, pp. 783-797.

Streim JE, Gottlieb GL. Surgery in the patient with psychiatric illness. In Goldmann DR, Brown FH, Guarnieri DM (eds), Perioperative Medicine, The Medical Care of the Surgical Patient, 2nd ed. New York: McGraw Hill, 1994, pp. 361-371.

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April 14, 2002	Streim, JE. "Safer Drug Trials, for Young and Old Alike." Letter to the editor, New York Times, Section 4, p. 12.
July, 2002	Streim, J. "When the Mind Falters: Cognitive Losses in Dementia." Module 4, in Teaching and Learning to Care: Training for Caregivers in Long Term Care, Delaware Valley Geriatric Education Center, Institute on Aging, University of Pennsylvania, 2002. Teaching module with slides, video, and text support for training dementia caregivers

Patents: none

Witness Disclosure Requirement Pursuant to House Rule XI, Clause 2

Name: Joel E. Streim, MD

Representing: American Association for Geriatric Psychiatry

Federal grants for Joel E. Streim:

1. Competitive Pilot Project Fund, Department of Veterans Affairs VISN4, August 1, 2002-July, 31, 2005. "Factors Affecting Control of Diabetes in the Seriously Mentally Ill." $44,294.

2. Health Resources and Services Administration, Department of Health and Human Services, July 2003-June 2008. "University of Pennsylvania Geriatric Interdisciplinary Fellowship," Jerry C. Johnson, MD (PI) and Joel E. Streim, MD (co-PI). $400,000.

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WRITEN COMMITTEE QUESTIONS AND THIER RESPONSES

CHAIRMAN SMITH TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Christopher H. Smith, Chairman
Committee on Veterans' Affairs
January 28, 2004

Hearing on the Department of Veterans Affairs Policies Affecting the Millions of Veterans Who Will Need Long-Term Care in the Next Ten Years

Question 1: Dr. Roswell: Your statement indicated that VA anticipates that "each VISN should manage between 1,000 and 1,500 ... [high resource utilization, chronic disease] patients using home tele-health and disease management." This guidance is silent on the number of *institutional* care patients that networks should be managing. What is your guidance to the field on the management of institutional care workloads?

Response: VA has provided the following guidance on the management of institutional care workloads:

- Long-term care should be provided in the least restrictive setting that is compatible with the veteran's medical condition and personal circumstances, giving preference to home and community-based settings and reserving nursing home care for situations where the veteran can no longer be safely cared for at home, where respite or rehabilitative services are needed, or where veterans have special needs (such as spinal cord injury) that are best met in VA facilities.
- Nursing home care shall be provided or paid for when a veteran who is entitled to such care under the provisions of the Millennium Act (for example, 70% or more service-connected) requires nursing home care. Nursing home care may be provided for other veterans as resources permit.
- In order to comply with the capacity requirements of the Millennium Act, each VISN has been assigned a target Average Daily Census (ADC) level that, in aggregate, will restore VA Nursing Home Care Unit ADC to the 1998 Millennium Act baseline during FY 2004. We are providing additional information in our response to question 2 below. (Note, however, that VA requests in the FY 2005 budget proposal that Congress modify the capacity requirement of the Millennium Act to permit counting of all institutional and non-institutional census toward meeting the capacity requirement).

Question 2: Please provide the Committee a copy of your official guidance to the field on setting the number of institutional care patients that networks should be managing as a part of their overall long-term care practices. Assuming you have a written policy directive, are the networks meeting the requirements of your written policy? What actions are taken against networks that do not adhere to your policy?

Response: Attachment 1 provides a section contained in the Network Performance Monitors addressing the targeted rates of ADC in VA Nursing Home Care Units (VANHCU). This attachment shows that, as of the first quarter of FY 2004, four of the 21 Networks are meeting or exceeding their targets, and that another two are at 94% and 99.7% of their targets, respectively. Nationwide, VA is at 88.7% of the national target.

This information is discussed with VISN Directors quarterly during the performance reviews with the Deputy Under Secretary for Health for Operations and Management. Areas of concern are discussed with the Network Director with an emphasis on actions to meet the monitor.

Question 3: The veteran population most in need of long-term care – veterans who are 85 years old and older – increased by about 100 percent during the past five-year period, but VA's recorded growth in overall long-term care programs was only 11 percent. Is VA meeting its recognized share of the burden of care for these oldest veterans and what is your basis for the conclusion that VA meets that burden?

Response: The institutional long-term care average daily census (ADC) remained stable between 1998 and 2003, while the non-institutional census grew by 57%, in accordance with VA's emphasis on shifting long-term care from institution-based programs into home and community-based programs, provided there will be no detriment to the veterans affected. Further increases are needed, and VA has established ambitious targets for expansion both of care coordination and traditional home and community-based services over the next two years. Completion of the new Long-Term Care Planning Model later this year will provide additional data to help guide planning for future years.

Question 4: We received testimony from the Alzheimer's Association (AA) during this hearing about the successful joint VA-AA programs in Network 2 in Upstate New York. Is there something unusual that characterizes that VISN's leadership and management of its long-term care programs to encourage such coordination, and is the Department trying to duplicate these kinds of joint programs in other VISNs?

Response: VISN 2 leadership has demonstrated an exemplary willingness to explore innovative models of long-term care. As the Veterans Health Administration's (VHA's) competitively selected demonstration site for National Chronic Care Consortium (NCCC) projects and a competitively selected participant in the Chronic Care Networks for Alzheimer's Disease (CCN/AD) national demonstration project co-sponsored by NCCC and the Alzheimer's Association, VISN 2's clinical and administrative leaders played a key role in the development of the basic CCN/AD partnership model of dementia care and its subsequent adaptation for VA implementation across VISN 2 medical centers. Through its VISN-wide care-line management structure, VISN 2's Geriatrics and

Extended Care Careline coordinated multiple resources required for participation in CCN/AD at all of the VISN's medical centers and facilitated the creation of dementia care partnerships between each medical center and its local Alzheimer's Association chapter.

Encouraged by the results of this pilot project, VA is now developing two proposals to test VA-specific versions of this partnership model of care in a controlled research format. These proposals have been submitted to VA's Health Services Research and Development Service. If these proposals successfully pass the merit review process essential for funding, the programs will be implemented in a number of VISNs in partnership with local Alzheimer's Association chapters.

Question 5: Please provide the Committee a report of your efforts by network to either replicate the kind of coordination reported in VISN 2 by the AA witness, or other innovative joint efforts VA makes with outside organizations concerned about the elderly.

Response: As mentioned above, two research proposals have been developed for submission to VA's Health Services Research and Development Service, to test VA-specific versions of the Chronic Care Networks for Alzheimer's Disease (CCN/AD) partnership model of care. If these proposals successfully pass the merit review process essential for funding, the programs will be implemented in a number of VISNs in partnership with local Alzheimer's Association chapters.

In VA's AHEAD project (Advances in Home Based Primary Care for End of Life in Advancing Dementia), 40 teams from home and outpatient primary care settings in 18 VISNs have been trained to apply a rapid-cycle, quality improvement process to the care of community-dwelling veterans with dementia, with a goal of helping these veterans remain at home as long as possible and desired. During the training for the AHEAD project, we emphasized the importance of coordination of services with community organizations such as the Alzheimer's Association as a means of enhancing and complementing the services VA provides. The CCN/AD project toolkit was among the resource materials provided to the AHEAD teams. Since it is essential to the program to reach as wide an audience as possible, two VA national satellite videoconferences have been scheduled to present the AHEAD quality improvement dementia training to additional VA care providers.

Question 6: In December, the IG reported on VA homemaker and home health aide programs. The report noted that $10.7 million or more annually could have been available to provide needed services if VHA had implemented prior OIG recommendations of seven years' duration. How do you explain this long and costly delay that serves to deny veterans with necessary services?

Response: The estimate of monetary savings reported by the IG was based on a single point-in-time audit of a limited number of VA facilities. It is unclear whether the projected savings could have been attained in prior years. After much study, VA established a basis for determining its payment rates for all home care services, and a VHA Handbook, "Home Health and Hospice Care: Reimbursement," is in the final stages of concurrence.

Question 7: Assuming the VA's health care networks were established on the basis of equity of access, and assuming the VERA system allocates resources in accordance with the principles it espouses, the Committee believes that the levels of nursing home workload accomplished among the networks should equally reflect the demand expressed by veterans who need such services. However, both GAO and the IG have reported geographic service gaps that were observed in their reviews of VA long-term care. What steps is the Department taking to make access to long-term care equitable across the country, to address the known service gaps?

Response: VA has set ambitious national targets for the continued growth of long-term care services over the next two years in the FY 2005 budget proposal. Targets for each VISN have been established on the basis of past performance and estimated local demand for services. A performance measure has been established that requires not only an increase in overall census in long-term care programs, but also the extension of a spectrum of specific long-term care services to each facility in each VISN. Use of telehealth technologies and care coordination will further extend access to long-term care services, and rapid expansion of the Care Coordination program is also planned.

Care coordination is the process by which VA continuously monitors and assesses selected patients using telehealth technologies to proactively enable the prevention, investigation, and treatment that enhance the health of patients and prevent unnecessary and inappropriate utilization of resources. VA has recently established an Office of Care Coordination to oversee implementation of these activities. Through the Care Coordination program, VA uses best practices derived from scientific evidence to bring together health care resources from across the continuum of care in the most appropriate, effective, and efficient manner to care for the patient. Care coordination provides patients a continuous connection to clinical services from the convenience of their place of residence.

Question 8: Given that many VA medical centers have historically served as long- term care facilities (such as Knoxville, IA; St. Cloud, MN; Bedford, MA; Lyons, NJ, and there are many other examples), does that embedded facility history and institutional care culture influence how those facilities manage long-term care, considering your current policy governing these services at a national level?

Response: In recent years, VA's approach to geriatrics and extended care has evolved from an institution-focused model to one that is patient-centered. While VA remains committed to providing institutional long-term care for eligible veterans who need it, newer models of long-term care, both in VA and outside VA, include a continuum of home and community-based extended care services in addition to nursing home care. Provision of non-institutional care, when clinically appropriate, is responsive to the expressed desires of many of our patients.

We have no evidence that VA medical centers that have historically served as long-term care facilities are in any way biased by an "embedded facility history and institutional care culture." We believe that all our facilities are focused on providing the most clinically appropriate care for all patients. While facilities such as those named above continue to provide maintenance care for many veterans, they have been required to meet the standards of the Joint Commission on Accreditation of Health Care Organizations for many years. To improve upon that standard, the daily delivery of care has been further enhanced by improving the assessment and treatment planning process using the Resident Assessment Inventory Minimum Data Set (RAI/MDS), which is required of all VA nursing homes. The RAI/MDS (or simply RAI) is a comprehensive assessment tool, consisting of four basic components, the Minimum Data Set itself, Triggers, Resident Assessment Protocols, and Utilization Guidelines. Use of these four components yields information about a patient's functional status, strengths, weaknesses and preferences, and offers guidance on further assessment once problems or potential problems have been identified.

Question 9: Please provide the Committee a roster of VA facilities that primarily provide long-term care as their major mission, along with operating bed complements for each such facility.

Response: At the end of FY 2003, 132 VA facilities had designated nursing home care units. Seven of these facilities have nursing home care as a primary service or mission. Attachment 2 provides the VISN, facility identifier number, facility name, state, and number of operating beds for each of these 132 VA facilities.

Question 10: Since the CARES planning model ignored long-term care needs, were VA facilities whose primary mission is providing long-term care excluded from the CARES process altogether? If these facilities were not excluded from the CARES review, please explain your rationale for including them.

Response: The CARES planning model did not ignore long-term care needs. However, our initial forecasting models did not adequately address the future needs of veterans. Therefore, the CARES model ensured that current long-term care capacity was maintained. VA is now working on revising its long-term care projection model to adequately address the changing needs of veterans,

including the long-term health care needs of aging veterans with serious mental illnesses. These models will be incorporated into VHA's strategic planning process.

When the market plans were submitted in April 2003, the Under Secretary for Health's review of those plans determined that opportunities to reduce vacant space and achieve efficiencies were not fully addressed. Many of those campuses had long-term care missions. A selected list of those campuses was provided to Veterans Integrated Service Networks with the guidance to determine the preliminary feasibility of changing those campuses to 8-hour facilities by consolidating inpatient services at nearby acute care campuses and through selective contracting. The guidance also specified that outpatient services were to remain either on campus or in the area, and that contracting should be used to ensure that access is maintained.

Question 11: While VA was developing its long-term care planning model in 1998, the *VA Long term Care at the Crossroads* report was issued by your Federal Advisory Committee on Long Term Care. Please provide the Committee a status report of your current progress on the development of this model to forecast long-term care needs of veterans who receive care from facilities of the Veterans Health Administration, including a target date for finalization and publication of this model for management purposes.

Response: Since the time of the 1998 long-term care report, the original VHA long-term care model has gone through various cycles of incorporating updates to model inputs and parameters, to improve the basic model and its projection capabilities. However, a great variety of new data sources, modeling capabilities, and potential collaborators have now become available. In particular, over the past year or so, the VHA Office of the Assistant Deputy Under Secretary for Health (formerly VHA Office of Policy and Planning) has undertaken a far more ambitious effort than ever to modernize and improve the VHA Long-Term Care Model. In fact, VHA has been involved in a public-private collaboration with the Duke University Center for Demographic Studies, University of Pennsylvania researchers, the VA Office of the Actuary, the VA Office of Geriatrics and Extended Care, the National Center for Health Statistics, the Agency for Health Research and Quality, the Centers for Medicare and Medicaid Services, and the Bureau of the Census to develop a largely new and improved long-term care model.

This effort has to date incorporated updated and new survey, administrative, veteran population, and VHA Health Care Services Demand Model data and methods. However, at this time, we are unable to say with certainty when the model will be finalized and released to the Networks for their use.

VHA Long-Term Care Model development will continue in the future as new data, such as from surveys or from VHA Health Care Services Demand Model

updates, become available, or as VHA proceeds with VA, Medicare, and Medicaid file matching initiatives that lead to the production of VA/Medicare/Medicaid matched data that can be input into the model. All of this will yield a very dynamic and powerful model for projecting demand for VA sponsored and provided nursing home and home and community based care. As such, the VHA Long-Term Care Model will continue to be modified or adjusted and will continue to find wide utility in VA long-term care planning efforts for a long time to come

Question 12: Dr. Roswell, in your exchange with Chairman Simmons during the hearing, you noted that the *per diem* payments that VA provides to state veterans homes "...is only a small portion, roughly a third of the total *per diem* cost..." for the homes to provide veterans' care. The *per diem* payment level is set annually by your Administration. Please describe the formula or method of cost-based analysis you use to set this *per diem* amount each year for the several pertinent levels of care in state homes.

Response: Any increase in the per diem for State Home care is limited by 38 U.S.C. § 1741(c), which stipulates that the yearly increase cannot exceed the percentage increase for the cost of care in a VA general hospital. Generally, VA increases the per diem by that amount each year. In addition, VA may not pay more than 50% of the actual cost of care for veterans in any individual state.

Question 13: Are you considering offering a higher *per diem* payment for veterans with 70 percent or higher service-connected ratings, and if so, when will the higher level *per diem* take effect?

Response: State Veterans Homes are state programs for which VA provides financial assistance that is limited by statute to no more than 50% of the daily cost of care. VA is not considering offering a higher per diem payment for 70% or more service-connected veterans residing in state homes because of the statutory limitation and because doing so would divert resources from other VA programs for elderly and disabled veterans.

Question 14: The Colorado State Home at Fitzsimons has experienced severe operating difficulties, and your Denver Medical Center has removed all veterans from that home and placed them in other facilities. Please provide a report of VA's actions prior to the foreclosure of certification of this new veterans home by the state Medicaid agency, the current status of all the veterans you removed from the home, and VA's current actions to aid the home in restoring its certifications.

Response: No veterans have been removed from the Colorado State Home at Fitzsimons. New admissions to the home have been suspended pending correction of the deficiencies identified by the state Medicaid agency and

independently by VA. Both VA and CMS are considering withdrawing certification of the home, but neither has done so at this time.

After learning of the deficiencies at the home identified by the state Medicaid agency, the Denver VA Medical Center (VAMC) conducted an independent on-site survey of the home and confirmed that a number of deficiencies were present. The VAMC required the home to prepare a corrective action plan and has been monitoring implementation of that plan with daily telephone calls and at least weekly on-site visits. VA has made a number of recommendations to the home, serving in a consultative as well as oversight role. The Denver VAMC submits weekly reports to VA Central Office detailing progress made in implementing the corrective action plan.

Question 15: A forensic examination of the Fitzsimons deterioration and subsequent closure could aid other state homes, especially new homes coming on line in the next several years, to avoid a similar crisis situation. Please provide the Committee any VA forensic examination that was undertaken of the Fitzsimons situation, and the current status of any recommendations made therefrom.

Response: Assessment of the circumstances at Fitzsimons indicates that the previous leadership of the state home may have deliberately concealed deteriorating financial and clinical conditions from the state and from VA. The inspection process used by the state Medicaid agency detected the deficiencies within a few months and initiated corrective actions. The persons responsible resigned or were terminated from their positions by the state. VA employs a similar, independent inspection process that confirmed the state's findings.

To enhance our ability to detect deficiencies in care even earlier, VA is improving its oversight of the State Home Program in two key areas. All reports of on-site inspections performed in state homes by VA facilities are now automated into an electronic database maintained at VA Central Office. This allows review of the timeliness of inspections and supports comparative evaluation across standards, among homes, and among states. In addition, VA is working to implement electronic transfer of quality indicators and provide VistA-CPRS access to state homes to further improve comparison among homes and continuity of care for veterans receiving care both from VA and in a state home.

Attachment 1: Network Performance Monitors

Long Term Care Access:

Maintain VANHCU ADC at Targeted Rate.

Rationale for Monitor:

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, requires VA to ensure that the staffing and level of extended care services provided nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided during fiscal year 1998.

Congressional correspondence focused on VHA's noncompliance with the requirement of the Millennium Act to maintain a baseline of extended care services at the FY 1998 level of effort. Congressional committees have focused on the decrease of NHCU ADC between 1998 and 2000 with a minimal increase in non-institutional extended care services. The Department committed to restoring the NHCU census to the FY 1998 level by FY 2003 at the Senate Appropriations Committee (SAC) hearing in April 2001.

The target Average Daily Census (ADC) for VANHCUs were set for each VISN using VA's Long-Term Care (LTC) Planning Model. The 1998 Baseline or the 2003 Actual (whichever was a larger number) was chosen for the Target.

VA Nursing Home Care
FY 2004 Target & Performance

VISN	1998 Baseline ADC	Actual ADC 4th Quarter 2003	Avg. Oper. Beds (89.3% Occupancy.) Sep-03	Recommended Target ADC FY 2004 5-Nov-03
1	619	620	653	620
2	548	400	498	538
3	988	763	947	977
4	1185	1122	1191	1185
5	431	443	418	443
6	748	748	843	748
7	713	763	916	763
8	934	916	956	934
9	411	314	309	405
10	657	587	610	645
11	644	629	647	644
12	674	663	686	674
15	382	330	378	380
16	755	739	702	750
17	603	593	638	603
18	440	409	419	435
19	386	221	232	290
20	354	305	338	353
21	627	691	700	691
22	540	395	571	540
23	787	688	748	773
Total	**13426**	**12339**	**13399**	**13391**
			0.893	13391

The table on the following page illustrates the progress made towards the target for FY 2004.

VISN	1998 Baseline ADC	Actual ADC 4th Quarter 2003	% of Target Met, 4th Qtr. 2003	Target ADC FY 2004 5-Nov-03	Actual ADC 1st Qtr. 2004	% of Target Met, 1st Qtr. 2004
1	619	620	94.2%	620	503	81.1%
2	548	400	91.7%	538	415	77.2%
3	988	763	87.1%	977	757	77.4%
4	1185	1122	98.4%	1185	1021	86.2%
5	431	443	94.7%	443	384	86.8%
6	748	748	93.0%	748	703	94.0%
7	713	763	111.1%	763	761	99.7%
8	934	916	106.0%	934	832	89.1%
9	411	314	100.3%	405	318	78.6%
10	657	587	96.5%	645	558	86.5%
11	644	629	105.4%	644	646	100.4%
12	674	663	98.5%	674	680	100.8%
15	382	330	96.2%	380	279	73.3%
16	755	739	97.9%	750	739	98.5%
17	603	593	99.8%	603	667	110.6%
18	440	409	103.5%	435	461	106.0%
19	386	221	89.5%	290	219	75.6%
20	354	305	107.4%	353	296	83.9%
21	627	691	101.3%	691	578	83.7%
22	540	395	89.6%	540	382	70.7%
23	787	688	100.4%	773	679	87.8%
Total	**13426**	**12339**	98.3%	**13391**	**11877**	88.7%

Attachment 2

FY 2003 VA Nursing Home Care

VISN	Station #	Facility Name	State	FY03 Operating NH Beds
1	402	Togus	ME	100
1	518	Bedford	MA	304
1	523A5	Brockton VAMC	MA	120
1	608	Manchester	NH	112
1	631	Northampton	MA	55
1	689	West Haven	CT	40
2	528	Upstate New York HCS	NY	30
2	528A4	Upstate New York HCS-Batavia*	NY	90
2	528A5	Canandaigua	NY	138
2	528A6	Bath	NY	200
2	528A7	Syracuse	NY	50
2	528A8	Albany	NY	50
3	526	Bronx	NY	112
3	561A4	Lyons	NJ	270
3	620	Hudson Valley HCS	NY	199
3	620A4	Castle Point Division-Hudson Valley HCS	NY	98
3	630A5	New York Harbor HCS-St. Albans Campus*	NY	181
3	632	Northport	NY	170
4	460	Wilmington	DE	60
4	503	James E. Van Zandt VA (Altoona)	PA	40
4	529	Butler	PA	97
4	542	Coatesville	PA	261
4	562	Erie	PA	52
4	595	Lebanon	PA	136
4	642	Philadelphia	PA	240
4	646A4	Pittsburgh HCS-Aspinwall	PA	336
4	693	Wilkes Barre	PA	105
5	512	Baltimore	MD	70
5	512A5	Perry Point	MD	130
5	613	Martinsburg	WV	148
5	688	Washington	DC	120
6	517	Beckley	WV	50
6	558	Durham	NC	120
6	565	Fayetteville NC	NC	69
6	590	Hampton	VA	130
6	637	Asheville-Oteen	NC	120
6	652	Richmond	VA	98
6	658	Salem	VA	90

6	659	W.G. (Bill) Hefner Salisbury VAMC	NC	270
7	508	Decatur	GA	100
7	509	Augusta	GA	132
7	534	Charleston	SC	28
7	544	Columbia SC	SC	94
7	557	Dublin	GA	161
7	619A4	Tuskegee	AL	160
7	679	Tuscaloosa	AL	178
8	516	Bay Pines	FL	142
8	546	Miami	FL	172
8	548	W Palm Beach	FL	98
8	573	North Florida/South Georgia HCS-Gainesville	FL	30
8	573A4	North Florida/South Georgia HCS-Lake City	FL	210
8	672	San Juan	PR	120
8	673	Tampa	FL	180
8	673BY	Orlando	FL	118
9	596	Lexington-Leestown	KY	61
9	621	Mountain Home	TN	120
9	626A4	Middle Tennessee HCS-Alvin C. York Division	TN	165
10	538	Chillicothe	OH	162
10	539	Cincinnati	OH	64
10	541A0	Cleveland-Brecksv.	OH	190
10	552	Dayton	OH	265
11	506	Ann Arbor HCS	MI	46
11	515	Battle Creek	MI	109
11	550	Illiana HCS (Danville)	IL	217
11	553	Detroit (John D. Dingell)	MI	84
11	583	Indianapolis	IN	0
11	610	N. Indiana HCS-Marion	IN	180
11	655	Saginaw	MI	81
12	556	North Chicago IL	IL	204
12	578	Hines	IL	210
12	585	Iron Mountain MI	MI	40
12	676	Tomah	WI	188
12	695	Milwaukee WI	WI	113
15	589A4	Columbia MO	MO	38
15	589A5	Topeka - Colmery-O'Neil	KS	96
15	589A6	Leavenworth	KS	78
15	589A7	Robert J. Dole VAM&ROC (Wichita)	KS	40
15	657	St Louis-John Cochran	MO	71
15	657A4	Poplar Bluff	MO	40
15	657A5	Marion IL	IL	60
16	502	Alexandria	LA	154
16	520	Gulf Coast HCS	MS	160

16	580	Houston	TX	120
16	586	G. V. (Sonny) Montgomery VAMC	MS	120
16	598	Central AR. Veterans HCS LR	AR	152
16	629	New Orleans	LA	60
16	635	Oklahoma City	OK	20
17	549	Dallas VAMC	TX	116
17	549A4	Bonham VAMC	TX	136
17	671	San Antonio VAMC	TX	90
17	671A4	Kerrville VAMC	TX	154
17	674	Temple VAMC	TX	132
17	674A4	Waco VAMC	TX	140
18	501	New Mexico HCS	NM	36
18	504	Amarillo HCS	TX	120
18	519	West Texas HCS	TX	160
18	644	Phoenix	AZ	104
18	649	Northern Arizona HCS	AZ	85
18	678	S. Arizona HCS	AZ	84
19	436GJ	Miles City*	MT	30
19	442	Cheyenne	WY	50
19	554	Eastern Colorado HCS	CO	60
19	554A4	Eastern Colorado HCS- Southern Colorado*	CO	40
19	575	Grand Junction	CO	30
19	666	Sheridan	WY	50
20	531	Boise	ID	32
20	648A4	Vancouver	WA	72
20	653	Roseburg HCS	OR	75
20	663	Seattle	WA	59
20	663A4	American Lake	WA	72
20	668	Spokane	WA	38
20	687	Walla Walla	WA	30
21	459	Pacific Islands HCS (Honolulu)	HI	60
21	570	Fresno	CA	60
21	612	N. California HCS-Martinez*	CA	90
21	640	Palo Alto-Palo Alto	CA	62
21	640A0	Palo Alto-Menlo Pk	CA	242
21	640A4	Livermore	CA	150
21	654	Sierra Nevada HCS	NV	60
21	662	San Francisco	CA	120
22	600	Long Beach HCS	CA	110
22	605	Loma Linda VAMC	CA	108
22	664	San Diego HCS	CA	69
22	691	Greater Los Angeles HCS	CA	164
22	691A4	Sepulveda*	CA	56
23	437	Fargo	ND	50

23	438	Sioux Falls	SD	58
23	568	Fort Meade	SD	104
23	618	Minneapolis	MN	104
23	636A4	Grand Island Div.-Central Plains Health Network*	NE	76
23	636A7	Knoxville Division-Central Plains Health Network	IA	226
23	656	St Cloud	MN	220

Questions for the Record
Honorable Christopher H. Smith, Chairman
Committee on Veterans' Affairs
January 28, 2004

Hearing on the Department of Veterans Affairs Policies Affecting the Millions of Veterans Who Will Need Long-Term Care in the Next Ten Years

1. **Ms. Sabo: it is encouraging to hear that Partners in Dementia Care has been highly effective in connecting eligible veterans to VA services. Could this kind of program be a successful model to improve care for aging veterans who live in rural areas?**

   In VISN 2, the Partners in Dementia Care project was implemented in many rural areas. The VA has numerous community-based outpatient clinics (CBOCs) that serve rural communities in upstate New York. The four Alzheimer's Association chapters that participate in the Partners in Dementia Care project in VISN 2 also have satellite offices in rural communities. Together, the VA and the Alzheimer's Association are able to serve many more veterans with Alzheimer's disease and other dementias than could be served by either organization on its own. Needless to say, however, both organizations continue to struggle to meet the needs of people in rural communities.

   One example of the way partnership with the Alzheimer's Association helps VISN 2 serve veterans from rural areas is the placement of an Alzheimer's Association chapter staff member at the VA clinic in Rome, NY on a part-time basis. The chapter staff member is able to assist VA clinic staff with connecting veterans and their families to needed VA and non-VA community services. Alzheimer's Association chapters are also able to provide support groups for family caregivers of veterans with Alzheimer's disease and other dementias who live in rural communities. In communities where neither the VA nor the chapter has a presence, chapters can help train other community organizations, such as the local Area Agency on Aging, to identify veterans with Alzheimer's disease and other dementias who may need help and connect them to the VA and the local chapter.

2. **In your opinion, how could VA provide improved long-term care services, including nursing home beds and related services, for veterans with Alzheimer's disease and other dementias who need such services?**

   The Partners in Dementia Care project provides a model of care that can help improve long term care for veterans with Alzheimer's disease and other dementias. The project model has four main components: identification of people with possible dementia; diagnostic assessment; ongoing medical and non-medical care management; and family caregiver support. This model of care focuses VA and non-VA resources to maximize the health and

Submitted by Linda Sabo, Executive Director, Western New York Chapter, Alzheimer's Association, 2805 Werhle Drive, Suite 6, Williamsville, NY 14221, 716-626-0600 (tel), 716-626-2255 (fax), Linda.Sabo@alz.org.

functioning of veterans with Alzheimer's and other dementias and support their family caregivers so that the veteran can be cared for at home for as long as possible, thus delaying nursing home placement until it is essential. The care and support needs of these veterans and their families are carefully assessed and monitored over time, and Alzheimer's Association chapter staff help to identify community services that will be helpful to the veteran and family and assist the family in arranging these services.

The Partners in Dementia Care project also helps improve the quality of VA long-term care services by providing training about Alzheimer's and dementia Care for VA staff. In VISN 2, training has been provided in many different formats, including large group lectures, small meetings, and one-on-one case based discussions. VA physicians who are knowledgeable about Alzheimer's and dementia care provide initial orientation to the project model of care. Ongoing training is provided in formal sessions with experts from nearby academic medical centers and informally by dementia care managers (VA nurses and social workers) who coordinate the Partners in Dementia Care project in individual medical centers. Each of the four Alzheimer's Association Chapters that participate in the project in VISN 2 offers training for nursing home, home health, and other care providers, and the Partners in Dementia Care project brought this training into the VA. The Rochester Chapter conducted a train-the-trainer program for VA staff in the Canandaigua and Bath medical centers, so that trained VA staff could provide training for others in these facilities.

3. **As several of our witnesses stated at this hearing, mental health care remains a great unmet need among elderly populations. What percentage of veterans with dementia do you anticipate would need traditional, chronic nursing home care over the next ten years?**

Given current care practices almost all people with Alzheimer's disease and other dementias (Veterans and non-Veterans) are likely to need a nursing home level of care at some time in the course of their illness. Some families are able to provide this level of care at home, especially if they have access to significant amounts of home health and respite care services, but most families are not able to provide this level of care. The goal in certainly to maintain the individual at home for as long as possible, but nursing home care should be available when the family can no longer manage the individual's care.

Some people with Alzheimer's disease and other dementias (Veteran and non-Veterans) have severe behavioral symptoms that may require specialized placements, at least until the symptoms are reduced. Specialized settings generally are not needed however, if the staff in traditional VA and non-VA nursing homes receive adequate training about Alzheimer's and dementia care, and especially about how to avoid or reduce behavioral symptoms. Training is critical for appropriate care, and access to mental health consultation can help staff in traditional nursing homes effectively manage most behavioral symptoms of residents with dementia.

Submitted by Linda Sabo, Executive Director, Western New York Chapter, Alzheimer's Association, 2805 Werhle Drive, Suite 6, Williamsville, NY 14221, 716-626-0600 (tel), 716-626-2255 (fax), Linda.Sabo@alz.org.

4. **Do you believe that VA will be able to position its resources to provide a sufficient capacity of nursing home beds and other resources needed to care for veterans with dementias?**

Whether the VA has sufficient capacity to provide needed long-term care services depends on course, on how many veterans are eligible and chose to use VA services, the amount of the overall VA appropriation, and the proportion of that appropriation that VISN's and individual medical centers decide to spend on long term care versus acute and other health care. Within these constraints, the VA must balance the important needs of veterans for nursing home care and home-and community based care. Both are important, and both must be available. Experience in the Partners in Dementia Care project shows that partnership with Alzheimer's Association Chapters can help the VA stretch its resources for long-term care while simultaneously improving outcomes for veterans with Alzheimer's disease and other dementias.

Submitted by Linda Sabo, Executive Director, Western New York Chapter, Alzheimer's Association, 2805 Werhle Drive, Suite 6, Williamsville, NY 14221, 716-626-0600 (tel), 716-626-2255 (fax), Linda.Sabo@alz.org.

National Association of State Veterans Homes
"Caring for America's Heroes"

Return Address:
Philip D. Jean
President, NASVH
Maine Veterans' Home-Scarborough
290 US Route One
Scarborough, ME 04074
(207) 883-7184

March 12, 2004

The Honorable Christopher H. Smith
Chairman
House Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, D.C. 20515

The Honorable Lane Evans
Ranking Member
House Committee on Veterans' Affairs
U.S. House of Representatives
333 Cannon House Office Building
Washington, D.C. 20515

Re: Additional Questions Posed by the Committee on Veterans' Affairs in Connection with the January 28, 2004 Hearing on the Department of Veterans Affairs Policies Affecting the Millions of Veterans Who Will Need Long-Term Care in the Next Ten Years

Dear Chairman Smith and Congressman Evans:

This letter is in response to correspondence from Chairman Smith, dated February 10, 2004, posing questions in connection with my testimony, as President of the National Association of State Veterans Homes ("NASVH"), before the House Committee on Veterans' Affairs (the "Committee") on January 28, 2004. The state veterans homes program remains by far the most efficient and cost-effective method of providing long-term care and domiciliary care to veterans of the United States armed forces, and we appreciate the interest of the Committee in the work and continued financial viability of the state veterans home program.

The ten questions posed in the Chairman's letter, and our answers thereto, are set forth below.

I. Question: Mr. Jean: Ms. Jade Gong in her testimony suggested that consideration be given to utilizing the state home construction and per diem grant programs to develop assisted living facilities for veterans. What effect do you think such a proposal would have on the state home program?

Answer: The state home construction and per diem grant programs should be used to develop assisted living facilities for veterans. In fact, the state veterans home "domiciliary care" program currently administrated by the United States Department of Veterans Affairs ("VA") meets the definition of "assisted living" under several state health care systems. Construction and operational support for additional assisted living facilities, however, should be closely coordinated with the existing funding priorities established by the Veterans Millennium Health Care and Benefits Act of 1999 (the "Millennium Act"). The funding priority system set forth in the Millennium Act allocates new state home construction grants first to states that both have a demonstrated need for new veterans beds at state veterans home facilities and have raised, in immediately-available cash, the 35% local state share of construction costs necessary to build such facilities. The funding priorities established by the Millennium Act are working well and should be continued by Congress. These funding priorities discourage overbedding in certain states and encourage the construction of new state veterans homes in states

that have relatively large veteran populations and that have relatively few veterans beds in state veterans home facilities to serve such populations. The funding priorities established by the Millennium Act also encourage the repair and rehabilitation of existing state veterans homes over the construction of new state veterans home facilities that may not be needed. These are all common sense approaches to managing the growth of new state veterans home facilities, and we believe that any encouragement by Congress of the construction and operation of new assisted living facilities should be integrated intelligently into the funding priorities of the Millennium Act. Lastly, the most important thing that Congress could do to encourage the construction and operation of additional assisted living facilities for veterans would be to set the VA per diem rate for such facilities high enough to assure their profitable operation. Only in this way will significantly more states be encouraged to construct and operate additional assisted living facilities for veterans.

II. Question: Is assisted living an area of developing interest for members of your association, and how would you describe this type of care as different from care now provided in state domiciliary care programs?

Answer: Assisted living is a strong component of the current state veterans home program. As stated in our answer to Question I, "assisted living care" under the state veterans home program is often indistinguishable from "domiciliary care" as administered by the VA and various levels of residential assisted living programs administered by state health care systems. Numerous state home construction grants are awarded annually by the VA for the construction or rehabilitation of domiciliary care facilities, and the interest of states in providing domiciliary care to their veteran populations is strong and growing. Simply put, assisted living care or domiciliary care for veterans is residential health care for veterans that is medically less complicated and less demanding than is skilled nursing care, long-term geriatric nursing care, respite care or hospice care. Assisted living care or domiciliary care within the state veterans home system should be encouraged and expanded to the point that, together with existing skilled and long-term geriatric nursing care options, it provides a seamless continuum of care for veterans, from the time that such veterans first require basic residential veterans health care services, until the time that such veterans require intensive skilled nursing care, long-term geriatric care, respite care or hospice care. Such a seamless continuum of care at state veterans homes facilities would allow veterans to "age in place" at a single state veterans home facility without needlessly being transferred and repeatedly uprooted from friends, family, and familiar surroundings as their aging process advances.

III. Question: Congress authorized state homes to provide adult day care in coordination with VA. How many homes are currently providing adult day care to veterans and what have been your collective experiences?

Answer: Currently, there are only two state veterans home facilities in the nation that operate adult day care programs. One such adult day care facility is located at Phoenix, Arizona, and the other such adult day care facility is located at Stony Brook, New York. There are currently so few adult day care programs for veterans because state veterans adult day care programs are required by the VA to provide most of the same nursing and therapy services in a non-residential setting that a state veterans nursing home is required to provide in a residential setting. The most significant difference between a veterans adult day care program and veterans nursing care program is that in an adult day care program the veteran goes home at the end of the day. The other significant difference between a veterans adult day care program and a veterans nursing care program is that a state operator of a veterans adult day care program is paid significantly less ($42.57 per day) by the VA to operate such a program than a state operator would be paid ($57.78 per day) by the VA to operate a veterans nursing home program.

Please note that these rates were slightly increased to their present levels only very recently.

IV. Question: Do you have any further recommendations to Congress or the Department with regard to the management of the adult day care programs in which state homes are now participating?

Answer: Congress should work with the states and with the VA to design a veterans adult day care program that is financially viable for the state veterans home system to operate. This could involve either increasing the amount of money paid to state operators to operate state veterans home adult day care programs, or decreasing the amount of services required by the VA to be provided by such operators of such programs.

V. Question: You also state that State Veterans Homes are required to meet very stringent and very costly VA standards for veterans care as a condition for receiving VA per diem payments. Can you describe in general terms and quantify the VA requirements that exceed the usual standards of care applicable to nursing homes in community settings?

Answer: The VA requires registered nurses to be on duty at state veterans homes 24 hours per day, 7 days per week. The Centers for Medicare & Medicaid Services ("CMS") require registered nurses to be on duty at community nursing homes only 8 continuous hours per day. The VA requires a full medical history to be obtained from each resident and a physical examination to be performed for each resident within 72 hours of admission to a state veterans home. CMS has no similar requirements for community nursing homes. The VA requires annual physicals and complete pharmacy and laboratory reviews for each resident of a state veterans home. CMS has no similar requirements for community nursing homes. The VA requires that social workers at a state veterans home have a master's degree in social work and a state social worker's license. CMS has no similar requirements and requires only that a social worker at a community nursing home have a bachelor's degree in social work. The VA requires extensive survey and reporting activities of the state veterans homes including sentinel event reporting and root cause analysis procedures, an annual VA compliance survey (in addition to a state compliance survey), veterans benefits claims management, VA census management (to assure that at least 75% of residents are eligible veterans), and unique billing and reporting requirements to obtain the VA per diem payments from VA medical centers. CMS has no similar requirements for community nursing homes, except requiring that an annual state compliance survey be performed.

Moreover, the VA requires extra space for each nursing home resident: 150 square feet and 115 square feet for each resident of a single-resident room and a multiple-resident room respectively, compared to CMS requirements at community nursing homes of 100 square feet and 80 square feet for each resident of a single-resident and multiple-resident room respectively. This causes higher per resident housekeeping and maintenance costs at state veterans homes compared to community nursing homes. The VA prohibits nursing shift supervisors at state veterans homes from providing direct care to residents unless a facility has 60 or fewer residents. CMS has no similar requirement for community nursing homes. The VA requires state veterans homes to have medical directors that: "participate in establishing" the policies and procedures of the homes; "direct" medical care; monitor employees' health status; review mandated credentialing and privileging processes; and assist the state veterans home to provide continuous medical coverage 24 hours per day to handle medical emergencies. CMS has no such requirements for community nursing homes, except that it requires physicians associated with nursing homes to "implement" policies developed by others for such homes and to "coordinate" whatever

medical care that is provided at such community nursing homes. Contracting with medical directors to perform all of the above required additional services at state veterans homes is a significant additional cost of care at state veterans homes. For the convenience of the Committee we have also provided the information contained in this Answer in chart form, attached to this letter.

VI. Question: The state homes are an important resource enabling VA to outplace many veterans at a considerably lower cost than it would otherwise incur if these veterans received nursing home care in VA beds. Has the case mix of veterans state homes grown more acute since enactment of the Millennium Act, and what are your views on the reasons for such change?

Answer: The case mix and the seriousness of illnesses displayed by residents at state veterans homes, especially those state veterans homes that are Medicaid-certified, has become substantially more acute since enactment of the Millennium Act. I do not believe, however, that this is in any way solely due to the enactment of the Millennium Act. The cause of the rise in acuity of residents in state veterans homes, especially those that are Medicaid-certified, is that state Medicaid programs are making it substantially more difficult nationally for persons to qualify for Medicaid benefits in nursing homes. State Medicaid agencies are strictly administering resident assessment examinations on items such as "activities of daily living," and, as a result, residents of state veterans homes that are Medicaid-certified are simply "much sicker" than they were several years ago. Coupled with the fact that state veterans homes typically are populated with many more male residents than female residents (a typical state veterans home has a 75% male resident population, compared to a 25% male resident population at a community nursing home), state veterans homes typically require more direct-care staff per resident than community nursing homes. All of this has meant that, in recent years, it has become much more important for Medicaid-certified state veterans homes to retain VA per diem payments in addition to whatever Medicaid payments that they receive, to help cover their increased costs of care caused in part by the significantly increased acuity of their residents.

VII. Question: Please provide a report to the Committee of the number of state home residents as of December 31, 2003, who are veterans rated service-disabled at 70 percent or higher.

Answer: According to the best information supplied to us by the VA, the percentage of veterans who are rated service disabled at 70 percent or higher and residing at state veterans homes at any given time is between 4 - 10% of the overall resident population at state veterans homes.

VIII. Question: Mr. Jean, state veterans' homes are an important part of the overall capability to provide long-term care for veterans, and the state homes are doing a wonderful job. What is the view of your association as to the portion of the overall long-term care burden that Congress should expect be borne by state veterans' homes?

Answer: State veterans homes are the logical choice to provide long-term nursing care to as many eligible veterans as possible. This is so because the state veterans home system can provide long-term veterans nursing care at significantly less cost to taxpayers than the Federal government. For example, the average daily cost of care for a veteran at a long-term care facility run directly by the VA is estimated nationally to be $376.55 per day. The same average daily cost of care at a state veterans long-term care facility is estimated to be far less. For example, the average daily cost for long-term nursing care at the Maine Veterans' Homes is only $185.51. The same cost of care at a Washington State Veterans' Home is $231 per day, while Florida's cost of care is estimated to be in the range of $200-243 per day. Accordingly, it seems logical that the state veterans home

system should be encouraged to provide long-term nursing care services to as many veterans as possible, and that Congress, the VA, and the States should do as much as possible to provide the state veterans home system with an adequate revenue stream, using VA per diem payments, State appropriations, and Medicaid payments (if applicable) to assure that state veterans homes are able to cover their reasonable costs of care.

IX. Question: Please describe the flow of funds from VA (per diem grant payments) to state veterans homes, including the process used to determine the amount due and to whom or through whom the payments are made to homes.

Answer: VA per diem payments typically are made to a state veterans home system according to the following procedure. On a monthly basis, each state veterans home system computes the total number of eligible veterans residing in such state veterans home system during the previous month, and multiplies this amount by the total number of days in the month during which such residents resided in such state veterans home system. The resulting product is the "total eligible resident-days per month" and this amount is transmitted by each state veterans home system to the VA Medical Center ("VAMC") overseeing such, state veterans home system. The VAMC then transmits this amount of total eligible resident days to VA headquarters in Washington, D.C., which multiplies this amount of total eligible resident days by the amount of the applicable VA per diem and electronically deposits the appropriate total per diem payment amount in the account of the state veterans home system. The state veterans home system then uses this amount to pay for the costs of care of its residents.

The manner in which a state veterans home system uses VA per diem payments to pay for the costs of care of its residents is typically according to the following general procedure. If a resident is able to pay for a portion of his or her cost of care at a state veterans home, the VA per diem amount typically is credited to the resident's account to help the resident pay for the cost of such resident's care. If a resident is not helping to pay for his or her cost of care at a state veterans home (*e.g.*, the resident has qualified for Medicaid benefits), the VA per diem amount is either retained by the state veterans home to pay for any shortfall between the maximum amount that Medicaid will pay for the resident's care and the actual cost of care, or returned to the Federal Medicaid system.

X. Question: Is there any extant situation that occurs in which a state veterans home might have excess funds that are returned to a general treasury fund in a particular state? Please describe any such situation.

Answer: I am not aware of any situation nationally in which a state veterans home returns excess funds to a general treasury fund of its governing State. To the best of my knowledge, all State and Federal funds received by state veterans homes are expended directly on the care of residents in such state veterans home systems.

I hope that the above responses to the Committee's questions have been helpful to the Committee. Please contact me if I can provide any additional information on behalf of NASVH.

Sincerely,

Philip J. Jean

Philip Jean, MBA, CNHA
President

COMPARISON OF SVH REGULATORY REQUIREMENTS

REQUIREMENT	VA	CMS
Physician Services		
Physician examinations	1) Full history and physical within 72 hours 2) Yearly medical history and physicals with complete lab and pharmacy reviews	No requirement
Policies and procedures	MD required to **participate in establishing** policies and procedures	MD responsible for **implementing** policies and procedures
Medical Care	MD required **to direct** and coordinate care	MD required to coordinate care
Employees' health status	MD required to monitor	No requirement
Credentialing	Participate in mandated credentialing & privileging process	No requirement
Physician Coverage	Assist facility in providing continuous coverage to handle medical emergencies	No requirement
Registered Nurses		
Coverage	**24** hrs day/7 days week	**8** consecutive hrs per day/ 7 days week
Shift supervisors	Prohibits shift supervisors from providing direct care (unless 60 or < residents)	No requirement
Social Workers		
Educational requirements	MSW & license	Bachelor's degree
Survey Process		
	Sentinel event reporting and root cause analysis process and state reporting system	State reporting system
	Additional survey	State Medicaid survey
	Veterans benefits claims management	Not applicable
	VA unique census management, billing and reporting	Not Applicable
Room size (larger areas require additional housekeeping support)		
Multiple resident rooms	115 sq. ft.	80 sq. ft.
Single rooms	150 sq. ft.	100 sq. ft.
Credentialing & Privileging		
Process	JCAHO level credentialing and verification standards	Verify license

	State	State Home		DOM	NHC	HOSP	ADHC
9	14. Kentucky	Wilmore		0	300	0	
9		Hazard		0	120	0	
15		Hanson		0	120	0	
			Total Beds	0	540	0	
16	15. Louisiana	Jackson		0	161	0	
16		Monroe		0	156	0	
			Total Beds	0	317	0	
1	16. Maine	Augusta		0	120	0	
1		Bangor		0	120	0	
1		Caribou		0	40	0	
1		Scarborough		0	120	0	
1		South Paris		28	62	0	
			Total Beds	28	462	0	
5	17. Maryland	Charlotte Hall		100	278	0	
1	18. Massachusetts	Chelsea		305	189	20	
1		Holyoke		30	274	12	
			Total Beds	335	463	32	
11	19. Michigan	Grand Rapids		140	618	0	
12		Marquette		59	184	0	
			Total Beds	199	802	0	
23	20. Minnesota	Fergus Falls		0	85	0	
23		Hastings		200	0	0	
23		Luverne		0	85	0	
23		Minneapolis		61	346	0	
23		Silver Bay		0	87	0	
			Total Beds	261	603	0	
16	21. Mississippi	Collins		0	150	0	
16		Jackson		0	150	0	
16		Kosciusko		0	150	0	
9		Oxford		0	150	0	
			Total Beds	0	600	0	
15	22. Missouri	Cameron		0	200	0	
15		Cape Girardeau		0	150	0	
15		Mexico		0	150	0	
15		Mount Vernon		0	99	0	
15		Saint James		0	150	0	
15		Saint Louis		0	200	0	
15		Warrensburg		0	200	0	
			Total Beds	0	1149	0	
19	23. Montana	Columbia Falls		60	90	0	
19		Glendive		0	80	0	
			Total Beds	60	170	0	