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OPTIONS TO NURSING HOME CARE—IS VA PREPARED?

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

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APRIL 25, 2002

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OPTIONS TO NURSING HOME CARE—IS VA PREPARED?

THURSDAY, APRIL 25, 2002

U.S. SENATE,
COMMITTEE ON VETERANS AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10:25 a.m., in room SR–418, Russell Senate Office Building, Hon. John D. Rockefeller IV, chairman of the committee, presiding.

Present: Senators Rockefeller, Graham, Wellstone, Specter, and Hutchinson.

Chairman ROCKEFELLER. The hearing will come to order, and I will forego my opening statement for the moment and yield with the permission of Senator Hutchinson to Senator Wellstone who has another pressing engagement.

Senator WELLSTONE. Thank you so much for your graciousness, and then I really guess that what I want to say today, and I am going to try to be back for more of the committee hearing, Mr. Chairman and Senator Hutchinson, is that I was excited when this Millennium bill based in 1999 and would thank you for your leadership.

I mean having had two parents with Parkinson's and kind of going through this ourselves about what do you do. People get elderly and struggle with these illnesses. How do you help them stay at home, live at home in as near normal circumstances with dignity, or if they need to go in a nursing home, how do we make sure that we—or we need respite care and all the rest. I thought that we in passing this legislation made a really significant commitment, and I guess my message for the VA today is you all have got to follow through. We are not doing this.

I mean we did not pass a law just for symbolic reasons. We passed this law to make this happen, and it is not happening, and either the VA is going to have to sort of reorder its priorities and figure out how with its staff and its resources it, in fact, lives up to this mandate or to this vision or to this mission. You know it's noble.

Or if the VA needs more resources, then, you know, we need to know how much more and why and what we need to do. I just put it in the context of—I said to Secretary Principi, whom I think is one the nicest, best people in government service, when he came here, you are great and people love you in Minnesota, but this budget is a straightjacket. And we got long waits and people are not getting access to specialty care in Minnesota now, and we are not having any more outreach community clinics.

This is a horrible budget, and I am getting increasingly impatient that the VA is not, in fact, making this piece of legislation a reality in terms of actually providing help for a lot of our veterans who are now senior citizens and need the help.

So there is a big missing piece here somewhere and this hearing therefore is extremely important. I thank you. I am going to try to come back, too.

Chairman ROCKEFELLER. Thank you, Senator Wellstone. I now want to introduce Senator Hutchinson for the purpose of making an introduction not on the first but on the second panel.

Senator HUTCHINSON. Mr. Chairman, I thank you for your willingness to allow me to do this, because our schedules are so crazy up here, and I am afraid I will not be here when Tom testifies, and I did want to take the opportunity to say a word of welcome to one of my constituents who will be testifying on the second panel, and, Mr. Chairman, I also want to thank you for calling the hearing today. I think this is a very, very important topic, and the GAO study is going to be, I think, revealing, and this is a timely hearing, and I thank you for doing that.

But it is my great privilege to welcome one of my constituents, Tom McClure, from Hot Springs, AR. Tom has dedicated his entire professional life to helping others, particularly veterans. He has served in the VA for 27 years. In January of 2000, he was appointed as the coordinator for the VA Medical Care Foster Home Program in central Arkansas.

The Foster Home Program that Tom oversees is really, I think, a model, and it is also very much a win-win for the veterans and the Veterans Administration because the program offers the veteran a loving, caring home to reside in at no cost to the Veterans Administration.

The program maintains a comprehensive medical plan by a multidisciplinary team of care providers and increases customers' satisfaction for the VA. Initially it was just a pilot program, but it was so successful that the Arkansas VA continued to fund the Foster Home Program out of their own operating funds.

So, Tom, we thank you for your work and the committee is pleased to have you with us today. We look forward to your testimony. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Hutchinson, very much. We appreciate your being here and making that introduction. I think I can probably go ahead as chairman and give my opening statement.

So I will. And it basically is what Paul was saying and what Tim was saying. In my mind, it is about the eighth hearing we have had on this subject, and the Millennium bill passed in 1999. I remember every single second of the conference committee. I was surprised that the House went along with it to the extent that they did, but they did.

It was the first time that long-term care coverage has happened in public policy since Medicaid. It was an extremely exciting concept that we could actually do some long-term care on a non-institutional basis and absolutely nothing has happened.

That was in 1999, so it was 1999, 2000, 2001, 2002. I call this an embarrassment because ignoring the single-most important de-

mand for long-term care will only intensify. And so we have hearings, and we ask why, and we get answers that are not satisfactory—OMB rules and regulations, this and that.

But it always occurs to me that the Department of Veterans Affairs is the second largest organization outside of the Department of Defense in all of government, 220,000 people, led by a very able administrator and health deputy, and it seems to me that 220,000 people collectively would be able to find a way to take a law that was passed over 3 years ago, which addresses the primary concerns of veterans, and put it into practice, and this particular senator is now past the point of impatience.

I am very angry about it. Therefore, this hearing is being set up in a very different way. We are having people who are making this work. We are having a GAO report, and then we are having the VA as the last panel so that the head of the health administration can hear and be told about what others before him said, because there are people who out there on their own are deciding to make this work.

When Secretary Principi, who as Paul indicated is a wonderful person and really is, and is beloved by veterans and by this chairman, when he was up for his confirmation, I said, you know, I said the only question that is worth asking you really, because I know you and you have been here before, is are you willing to go face to face with the President of the United States, much less OMB, on budget issues, and he said, yes, I will.

And I think the answer is no, he has not. And that is very clear or else it seems to me that this, the most important issue of long-term care, the one thing other than death and taxes that we all absolutely are going to face at some point, either in the comfort of home, as is contemplated here, or in a nursing home. For the first time in many years a government action relating to long-term care has been enacted, and then VA says, oh, by the way, we are hung up on rules and regulations.

I do not buy that. I do not care if it is President Clinton. I do not care if it is President Bush. I do not care who it is. It is inexcusable. It is absolutely inexcusable, and so this hearing is for the purpose of either embarrassing or humiliating the VA into doing something. It is therefore what I would call a constructive hearing because its purpose is to get something going which is already in law.

If there is a Federal law, we try to follow it. So I am ready to hear about the lack of guidance from central offices and OMB and regulations going back and forth, but they carry no—they create not a ripple of interest on my part anymore. I am only interested in a result, and I do not know, I am not seeking to do retribution here, but I am getting very close to it. I am getting very close to it because this is something that was not only really important to me. I happened to negotiate this personally, and as I say, it is the one thing everybody needs.

I had a mother who died from Alzheimer's. That took 10 years. It was not pleasant. I am not poor, so we were able to afford to give her what she needed, but she needed a whole lot. And so do veterans and many are poor and they cannot do it on their own.

So we have a law which is being ignored and excuses do not work anymore.

So we have people who are doing things. You know it is not like this cannot be done, because that is why we are going to have some witnesses from some VA places who are going ahead with this on their own. I do not know if they are in violation of VA rules or not, but to me they are heroes, and we are going to hear from them.

There are more veterans today than ever seeking alternatives to nursing homes—what is known as non-institutional care. They want to remain in the community. They want to remain in their home. My mother wanted to spend her last period of time in her home listening to the music that she loved, and I mean that is human nature. She was beyond the point of knowing where she was at that point, but it was incredibly important to those who cared about her. The Department of Veterans Affairs cares about veterans, and they have to show that through what they do.

So 35 percent of the veteran population is 65 years or older. The law and the demand gave VA a very clear mandate for action. It was not—this would be a nice thing for you to consider. It is something you are going to do. Mandate is a strong word, not beloved by the American people, but beloved by people who pass laws and want to see them enacted.

So the VA has been excruciatingly slow. Today we are going to try to get some answers about why this has happened and more importantly what the VA is going to do to change their ways, and I do not want to hear a lot about OMB because there are people here who evidently are not worried about OMB and who are doing things on their own.

Dr. Roswell, for whom I have enormous respect—his new job is Under Secretary—needs to know and does, I am sure, the time for action is immediate. So there are clinicians here who have gone ahead. I am always gratified when you see people who work in large organizations who go against the grain and do things because they believe it. I want them to be applauded and showcased here and for us to learn from them.

So I am not only no longer interested in dilatory tactics, but I am going to find ways to get very difficult about this, and I suspect that my good friend from Pennsylvania will join me in that effort. I yield to him at this point.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

I called today's hearing to focus on VA's inaction in making long-term care services available to veterans—especially those who can and wish to reside in the community. This inaction is a terrible failure, to be sure. Veterans need these services, Congress was clear in demanding that they be provided, and for a variety of reasons, VA has chosen to both ignore the mandate and failed to meet veterans' needs.

There is another side to this story: despite a dearth of guidance from Central Office, there are places on the VA landscape where some truly wonderful things are happening to keep veterans well cared for and in the setting of their choice. Good programs must be fostered, but in the VA environment, long-term care services are frequently starved.

Today, more and more veterans are seeking alternatives to nursing homes. They want to remain in the community and, with the right kind of support and care from VA, are able to do so—even with chronic and debilitating conditions.

In 1999, Congress spoke clearly about the need for VA to step up its long-term care effort, not because we had issues about quality, but because of the high demand for care. The numbers bear repeating: About 35 percent of the veteran population is 65 years or older—it is the single largest segment of today's veteran population—and many need long-term care services. While the law and the demand gave VA a clear mandate for action, VA has moved excruciatingly slow. Today we will try to get some answers about why that has happened and, more importantly, about what VA will do to correct the situation. With Dr. Roswell new in his job as Under Secretary, the time is ripe for action.

As I noted, there are VA clinicians who, in grappling with the demand, have not waited but have found some innovative solutions. I am always deeply gratified by the level of dedication and innovation of VA employees, and I applaud those who have moved forward.

While the focus of this hearing is on options to nursing homes, I note the need for VA nursing home beds. For many veterans, non-institutional options will not work, and because of this Congress is on record stating that VA must have sufficient nursing home capacity. I am concerned, however, that the quest to maintain and fill nursing home beds not overshadow the need for other options. I know that VA is concerned about this as well, and is requesting some relief.

It is vital that VA's role as a model for long-term care be recognized and rewarded, because we will have enormous problems with demand for this care in the years ahead. The only entity of any scope, size, or capacity that is dealing with how to meet the needs of an older population—albeit at a slower pace than I'd like—is VA. This role of VA must be highlighted and supported. I am here to do just that.

Senator SPECTER. Thank you very much, Mr. Chairman. I would ask unanimous consent that my written statement be included in the record.

Chairman ROCKEFELLER. Absolutely.

Senator SPECTER. I do not want to speak too long because I am anxious to hear how nasty you are going to be. [Laughter.]

As I said to Senator Rockefeller on the floor a few minutes ago, it is time to get tough about this. I will support strong action by the chairman. We passed this legislation over a lot of objections in the House and the Senate, and we meant it. We want it to be carried out. And I commend you, Mr. Chairman, for having convened this oversight hearing.

I regret being a little late arriving. We had a markup in the Environment and Public Works Committee and Judiciary Committee has scheduled an executive meeting later this morning, so I may have to excuse myself. But I will stay as long as I can, and I will review the record. I think this is a very, very important session, and I have never seen you nasty, so I am looking forward to that. [Laughter.]

[The prepared statement of Senator Specter follows:]

PREPARED STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Thank you, Mr. Chairman, for convening this hearing on the important issue of long-term care for our Nation's veterans. I know you and I both agree this is a critical service for America's veterans, their families, and for the Nation as a whole.

Mr. Chairman, in 1999, you and I worked together diligently here in the Senate, and in Conference with the House of Representatives, to ensure that our veterans would have universal access to noninstitutional long-term care provided by the Department of Veterans Affairs. At that time, our proposal was met with great hostility by the some Members of the House. However, we prevailed in our efforts to make these services available to all of our aging veterans. Unfortunately, the VA has failed to abide by the law.

As the testimony by our GAO witness will demonstrate, more than two and one half years after the passage of the Veterans Millennium Health Care and Benefits Act of 1999, VA is still not providing access to these crucial services for all of our veterans in need of this care.

Fortunately, the need for these services has not gone unnoticed on the front lines of some VA hospitals throughout the nation. As the testimony of the members of

our second panel show, innovation and compassion for our veteran patients is alive and well in VA hospitals. Unique programs, such as foster care for elderly veterans in Arkansas and vigorous case management of dementia patients in New York is showing Congress, and more importantly, the leadership of VA Central Office, that if the resources are available to assist in the creation of special programs, we can do wonders for thousands of sick and elderly veterans.

Mr. Chairman, I sincerely expect that this hearing will light a fire in VA Central Office at the highest levels, including the Secretary's Office. VA must know that when Congress passes a law, we expect—and we demand—that it be carried out. Institutional and noninstitutional long-term care services are vital for our aging veteran population. Congress has said so in statute. Now VA must say so in action.

Thank you very much Mr. Chairman for holding this hearing. I look forward to receiving the testimony of the witnesses.

Chairman ROCKEFELLER. So we are going to go right to our first panel. And I would ask them to come to the table. They are representatives of the General Accounting Office, and they are going to report on VA's response to the long-term care provisions of the Millennium Act. I welcome Cindy Bascetta, who is the Director of Veterans' Health Care Issues at GAO. I am comforted by that position, just knowing that it is there, Cynthia, so I am already happy about you.

And also Jim Musselwhite, who is Assistant Director for Health Care. Ms. Bascetta, why do you not go ahead? Now we have a 5-minute rule.

Ms. BASCETTA. Right.

Chairman ROCKEFELLER. I am sure you have been warned about that.

Ms. BASCETTA. Absolutely.

Chairman ROCKEFELLER. Nobody has ever disobeyed that. [Laughter.]

Ms. BASCETTA. And I do not intend to.

STATEMENT OF CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE, VETERANS' HEALTH AND BENEFITS ISSUES, UNITED STATES GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JIM MUSSELWHITE, ASSISTANT DIRECTOR, HEALTH CARE, GAO

Ms. BASCETTA. Mr. Chairman, Senator Specter, thank you for inviting me here today to discuss our work on VA's non-institutional long-term care services. It is no surprise, as you have pointed out, that demographic pressures will increase the demand for long-term care. The number of veterans aged 85 and older, those most at risk of needing long-term care, is expected to triple over the next decade. While not all of their needs can be met in non-institutional settings, aging veterans are likely to be no different from other elderly Americans in preferring care that allows them to remain in their homes or in other settings that are less restrictive than nursing homes.

As you know, although VA has been providing long-term care including non-institutional care on a discretionary basis, the Millennium Act requires adult day health care, geriatric evaluation, and respite care for all eligible veterans.

Today, I would like to discuss our findings about VA's efforts to expand these services and highlight our early work on the availability of non-institutional services in general across the VA system.

Mr. Chairman, as you have pointed out, more than 2 years after enactment, VA has not completed its response to the Millennium Act. VA has issued proposed regulations that would make the three services available in non-institutional settings, and we understand that final regulations will be issued next week.

In the interim, however, I would like to point out that VA did issue a policy directive in October 2001 requiring that all eligible veterans have access to these services outside of institutions. Nevertheless, none of the three are universally available. In a survey we conducted of all 139 medical facilities, 99 reported offering adult day health care, 74 offered non-institutional geriatric evaluation, and 29 offered non-institutional respite care.

According to VA, central monitoring of medical facilities to ensure that they provide non-institutional access to all three services will begin soon.

Our survey also showed that the six other non-institutional services offered by VA also vary in their availability from network to network. Most commonly offered by more than 120 medical facilities are homemaker and home health aide services as well as skilled home health care. In contrast, non-institutional clinics for Alzheimer's and dementia care are available at fewer facilities with only 32 reporting such care.

In addition, we found that several facilities reported offering at least eight of the nine non-institutional long-term care services, but some offered only one non-institutional service or none at all. The results of our survey are similar to the distribution of services noted almost 4 years ago by the Advisory Committee on the Future of VA Long-Term Care. In its report, called "VA Long-Term Care at the Crossroads," the committee stated that despite a continuum of offerings, VA services were not universally available and access was often restricted.

VA headquarter's officials agree today that non-institutional services are not yet equally accessible across the country. Despite this picture, VA has roughly doubled the proportion of long-term care provided outside of institutions over the past decade. Nonetheless, like Medicaid, the largest payer of long-term care, VA costs for non-institutional care remain dwarfed by its costs for nursing home and other institutional care.

Over the next 10 years, the nation's health system as well as VA will face significant aging of the population particularly for those 85 years or older. Nearly 20 percent of individuals in this group report a disability compared to about 5 percent between the ages of 65 and 84.

Like its non-VA counterparts, VA needs to prepare for these demographic challenges. The task force and the Millennium Act reflect the importance of providing a continuum of non-institutional services more evenly throughout the country to help meet this challenge.

Our ongoing review, conducted at your request, will assess the reasons for the current unevenness in non-institutional long-term care services across the networks. Providing more universal access to non-institutional care could help VA meet the growth in demand and at the same time offer veterans more options from which to

choose. This concludes my prepared statement, and I would be happy to answer any questions.

[The prepared statement of Ms. Bascetta follows:]

PREPARED STATEMENT OF CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE, VETERANS' HEALTH AND BENEFITS ISSUES, UNITED STATES GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss noninstitutional long-term care services offered by the Department of Veterans Affairs (VA). These services, such as homemaker services and adult day health care, are delivered to veterans in their own homes and other locations in the community. VA will see increasing demand for long-term care in the coming years as the veteran population ages. Of particular significance is the expected tripling of the number of veterans age 85 and older—the group most in need of long-term care. Although not all veterans' care needs can be met in noninstitutional settings, veterans may prefer such care because it allows them to remain in their homes or in other settings that are less restrictive than institutions.

VA generally provided or paid for long-term care on a discretionary basis until passage of the Veterans Millennium Health Care and Benefits Act in November 1999.[1] The Millennium Act required VA to offer certain long-term care services to eligible veterans, including services provided in noninstitutional settings. In particular, adult day health care, geriatric evaluation, and respite care are to be made available to eligible veterans.

As part of our ongoing work addressing the availability of noninstitutional long-term care in VA, you asked us to provide information on (1) VA's efforts to expand noninstitutional long-term care in response to the Millennium Act's requirements,[2] and (2) the noninstitutional long-term care services that VA's medical facilities offer. My statement focuses on the information we provided in a letter on VA's noninstitutional long-term care services,[3] which is being released today. That letter is based on data from a survey of all 139 VA medical facilities,[4] interviews with officials in VA's Geriatrics and Extended Care Strategic Healthcare Group, and interviews with VA field officials responsible for long-term care services. To determine which noninstitutional long-term care services to include in our survey, we compiled a list of the services as identified by VA officials and in VA documents. (Descriptions of these noninstitutional services are provided in appendix I.)

In summary, more than 2 years after the act's passage VA has not completed its response to the act's requirement that eligible veterans be offered adult day health care, geriatric evaluation, and respite care. Although VA published proposed regulations that would make these three services available in noninstitutional settings to eligible veterans,[5] the regulations had not been made final as of April 17, 2002. To be responsive to the act's requirements before its draft regulations were made final, VA issued a policy directive requiring that these three services be available in noninstitutional settings. VA also offers other noninstitutional services. At the time of our review, however, both the services required as a result of the act and VA's other noninstitutional services were unevenly available across the VA system.

BACKGROUND

VA served about one-third of its fiscal year 2001 long-term care workload, or average daily census, in noninstitutional settings (see table 1). Noninstitutional care accounted for about 8 percent of VA's long-term care costs during the same year.

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[1] Pub. L. No. 106–117, 113 Stat. 1545 (1999).

[2] Although nursing home care and domiciliary care are also required by the act, we do not address these requirements.

[3] *VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven* (GAO–02–510R, March 29, 2002).

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

[5] 66 Fed. Reg. 50,594 (2001).

Table 1: VA Long-Term Care Workload and Costs, by Care Setting, Fiscal Year 2001

Long-term care setting	Average daily census [a]	Total cost
Institutional [b]	45,033	$2,888,659,000
Noninstitutional	23,205	239,939,000
Total	68,238	$3,128,598,000

Source: VA.

[a] The average daily census represents the total number of days of inpatient care for institutional care and the total number of outpatient encounters for noninstitutional care, each divided by the number of days in the year. These figures may overstate the number of veterans receiving noninstitutional services because some veterans may receive more than one noninstitutional service on a particular day.

[b] Institutional long-term care includes care that VA provides or pays for in nursing homes and other residential settings.

The proportion of VA's long-term care costs for noninstitutional care has doubled over the past decade, as shown in figure 1. This has occurred as part of a larger trend within VA toward reducing its heavy reliance on inpatient care. Nevertheless, VA's costs for noninstitutional long-term care remain small relative to its costs for institutional long-term care.

Figure 1: VA Long-Term Care Costs, By Care Setting, Fiscal Year 1991–Fiscal Year 2001

	1991	2002
Noninstitutional long-term care	4%	8%
Institutional long-term care	96%	92%

Source: VA.

Medicaid—the nation's largest purchaser of long-term care—has seen a similar increase in the proportion of its long-term care costs for noninstitutional services. As in VA, the proportion of Medicaid's long-term care costs for this purpose has doubled, from 13 percent in 1990 to 27 percent in 2000. However, similar to VA, the bulk of Medicaid's long-term care costs are still for institutional care.

VA is one of several federal agencies attempting to emphasize noninstitutional long-term care. Executive Order 13217,[6] signed in June 2001, directs six federal agencies to evaluate their policies, programs, statutes, and regulations to determine whether any should be revised or modified to improve the availability of noninstitutional services for qualified individuals with disabilities.[7] Although VA was not among the agencies named in the order, VA joined the effort on a voluntary basis and subsequently reported that it will evaluate its noninstitutional long-term care services to determine whether any could be expanded or modified to further promote noninstitutional services to veterans with disabilities.

VA will face increasing demand for long-term care as our nation's veteran population ages. VA statistics show that, although the total number of veterans will decline in the next 10 years, the number of veterans age 85 and older will triple during that time. This will significantly increase the need for VA's long-term care resources because although a chronic physical or mental disability may occur at any age, the older an individual becomes, the more likely it is that a disability will develop or worsen. Indeed, while about 4.8 percent of persons age 65–84 report a disability, the proportion nearly quadruples to 18.1 percent among those 85 and older.[8]

As a result of this demographic pressure, concerns have been raised for some time about VA's ability to meet the expected rise in demand for long-term care services. In 1997 VA established a Federal Advisory Committee on the Future of VA Long-Term Care composed of national leaders in long-term care, and charged it with evaluating VA long-term care services and developing a strategy for meeting future needs. In its June 1998 report,[9] the committee stated that VA long-term care was unevenly funded and recommended that VA expand noninstitutional long-term care

[6] 66 Fed. Reg. 33,155 (June 18, 2001).

[7] The agencies were the Departments of Education, Health and Human Services, Housing and Urban Development, Justice, and Labor, and the Social Security Administration.

[8] These data represent individuals reporting a problem with two or more of the following six activities of daily living: bathing, dressing, eating, transferring between bed and chair, toileting, and getting around inside the home. Data are from the Department of Health and Human Services' 1994–95 National Health Interview Survey on Disability.

[9] Department of Veterans Affairs, *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).

services and emphasize these services, when clinically appropriate, for veterans needing long-term care.

VA'S RESPONSE TO THE MILLENNIUM ACT IS NOT COMPLETE

The Millennium Act requires VA to provide adult day health care—noninstitutional care in which health maintenance and rehabilitative services are provided to frail elderly veterans in an outpatient day setting. The act also requires that VA provide two additional services, geriatric evaluation and respite care,[10] but does not specify whether these services must be provided in institutional or noninstitutional settings.

More than 2 years after the act's passage, however, VA has not completed its response to the act's requirement that all eligible veterans be offered these three services. In October 2001, VA published proposed regulations to add the three required services in noninstitutional settings to its medical benefits package, the standard health plan available to all veterans enrolled in VA's health care system. As of April 17, 2002, final regulations had not been published, although VA officials told us that VA sent draft final regulations to the Office of Management and Budget for approval on March 14, 2002.

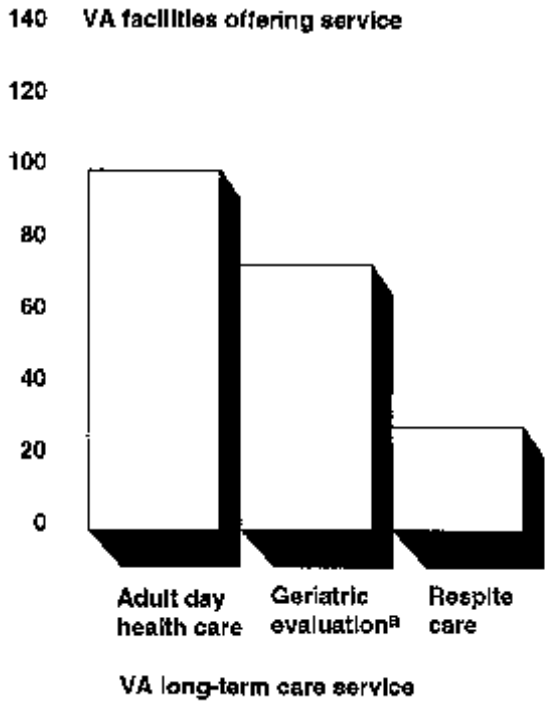
To be responsive to the act's requirements before its draft regulations were finalized, however, VA issued a policy directive in October 2001 requiring that its medical facilities ensure that veterans have access to adult day health care, geriatric evaluation, and respite care in noninstitutional settings. A VA headquarters official told us that VA headquarters will soon begin monitoring medical facilities to ensure that they provide access to these three services in noninstitutional settings.

Both VA's directive and its proposed regulations specify that geriatric evaluation and respite care be provided in noninstitutional settings even though the act does not state whether they must be provided in institutional or noninstitutional settings. (Adult day health care is by definition a noninstitutional service.) VA officials told us that VA chose to make clear its intent to have these services provided in noninstitutional settings because they were already widely offered in institutional settings. In fact, prior to the act VA was not authorized to provide noninstitutional respite care—until then, VA could provide respite care only in institutional settings. In contrast, prior to the act VA provided both adult day health care and noninstitutional geriatric evaluation; VA headquarters encouraged facilities to offer these services and provided guidance for facilities to use when doing so.

When VA issued its policy directive in October 2001, it was far from its goal of universal access to these three noninstitutional services, as shown in figure 2. Among the three services, adult day health care was most widely available, followed by geriatric evaluation and respite care. VA officials told us that noninstitutional respite care is not widely offered because until the Millennium Act VA was not authorized to provide respite care in noninstitutional settings.

[10] Geriatric evaluation involves evaluation of veterans with particular geriatric needs and is generally provided by VA through one of two services, geriatric evaluation and management or geriatric primary care. Respite care is a program in which brief periods of care are provided to veterans in order to give veterans' regular caregivers a period of respite.

FIGURE 2: NUMBER OF 139 VA FACILITIES OFFERING CERTAIN LONG-TERM CARE SERVICES REQUIRED BY THE MILLENNIUM ACT AND AVAILABLE IN NONINSTITUTIONAL SETTINGS, FALL 2001



Source: GAO survey of VA facilities; VA headquarters data.
Note: Responses to our survey were submitted in September and October 2001.

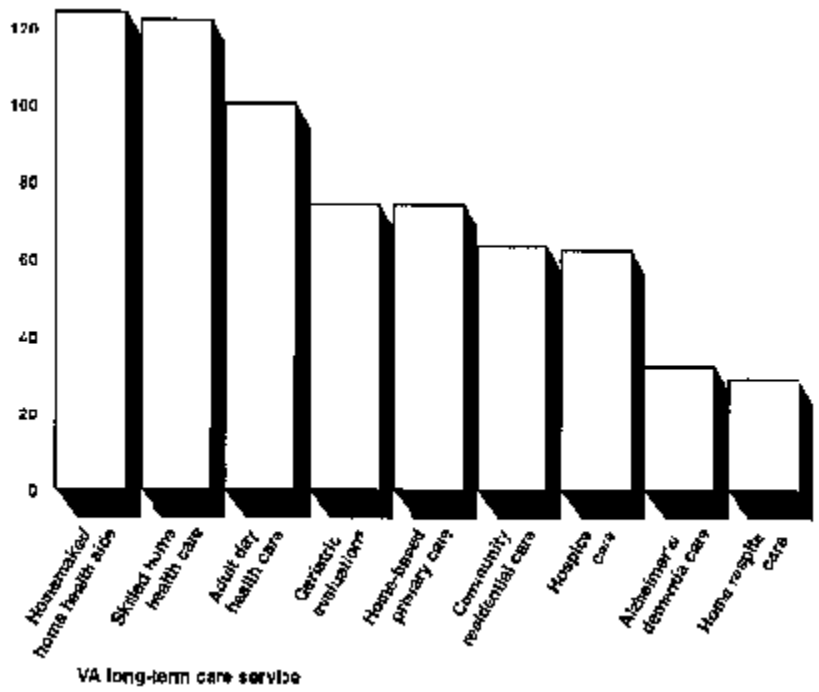
[a] "Geriatric evaluation" encompasses facilities reporting geriatric evaluation and management services in our survey and additional facilities reported by VA headquarters as offering geriatric primary care.

AVAILABILITY OF OTHER NONINSTITUTIONAL SERVICES IS ALSO UNEVEN

Uneven availability of noninstitutional services is not limited to the three services that VA requires its facilities to offer in response to the Millennium Act. Although at least nine different noninstitutional long-term care services are provided or contracted for by VA (including the three services that VA requires as a result of the act), considerable unevenness exists in what services are offered by individual facilities. For example, 123 VA facilities reported offering skilled home health care,[11] while about half as many facilities—63—reported offering community residential care. Figure 3 shows the number of VA's 139 facilities at which these nine noninstitutional long-term care services are offered.

[11] Skilled home health care consists of professional home health care services, mostly nursing services, purchased by VA and delivered by non-VA health care providers.

FIGURE 3: NUMBER OF 139 VA FACILITIES AT WHICH NONINSTITUTIONAL LONG-TERM CARE SERVICES ARE OFFERED, BY SERVICE (FALL 2001)



Source: GAO survey of VA facilities; VA headquarters data.
Note: Responses to our survey were submitted in September and October 2001.

[a] Includes facilities reporting geriatric evaluation and management services in our survey and additional facilities reported by VA headquarters as offering geriatric primary care.

Similar variation exists in the number of services offered by individual facilities. For example, while several facilities reported offering at least eight of the nine noninstitutional long-term care services we identified, one facility reported offering only one noninstitutional service, and two more facilities reported offering none at all.

These results are similar to the distribution of services noted by the 1998 Advisory Committee on the Future of VA Long-Term Care, which stated that VA long-term care—institutional as well as noninstitutional—was not available universally and that access to long-term care was often restricted. Similarly, a VA headquarters official we spoke with noted that VA's noninstitutional long-term care services are not equally accessible across the country.

CONCLUDING OBSERVATIONS

As the veteran population ages, VA will face increasing demand for long-term care services. Providing more even access to noninstitutional long-term care services across VA facilities, including those services now required as a result of the Veterans Millennium Health Care and Benefits Act, could help VA meet this demand while at the same time offering veterans more options from which to choose.

* * * * *

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the other committee members may have.

CONTACTS AND ACKNOWLEDGMENTS

For more information regarding this testimony, please contact me or James Musselwhite. Joe Buschy and Steve Gaty also made key contributions to this statement.

APPENDIX I: NONINSTITUTIONAL LONG-TERM CARE SERVICES OFFERED BY VA

• Adult day health care: health maintenance and rehabilitative services provided to frail elderly veterans in an outpatient day setting.
• Alzheimer's/dementia care: specialized outpatient services such as behavioral and medical management provided to veterans with Alzheimer's disease or related dementias.
• Community residential care: a service in which veterans who do not require hospital or nursing home care—but who (because of medical or psychosocial health conditions) are unable to live independently—live in VA-approved community residential care facilities; VA pays administrative costs only.
• Geriatric evaluation: evaluation of veterans with particular geriatric needs, generally provided by VA through one of two services: (1) geriatric evaluation and management (GEM), in which interdisciplinary health care teams of geriatric specialists evaluate and manage frail elderly veterans, and (2) geriatric primary care, in which outpatient primary care, including medical and nursing services, preventive health care services, health education, and specialty referral, is provided to geriatric veterans.
• Home-based primary care: primary medical care provided in the home by VA physicians, nurses, and other VA healthcare professionals to severely disabled, chronically ill veterans whose conditions make them unsuitable for management in outpatient clinics.
• Homemaker/home health aide: home health aide and homemaker services, such as grooming, housekeeping, and meal preparation services.
• Home respite care: home-based services provided to veterans on a short-term basis to give veterans' caregivers a period of relief or respite.
• Hospice care: home-based palliative and supportive services for veterans in the last phases of incurable disease so that they may live as fully and as comfortably as possible.
• Skilled home health care: medical services provided to veterans at home by non-VA health care providers.

UNITED STATES GENERAL ACCOUNTING OFFICE,
WASHINGTON, DC,
March 29, 2002.

Hon. John D. Rockefeller IV,
Chairman, Committee on Veterans' Affairs,
U.S. Senate.

Hon. Lane Evans,
Ranking Democratic Member,
Committee on Veterans' Affairs,
House of Representatives

Subject: VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven [GAO–02–510R VA Long-Term Care Services]

The Department of Veterans Affairs (VA) spent about $3.1 billion on long-term care in fiscal year 2001, an amount that is likely to increase in the coming years as the veteran population ages. VA provides or pays for long-term care in institutional settings such as nursing homes and through noninstitutional care in veterans' own homes and other locations in the community. VA generally provided or contracted for long-term care on a discretionary basis until passage of the Veterans Millennium Health Care and Benefits Act in November 1999.[1] The Millennium Act required VA to offer certain long-term care services to eligible veterans, including care in noninstitutional settings. As part of our ongoing work addressing the availability of noninstitutional long-term care in VA, you asked us to provide the information we have obtained to date on (1) VA's efforts to expand noninstitutional long-term care in response to the act's requirements and (2) the noninstitutional long-term care services that VA's medical facilities offer. As agreed with your offices, we are also providing data on the number of institutional services offered by VA's facilities, and their utilization, to place the noninstitutional services in perspective.

In summary, more than 2 years after the act's passage VA has not completely implemented its response to the act's requirement that all eligible veterans be offered

[1] Pub. L. No. 106–117, 113 Stat. 1545 (1999).

adult day health care, respite care, and geriatric evaluation. Although VA published draft regulations that would make these three services available in noninstitutional settings to eligible veterans, the regulations had not been made final as of March 19, 2002. To be responsive to the act's requirements before its draft regulations were finalized, VA issued a policy directive requiring that these three services be available in noninstitutional settings. At the time of our review, however, access to these services was far from universal in VA. More generally, the availability of all VA noninstitutional long-term care services, including the newly required services, is uneven across the VA system. In commenting on a draft of this letter, VA officials generally agreed with our assessment.

To determine the status of VA's efforts to expand noninstitutional long-term care in response to the Millennium Act's requirements, we interviewed officials in VA's Geriatrics and Extended Care Strategic Healthcare Group and evaluated directives, regulations, and other guidance that had been prepared in response to the act. To determine which long-term care services are offered by each of VA's 139 facilities,[2] we compiled a list of the services as identified by VA officials and in VA documents. We subsequently used a survey instrument to collect data on the types of services offered at each of VA's 139 facilities and the utilization of these services. In constructing this survey, we consulted with VA headquarters officials and pretested it with VA field staff to ensure that it would be clear to the respondents. We received responses for all 139 VA facilities. However, we did not conduct site visits or otherwise attempt to verify any of the data provided to us in the surveys. Our work was conducted from September 2001 through March 2002 in accordance with generally accepted government auditing standards.

BACKGROUND

VA served about one-third of its fiscal year 2001 long-term care workload, or average daily census, in noninstitutional settings (see table 1). Noninstitutional care accounted for about 8 percent of VA's long-term care costs during the same year.

Table 1: VA Long-Term Care Workload and Costs, by Care Setting, Fiscal Year 2001

Long-term care setting	Average daily census[a]	Total cost
Institutional[b]	45,033	$2,888,659,000
Noninstitutional	23,205	239,939,000
Total	68,238	$3,128,598,000

Source: VA.

[a] The average daily census represents the total number of days of inpatient care for institutional care and the total number of outpatient encounters for noninstitutional care, each divided by the number of days in the year. These figures may overstate the number of veterans receiving noninstitutional services because some veterans may receive more than one noninstitutional service on a particular day.

[b] Institutional long-term care includes care that VA provides or pays for in nursing homes and other residential settings.

VA is not alone among federal agencies in spending a relatively small percentage of its long-term care dollars in noninstitutional settings. Noninstitutional care also accounts for a relatively small percentage of long-term care expenditures under Medicaid, the nation's largest purchaser of long-term care. In 2000, for example, about 27 percent of Medicaid's long-term care spending was devoted to noninstitutional care.

VA'S RESPONSE TO THE MILLENNIUM ACT IS NOT FULLY IMPLEMENTED

The Millennium Act requires VA to provide adult day health care—health maintenance and rehabilitative services provided to frail elderly veterans in an outpatient day setting. The act also requires that VA provide two additional services—geriatric evaluation (evaluation of veterans with particular geriatric needs, generally provided by VA through one of two services, geriatric evaluation and management or geriatric primary care) and respite care (brief periods of care provided to veterans in order to give veterans' regular caregivers a period of respite)—but does not specify whether these services must be provided in institutional or noninstitutional settings.[3] (Descriptions of these and other VA long-term care services are provided in

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

[3] Although nursing home care and domiciliary care are also required by the act, we do not address these requirements.

enclosure I.) The Millennium Act's long-term care provisions were written partly in response to the 1998 report of the Federal Advisory Committee on the Future of VA Long-Term Care.[4] The committee's report stated that VA long-term care was "marginalized and unevenly funded" and recommended that noninstitutional long-term care become the preferred option, when clinically appropriate, for veterans needing long-term care.

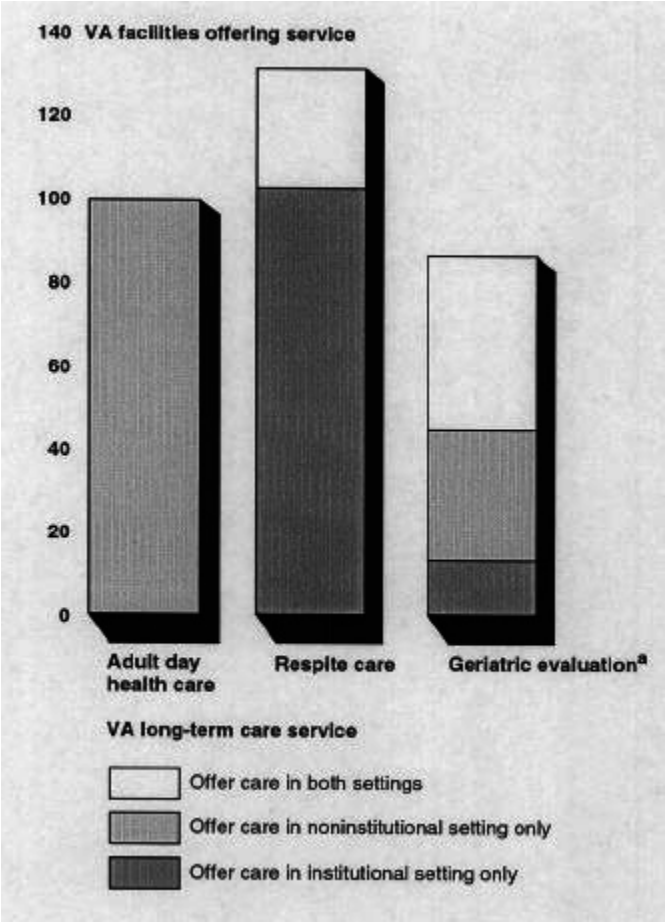
More than 2 years after the act's passage, however, VA has not completely implemented its response to the act's requirement that all eligible veterans be offered adult day health care, respite care, and geriatric evaluation. In October 2001, VA published draft regulations to add the three required services in noninstitutional settings to its medical benefits package, the standard health plan available to all veterans enrolled in VA's health care system. As of March 19, 2002, final regulations had not been published, although VA officials told us that VA sent the regulations to the Office of Management and Budget for approval on March 14, 2002.

To be responsive to the act's requirements before its draft regulations were finalized, however, VA issued a policy directive in October 2001 requiring medical facilities to ensure that veterans have access to adult day health care, respite care, and geriatric evaluations in noninstitutional settings. VA's directive—as well as its draft regulations—specifies that respite care and geriatric evaluation be provided in noninstitutional settings even though the act does not state whether these two services must be provided in institutional or noninstitutional settings. (Adult day health care is by definition a noninstitutional service.) VA officials told us that VA made this decision because respite care and geriatric evaluation were already widely offered in institutional settings. A VA headquarters official told us that VA headquarters will soon begin monitoring field facilities to ensure that they provide access to these three services in noninstitutional settings.

When VA issued its policy directive in October 2001, it was far from its goal of universal access to these three noninstitutional services, as shown in figure 1. Among the three services, respite care was most widely available, although at most facilities this care was still offered only in institutional settings. According to VA officials, noninstitutional respite care is not widely offered because until the Millennium Act VA was not authorized to provide respite care in noninstitutional settings. Second to respite care in availability was adult day health care, followed by geriatric evaluation.

[4] Department of Veterans Affairs, *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).

FIGURE 1: NUMBER OF 139 VA FACILITIES OFFERING CERTAIN LONG-TERM CARE SERVICES REQUIRED BY THE MILLENNIUM ACT AND AVAILABLE IN NONINSTITUTIONAL SETTINGS, DURING SEPTEMBER AND OCTOBER 2001



Source: GAO survey of VA facilities; VA headquarters data.

[a] Includes facilities reporting geriatric evaluation and management services in our survey and additional facilities reported by VA headquarters as offering geriatric primary care.

AVAILABILITY OF OTHER NONINSTITUTIONAL SERVICES IS UNEVEN

Uneven availability of noninstitutional services is not limited to the three services that VA requires its facilities to offer in response to the Millennium Act. Although at least nine different noninstitutional long-term care services are provided or paid for by VA (including the three services that VA requires as a result of the act), considerable unevenness exists in the number of these services offered by individual facilities and their utilization. For example, 123 VA facilities reported offering skilled home health care,[5] while about half as many facilities—63—reported offering community residential care. These results are similar to the distribution of services noted by the 1998 Advisory Committee on the Future of VA Long-Term Care, which stated that VA long-term care—institutional as well as noninstitutional—was not

[5] Skilled home health care consists of professional home health care services, mostly nursing services, purchased by VA and delivered by non-VA health care providers.

available universally and that access to long-term care was often restricted. Similarly, a VA headquarters official we spoke with noted that VA's noninstitutional long-term care services are not equally accessible across the country. The services offered by each VA facility during the September and October 2001 period, along with the number of veterans served in each, are shown in enclosure II.

AGENCY COMMENTS

We provided a draft of this letter to VA officials for comment and received oral comments on March 19, 2002. In providing comments, VA's acting chief consultant, Geriatrics and Extended Care Strategic Healthcare Group, stated that VA agrees that its efforts to provide certain noninstitutional long-term care services in response to the Millennium Act's requirements are not complete, and that the availability of noninstitutional services is uneven. The acting chief consultant also noted that VA's home health care programs are widely available as shown in our survey results. This official also provided technical comments that we have incorporated as appropriate.

As arranged with your offices, unless you publicly announce this letter's contents earlier we will make no further distribution until 30 days after its date. At that time, we will send copies to the secretary of veterans affairs and interested congressional committees. The letter will also be available on GAO's home page at http://www.gao.gov. If you have questions, please contact me or James Musselwhite. Joe Buschy, Steve Gaty, and Stefanie Weldon also made key contributions to this letter.

CYNTHIA A. BASCETTA,
Director, Health Care—Veterans' Health and Benefits Issues

ENCLOSURE I—VA LONG-TERM CARE SERVICES

NONINSTITUTIONAL SERVICES

- Adult day health care: health maintenance and rehabilitative services provided to frail elderly veterans in an outpatient day setting.
- Alzheimer's/dementia care: specialized outpatient services such as behavioral and medical management provided to veterans with Alzheimer's disease or related dementias.
- Community residential care: a service in which veterans who do not require hospital or nursing home care—but who (because of medical or psychosocial health conditions) are unable to live independently—live in VA-approved community residential care facilities; VA pays administrative costs only.
- Geriatric evaluation: evaluation of veterans with particular geriatric needs, generally provided by VA through one of two services: (1) geriatric evaluation and management (GEM), in which interdisciplinary health care teams of geriatric specialists evaluate and manage frail elderly veterans, and (2) geriatric primary care, in which outpatient primary care, including medical and nursing services, preventive health care services, health education, and specialty referral, is provided to geriatric veterans.[6]
- Home-based primary care: primary medical care provided in the home by VA physicians, nurses, and other VA healthcare professionals to severely disabled, chronically ill veterans whose conditions make them unsuitable for management in outpatient clinics.
- Homemaker/home health aide: home health aide and homemaker services, such as grooming, housekeeping, and meal preparation services.
- Home respite care: home-based services provided to veterans on a short-term basis to give veterans' caregivers a period of relief or respite.
- Hospice care: home-based palliative and supportive services for veterans in the last phases of incurable disease so that they may live as fully and as comfortably as possible.
- Skilled home health care: medical services provided to veterans at home by non-VA health care providers.

INSTITUTIONAL SERVICES

- Alzheimer's/dementia care: specialized inpatient services such as behavioral and medical management provided to veterans with Alzheimer's disease or related dementias.
- Community nursing home care: nursing home care provided to veterans in community nursing facilities.

[6] Geriatric primary care was not among the services included in our survey of VA facilities.

• Domiciliary care: residential rehabilitation and health maintenance services provided to veterans who do not require hospital or nursing home care but are unable to live independently because of medical or psychiatric disabilities; may be provided in VA domiciliaries or in state-owned and operated veterans' domiciliaries.[7]
• Geriatric evaluation and management (GEM): evaluation and management of frail elderly veterans by interdisciplinary health care teams of geriatric specialists; may be provided in a distinct GEM unit or in existing nursing home or hospital beds.
• Hospice care: palliative and supportive inpatient services for veterans in the last phases of incurable disease so that they may live as fully and as comfortably as possible; may be provided in a distinct hospice unit or in existing nursing home or hospital beds.
• Respite care: hospital or nursing home care provided to veterans on a short-term basis to give veterans' caregivers a period of relief or respite; may be provided in a distinct respite unit or in existing nursing home or hospital beds and may be provided in VA hospitals, VA nursing homes, or community nursing homes.
• State veterans' nursing home care: nursing home care provided to veterans in state-owned and operated veterans' nursing homes, for which VA pays a portion of daily costs.
• VA nursing home care: nonacute nursing care services, variously referred to as subacute, skilled, intermediate, or custodial nursing care, provided to veterans in a VA facility's nursing home care unit.

ENCLOSURE II—VA LONG-TERM CARE SERVICES BY VA FACILITY

This enclosure provides information on the types and utilization of long-term care services, both institutional and noninstitutional, that VA's 139 facilities reported as of the September and October 2001 time frame. Each table contains service utilization data for all VA facilities in one of the 22 VA health care networks existing at the time of our survey.[8] Following are the key methods we used to collect and present the data. Because of differences in the way utilization is calculated, the numbers in this enclosure should not be compared to those presented in table 1.
• We obtained data on the number of veterans receiving or authorized to receive services from each VA facility on the day the survey was completed.[9] For example, if a veteran was receiving homemaker/home health aide services 3 days per week at the time of our survey, that veteran would have been counted in the utilization total even if the veteran was not receiving services on the particular day the survey was filled out. As a result, the utilization we report may exceed the average daily census for individual services, particularly in noninstitutional services, because on a given day the number of veterans authorized to receive services may be greater than the number who actually receive services.
• Several facilities indicated they had "other" services—that is, services other than those we specifically asked about in our survey. In instances in which facilities reported "other" services with utilization of greater than 1,000 veterans, we note the types of "other" services these facilities reported.

[7] Because VA does not actively place veterans in state veterans' domiciliaries or state veterans' nursing homes (rather, veterans must apply to the facilities for admission, and admission requirements vary by state), state veterans' domiciliary and state veterans' nursing home services were not included in our survey of VA facilities.
[8] In 1995, VA created 22 Veterans Integrated Service Networks, a new management structure to coordinate the activities of and allocate funds to VA hospitals, outpatient clinics, nursing homes, and other facilities in each region. In January 2002, VA announced the merger of networks 13 and 14 into a single organization known as network 23. In this enclosure, we report on these two networks separately because at the time of our survey they were operating as individual networks.
[9] Although the surveys were sent out simultaneously, surveys for each facility were not completed on the same day.

Table 2: Long-Term Care Services Offered by VA Facilities in Network 1, Boston, Mass. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)								Total [a]
	Bedford	Boston HCS	Connecticut HCS	Manchester	Northampton	Providence	Togus	White River Junction	
Noninstitutional long-term care services:									
Adult day health care	68	80	49	13	19	4		48	281
Alzheimer's/dementia care	200						125		325
Community residential care	202				85		75		362
Geriatric evaluation and management	25		0				28	94	147
Home-based primary care	15		132			63			210
Homemaker/home health aide	45	235	52	28	115	12	42	13	542
Home respite care.									
Hospice care									
Skilled home health care	1	68	29		40	30	90	37	295
Other noninstitutional			368				0		368
Institutional long-term care services:									
Alzheimer's/dementia care	110						50		160
Community nursing home care	32	95	62	15	34	53	23	11	325
Domiciliary care	42								42
Geriatric evaluation and management	24		13			0	4		41
Hospice care	2	5	3	10	1	1	6	2	30
Respite care	122	9	3	40	0	3	2	46	225
VA nursing home care	152	146	9	70	59		38		474
Other institutional.									

Source: GAO survey of VA facilities.

Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 3: Long-Term Care Services Offered by VA Facilities in Network 2, Albany, N.Y. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)					Total [a]
	Albany	Bath	Canandaigua	Syracuse	Western New York HCS	
Noninstitutional long-term care services:						
Adult day health care	123	10	29	107	80	349
Alzheimer's/dementia care	100		49	318	222	689
Community residential care	0	68				68
Geriatric evaluation and management					62	62
Home-based primary care	140	160	109	762	259	1,430
Homemaker/home health aide	60	104	211	129	261	765
Home respite care.						
Hospice care			1	1		2
Skilled home health care	21		0	5	168	194
Other noninstitutional	2				13	15
Institutional long-term care services:						
Alzheimer's/dementia care			24			24
Community nursing home care	50	5	8	32	25	120
Domiciliary care		203				203
Geriatric evaluation and management.						
Hospice care	2	7	0	3	3	15
Respite care	1	4	1	4	6	16
VA nursing home care	28	147	80	30	111	396

Table 3: Long-Term Care Services Offered by VA Facilities in Network 2, Albany, N.Y. (Fall 2001)—Continued

VA service	Number of veterans in each service, by facility or health care system (HCS)					Total [a]
	Albany	Bath	Canandaigua	Syracuse	Western New York HCS	
Other institutional.						

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.
Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 4: Long-Term Care Services Offered by VA Facilities in Network 3, Bronx, N.Y. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)					Total [a]
	Bronx	Hudson Valley HCS	New Jersey HCS	Northport	New York Harbor HCS	
Noninstitutional long-term care services:						
Adult day health care		3	4	34	67	108
Alzheimer's/dementia care			321		29	350
Community residential care		272	230	215		717
Geriatric evaluation and management.						
Home-based primary care	107	65	143	45	137	497
Homemaker/home health aide		35	196	159	127	517
Home respite care.						
Hospice care.						
Skilled home health care	22	6	38	35	19	120
Other noninstitutional				241		241
Institutional long-term care services:						
Alzheimer's/dementia care					14	14
Community nursing home care		19	36	47	4	106
Domiciliary care		133	165		50	348
Geriatric evaluation and management	2			2	3	7
Hospice care	7	2	4	7	5	25
Respite care	2	3	2	1	6	14
VA nursing home care	69	180	260	101	153	763
Other institutional				11		11

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.
Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 5: Long-Term Care Services Offered by VA Facilities in Network 4, Pittsburgh, Pa. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)										Total [a]
	Altoona	Butler	Clarks-burg	Coatesville	Erie	Lebanon	Philadel-phia	Pitts-burgh HCS	Wilkes-Barre	Wil-mington	
Noninstitutional long-term care services:											
Adult day health care		26	6	46	1			44	2	0	125
Alzheimer's/dementia care				200							200
Community residential care	0		32	115		181	.....		91	4	423
Geriatric evaluation and management								24	5	925	954
Home-based primary care		31				0	56	123			210
Homemaker/home health aide		78	139	94	82	7	30	113	39	13	595
Home respite care		.....	0								0
Hospice care					0				1	.....	1
Skilled home health care	7	15	37	3	15	5	76	28	16	22	224
Other noninstitutional		50			2	0		26	1		79
Institutional long-term care services:											
Alzheimer's/dementia care				36		17		50			103
Community nursing home care	10	6	29	1	3	13	12	97	6	6	183
Domiciliary care		47		229				74			350
Geriatric evaluation and management						6					6
Hospice care	0		1		6	20		6	7	4	44
Respite care	1	4	0	3	1	40	4	8	60	2	123
VA nursing home care	40	70		217	32	74	208	336	0	56	1,033
Other institutional						38	12		0		50

Source: GAO survey of VA facilities.

Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 6: Long-Term Care Services Offered by VA Facilities in Network 5, Baltimore, Md. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)			Total [a]
	Martinsburg	Maryland HCS	Washington, D.C.	
Noninstitutional long-term care services:				
Adult day health care	7	198	81	286
Alzheimer's/dementia care		148		148
Community residential care		0	50	50
Geriatric evaluation and management		0	1,150	1,150
Home-based primary care		180	109	289
Homemaker/home health aide	18	252	117	387
Home respite care		0		0
Hospice care		10		10
Skilled home health care		180	5	185
Other noninstitutional		42	3	45
Institutional long-term care services:				
Alzheimer's/dementia care		0		0
Community nursing home care	22	26	65	113
Domiciliary care	281	50		331
Geriatric evaluation and management		24		24
Hospice care		23	16	39
Respite care	2	10	4	16
VA nursing home care	166	200	90	456
Other institutional		101		101

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.
Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 7: Long-Term Care Services Offered by VA Facilities in Network 6, Durham, N.C. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)								Total [a]
	Asheville	Beckley	Durham	Fayetteville (N.C.)	Hampton	Richmond	Salem	Salisbury	
Noninstitutional long-term care services:									
Adult day health care	61			16	18		70	14	179
Alzheimer's/dementia care	150				38		125		313
Community residential care		21			30		200		251
Geriatric evaluation and management			374						374
Home-based primary care	33		36						69
Homemaker/home health aide	76		33	0	60		40	43	252
Home respite care.									
Hospice care	4	1		2			5		12
Skilled home health care	94	8		70	21		65		258
Other noninstitutional									
Institutional long-term care services:									
Alzheimer's/dementia care.									
Community nursing home care	7	11	22	33	26	9	5	41	154
Domiciliary care					151				151
Geriatric evaluation and management			3			13	10		26
Hospice care	5	3	10	5	4	10	2	8	47
Respite care	2	2	4	4	0		5	4	21
VA nursing home care	98	36	98	37	72	71	80	204	696

Table 7: Long-Term Care Services Offered by VA Facilities in Network 6, Durham, N.C. (Fall 2001)—Continued

VA service	Number of veterans in each service, by facility or health care system (HCS)								Total [a]
	Asheville	Beckley	Durham	Fayetteville (N.C.)	Hampton	Richmond	Salem	Salisbury	
Other institutional								18	18

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.
Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 8: Long-Term Care Services Offered by VA Facilities in Network 7, Atlanta, Ga. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)								Total [a]
	Atlanta	Augusta	Birmingham	Central Alabama HCS	Charleston	Columbia (S.C.)	Dublin	Tuscaloosa	
Noninstitutional long-term care services:									
Adult day health care	19	0	8		10	29			66
Alzheimer's/dementia care		5							5
Community residential care	31	174		124		30			359
Geriatric evaluation and management					250	0			250
Home-based primary care	87	47	90	130	95	63			512
Homemaker/home health aide	67	149	24	46	50	62	78	104	580
Home respite care		0				0			0
Hospice care	6			0	8	5			19
Skilled home health care	62	83		21	75	60		35	336
Other noninstitutional	10	144		1,139b	18	13			1,324
Institutional long-term care services:									
Alzheimer's/dementia care		72		40				53	165
Community nursing home care	71	53	23	4	12	51	27	5	246
Domiciliary care		60							60
Geriatric evaluation and management		2			10	0			12
Hospice care		7		11		8	.....	4	30
Respite care	0	0		4		5	.....	1	10
VA nursing home care	100	53		80	28	81	115	116	573
Other institutional	0					.....		20	20

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.
Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.
[b] Geriatric primary care.

Table 9: Long-Term Care Services Offered by VA Facilities in Network 8, Bay Pines, Fla. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)						Total [a]
	Bay Pines	Miami	North Florida/South Georgia HCS	San Juan	Tampa	West Palm Beach	
Noninstitutional long-term care services:							
Adult day health care		43	29			13	85
Alzheimer's/dementia care.							

Table 9: Long-Term Care Services Offered by VA Facilities in Network 8, Bay Pines, Fla. (Fall 2001)—Continued

VA service	Number of veterans in each service, by facility or health care system (HCS)						Total [a]
	Bay Pines	Miami	North Florida/ South Georgia HCS	San Juan	Tampa	West Palm Beach	
Community residential care				90		165	255
Geriatric evaluation and management	30			300			330
Home-based primary care	100	150	195	82	143		670
Homemaker/home health aide	100	75	280	19	45	50	569
Home respite care					4		4
Hospice care					0		0
Skilled home health care	154	18	35	5	180	4	396
Other noninstitutional		1,528b	2,239c	373			4,140
Institutional long-term care services:							
Alzheimer's/dementia care			29		61		90
Community nursing home care	92	24	195	3	51	12	377
Domiciliary care	104				17		121
Geriatric evaluation and management	8	5	20			0	33
Hospice care	10	15	9	5	20	10	69
Respite care	8	4	7	5	11	3	38
VA nursing home care	102	127	116	116	161	98	720
Other institutional	24			27		17	68

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.
Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.
[b] Geriatric primary care and geriatric psychiatry care.
[c] Geriatric primary care.

Table 10: Long-Term Care Services Offered by VA Facilities in Network 9, Nashville, Tenn. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)						Total [a]
	Huntington	Lexington	Louisville	Memphis	Mountain Home	Tennessee Valley HCS	
Noninstitutional long-term care services:							
Adult day health care					18	12	30
Alzheimer's/dementia care		259				100	359
Community residential care	42	96			90	213	441
Geriatric evaluation and management		338				84	422
Home-based primary care				95			95
Homemaker/home health aide	36	31	27	59	162	194	509
Home respite care.							
Hospice care		4	1				5
Skilled home health care	28	65	325	214		178	810
Other noninstitutional				3	180	100	283
Institutional long-term care services:							
Alzheimer's/dementia care		34					34
Community nursing home care	53	33	36	40	49	43	254
Domiciliary care					330		330
Geriatric evaluation and management					20	4	24
Hospice care	.....	2	2		16	10	30
Respite care	4	4	2	0	5	3	18
VA nursing home care		18			63	110	191
Other institutional						43	43

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 11: Long-Term Care Services Offered by VA Facilities in Network 10, Cincinnati, Ohio (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)					Total [a]
	Chillicothe	Cincinnati	Cleveland	Columbus	Dayton	
Noninstitutional long-term care services:						
Adult day health care	2	85	13	26	29	155
Alzheimer's/dementia care.						
Community residential care	267	22	278	19	63	649
Geriatric evaluation and management	80	201	691		197	1,169
Home-based primary care			190		45	235
Homemaker/home health aide	230	37	380	44	171	862
Home respite care.						
Hospice care			1	.....	3	4
Skilled home health care	235	167	175	697	180	1,454
Other noninstitutional.						
Institutional long-term care services:						
Alzheimer's/dementia care					24	24
Community nursing home care	30	13	41	16	39	139
Domiciliary care	42	66	92		100	300
Geriatric evaluation and management			126		30	156
Hospice care	7	.....	14		22	43
Respite care	5	2	2		3	12
VA nursing home care	91	51	137		146	425
Other institutional.						

Source: GAO survey of VA facilities.

Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 12: Long-Term Care Services Offered by VA Facilities in Network 11, Ann Arbor, Mich. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)							Total [a]
	Ann Arbor	Battle Creek	Danville	Detroit	Indianapolis	Northern Indiana HCS	Saginaw	
Noninstitutional long-term care services:								
Adult day health care	0	16	57	5	26	4	0	108
Alzheimer's/dementia care.								
Community residential care	0	0	137	0	45	96	0	278
Geriatric evaluation and management					28			28
Home-based primary care		12	21	1	19	2		55
Homemaker/home health aide	43	79	66		48	7		243
Home respite care	0	0	0	0	0	0	0	0
Hospice care					3	4		7
Skilled home health care	1	2	6	6	17	22	1	55
Other noninstitutional.								
Institutional long-term care services:								
Alzheimer's/dementia care			23					23
Community nursing home care	19	17	34	15	54	35	5	179
Domiciliary care.								
Geriatric evaluation and management	16							16
Hospice care		11	42	2		1		56
Respite care	2	3	1	2	.....	1	2	11
VA nursing home care	15	86	125	62		125	70	483

Table 12: Long-Term Care Services Offered by VA Facilities in Network 11, Ann Arbor, Mich. (Fall 2001)—Continued

VA service	Number of veterans in each service, by facility or health care system (HCS)							Total [a]
	Ann Arbor	Battle Creek	Danville	Detroit	Indian-apolis	Northern Indiana HCS	Saginaw	
Other institutional.								

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.
Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 13: Long-Term Care Services Offered by VA Facilities in Network 12, Chicago, Ill. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)							Total [a]
	Chicago HCS	Hines	Iron Moun-tain	Madison	Mil-waukee	North Chicago	Tomah	
Noninstitutional long-term care services:								
Adult day health care	29	60	1	5	73	28	125	321
Alzheimer's/dementia care					73			73
Community residential care		20					0	20
Geriatric evaluation and manage-ment	440	805		300	106			1,651
Home-based primary care	92	219			115	115		541
Homemaker/home health aide	49	73	14	14	34	2	3	189
Home respite care.								
Hospice care			1	6	5			12
Skilled home health care	48	87	15		37		2	189
Other noninstitutional		180		38				218
Institutional long-term care services:								
Alzheimer's/dementia care						27		27
Community nursing home care	102	78	5	12	43	92	10	342
Domiciliary care					167	159		326
Geriatric evaluation and manage-ment	120	9		4	10	.....		143
Hospice care		15	5		30	7	4	61
Respite care	12	6	2	0	4	0	2	26
VA nursing home care		75	33		93	157	200	558
Other institutional		33			.....			33

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.
Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 14: Long-Term Care Services Offered by VA Facilities in Network 13, Minneapolis, Minn. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)					Total [a]
	Black Hills HCS	Fargo	Min-neapo-lis	Sioux Falls	St. Cloud	
Noninstitutional long-term care services:						
Adult day health care		2	95	6	58	161
Alzheimer's/dementia care	1	.....	14			15
Community residential care				30		30
Geriatric evaluation and management				5	10	15
Home-based primary care			25			25
Homemaker/home health aide	35	49	195	5	51	335

Table 14: Long-Term Care Services Offered by VA Facilities in Network 13, Minneapolis, Minn. (Fall 2001)—Continued

VA service	Number of veterans in each service, by facility or health care system (HCS)					Total [a]
	Black Hills HCS	Fargo	Minneapolis	Sioux Falls	St. Cloud	
Home respite care	0		.....	1	0	1
Hospice care	4	1	12	2	0	19
Skilled home health care	49	48	229	23	94	443
Other noninstitutional.						
Institutional long-term care services:						
Alzheimer's/dementia care.						
Community nursing home care	11	16	84	10	11	132
Domiciliary care	132				105	237
Geriatric evaluation and management				1		1
Hospice care	15	2	10	4	3	34
Respite care	4	1	4	3	6	18
VA nursing home care	63	31	76	30	215	415
Other institutional					41	41

Source: GAO survey of VA facilities.

Notes: In January 2002, VA announced the merger of networks 13 and 14 into a single organization known as network 23. In this enclosure we report on these networks separately because at the time of our survey they were operating as individual networks.

Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 15: Long-Term Care Services Offered by VA Facilities in Network 14, Lincoln, Neb. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)			Total [a]
	Central Iowa HCS	Iowa City	Nebraska/Western Iowa HCS	
Noninstitutional long-term care services:				
Adult day health care	4	53	2	59
Alzheimer's/dementia care.				
Community residential care	0			0
Geriatric evaluation and management		21	12	33
Home-based primary care	33			33
Homemaker/home health aide	8	81	32	121
Home respite care		.....	2	2
Hospice care	0	6	3	9
Skilled home health care	25	243	17	285
Other noninstitutional.				
Institutional long-term care services:				
Alzheimer's/dementia care.				
Community nursing home care	25	17	58	100
Domiciliary care	68		14	82
Geriatric evaluation and management	1			1
Hospice care	13	3	3	19
Respite care	1	0	2	3
VA nursing home care	179		54	233
Other institutional	14			14

Source: GAO survey of VA facilities.

Notes: In January 2002, VA announced the merger of networks 13 and 14 into a single organization known as network 23. In this enclosure we report on these networks separately because at the time of our survey they were operating as individual networks.

Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 16: Long-Term Care Services Offered by VA Facilities in Network 15, Kansas City, Mo. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)							Total [a]
	Columbia (Mo.)	Eastern Kansas HCS	Kansas City	Marion (Ill.)	Poplar Bluff	St Louis	Wichita	
Noninstitutional long-term care services:								
Adult day health care	1	7	7			13	6	34
Alzheimer's/dementia care.								
Community residential care					10	172		182
Geriatric evaluation and management						1,779		1,779
Home-based primary care	104					114		218
Homemaker/home health aide	57	99	65	32	.....	101	19	373
Home respite care						0	.....	0
Hospice care		0		3	2	0	.....	5
Skilled home health care		137	16	144	8	83	.....	388
Other noninstitutional		384					.....	384
Institutional long-term care services:								
Alzheimer's/dementia care.								
Community nursing home care	.....	42	50	26	12	36	11	177
Domiciliary care		176				36		212
Geriatric evaluation and management	12					8		20
Hospice care	4	4		1		1	0	10
Respite care	1	1	1	2	22	9	0	36
VA nursing home care	25	139		35	39	23	.....	261
Other institutional		0		20		5		25

Source: GAO survey of VA facilities.

Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 17: Long-Term Care Services Offered by VA Facilities in Network 16, Jackson, Miss. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)										Total [a]
	Alexandria	Central Arkansas HCS	Fayetteville (Ark.)	Gulf Coast HCS	Houston	Jackson	Muskogee	New Orleans	Oklahoma City	Shreveport	
Noninstitutional long-term care services:											
Adult day health care	14	75			11	18	43	43	7		211
Alzheimer's/dementia care									261		261
Community residential care		62			217	0		9		11	299
Geriatric evaluation and management.											
Home-based primary care		185		53	150			82	40	65	575
Homemaker/home health aide	20	179		.....	50	.....			27	28	304
Home respite care								.....			.....
Hospice care						.....		0	.....		0
Skilled home health care	16	76		6	111	.....	56	9	38	73	385
Other noninstitutional					0				236		236
Institutional long-term care services:											
Alzheimer's/dementia care	16	32		44							92
Community nursing home care	52	44	17	17	27	22	34	17	24	25	279
Domiciliary care		.....		66							66
Geriatric evaluation and management	1	18			10			0	0		29
Hospice care			.....	8	5		0	1			14
Respite care	1	8	1	2	5	57	0	0	1	1	76
VA nursing home care	130	110		65	110	114		53	21		603
Other institutional					0	0					0

Source: GAO survey of VA facilities.

Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 18: Long-Term Care Services Offered by VA Facilities in Network 17, Dallas, Tex. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)			Total [a]
	Central Texas HCS	North Texas HCS	South Texas HCS	
Noninstitutional long-term care services:				
Adult day health care	1	11	40	52
Alzheimer's/dementia care			100	100
Community residential care		67	0	67
Geriatric evaluation and management		60	2,000	2,060
Home-based primary care		161	168	329
Homemaker/home health aide	104	77	95	276
Home respite care	0	20		20
Hospice care		8	0	8
Skilled home health care		48	65	113
Other noninstitutional	12		230	242
Institutional long-term care services:				
Alzheimer's/dementia care	4	15	58	77
Community nursing home care	102	59	90	251
Domiciliary care	0	264		264
Geriatric evaluation and management	10	8		18
Hospice care	0	17	20	37
Respite care	0	10	10	20
VA nursing home care	379	210	214	803
Other institutional	124			124

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.
Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 19: Long-Term Care Services Offered by VA Facilities in Network 18, Phoenix, Ariz. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)							Total [a]
	Albu-querque	Amarillo	Big Spring	El Paso	Phoenix	Prescott	Tucson	
Noninstitutional long-term care services:								
Adult day health care	5				42	37	25	109
Alzheimer's/dementia care	141	0					10	151
Community residential care				19	22			41
Geriatric evaluation and management	111			40		177	114	442
Home-based primary care	124		0		84		203	411
Homemaker/home health aide	174	.....			57	2	138	371
Home respite care							6	6
Hospice care					15		31	46
Skilled home health care	5	5	0	12	200	74	138	434
Other noninstitutional						16		16
Institutional long-term care services:								
Alzheimer's/dementia care						16	7	23
Community nursing home care	70	4	4		64	16	56	214
Domiciliary care						120		120
Geriatric evaluation and management		.....				3	28	31
Hospice care	11	3	0		14	10	17	55
Respite care	9	0	0		4	0	6	19
VA nursing home care	3	117	40		46	57	1	264
Other institutional						4	16	20

Source: GAO survey of VA facilities.
Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 20: Long-Term Care Services Offered by VA Facilities in Network 19, Denver, Colo. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)							Total [a]
	Chey-enne	Denver	Fort Lyon	Grand Junction	Montana HCS	Salt Lake City	Sheridan	
Noninstitutional long-term care services:								
Adult day health care		15					3	18
Alzheimer's/dementia care.								
Community residential care		132	.....					132
Geriatric evaluation and management		150						150
Home-based primary care		72		.....		120		192
Homemaker/home health aide	82	116	0		8	60	22	288
Home respite care			0			0		0
Hospice care			.....		3	2		5
Skilled home health care	3	65	172	20	11	40	26	337
Other noninstitutional			.....					.....
Institutional long-term care services:								
Alzheimer's/dementia care			8					8
Community nursing home care	2	57	.....	7	33	28	2	129
Domiciliary care.								
Geriatric evaluation and management		4	.....		.....			4
Hospice care	5	10	.....	.....	3	1	1	20
Respite care	0	3	0	.....	3	0	1	7
VA nursing home care	37	43	27	30	.....		50	187
Other institutional			0			0		0

Source: GAO survey of VA facilities.

Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 21: Long-Term Care Services Offered by VA Facilities in Network 20, Portland, Oreg. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)								Total [a]
	Alaska HCS	Boise	Portland	Puget Sound HCS	Roseburg	Spokane	Walla Walla	White City	
Noninstitutional long-term care services:									
Adult day health care				40		15		2	57
Alzheimer's/dementia care			125	410					535
Community residential care.									
Geriatric evaluation and management			175		.....				175
Home-based primary care			116	137					253
Homemaker/home health aide	23	52	21	95	.....	25	8	31	255
Home respite care						20			20
Hospice care	1	1	46	8		3	.....		59
Skilled home health care	77	60	188	.....		4	3		332
Other noninstitutional			99	3,127b					3,226
Institutional long-term care services:									
Alzheimer's/dementia care				18	14				32
Community nursing home care	11	17	51	150	20	40	7	9	305

Table 21: Long-Term Care Services Offered by VA Facilities in Network 20, Portland, Oreg. (Fall 2001)—Continued

VA service	Number of veterans in each service, by facility or health care system (HCS)								Total [a]
	Alaska HCS	Boise	Portland	Puget Sound HCS	Roseburg	Spokane	Walla Walla	White City	
Domiciliary care			192					658	850
Geriatric evaluation and management		4		8	0				12
Hospice care		6	7	6	3	4	.....		26
Respite care	0	49	41	16	2	100	.....		208
VA nursing home care		15	270	105	32	28	21		471
Other institutional	33				.....				33

Source: GAO survey of VA facilities.

Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

[b] Geriatric primary care, geriatric memory disorder care, and other services.

Table 22: Long-Term Care Services Offered by VA Facilities in Network 21, San Francisco, Calif. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)						Total [a]
	Central California HCS	Honolulu	Northern California HCS	Palo Alto	Reno	San Francisco	
Noninstitutional long-term care services:							
Adult day health care		2	6	20	6	6	40
Alzheimer's/dementia care	.....			100		130	230
Community residential care.							
Geriatric evaluation and management	300	423		100			823
Home-based primary care	39	61	117	35	7	75	334
Homemaker/home health aide	6	11	67	20	45	70	219
Home respite care.							
Hospice care	2		0	5		5	12
Skilled home health care		6	20	15	3	25	69
Other noninstitutional	.....			50			50
Institutional long-term care services:							
Alzheimer's/dementia care				50			50
Community nursing home care	10	3	80	50	8	32	183
Domiciliary care				100			100
Geriatric evaluation and management	2			0			2
Hospice care	10	3	11	25	4	5	58
Respite care	300	4	5	200	3	3	515
VA nursing home care	43	41	62	343	50	75	614
Other institutional			27			0	27

Source: GAO survey of VA facilities.

Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Table 23: Long-Term Care Services Offered by VA Facilities in Network 22, Long Beach, Calif. (Fall 2001)

VA service	Number of veterans in each service, by facility or health care system (HCS)					Total [a]
	Greater Los Angeles HCS	Loma Linda	Long Beach	Southern Nevada HCS	San Diego	
Noninstitutional long-term care services:						
Adult day health care	.....	38			61	99
Alzheimer's/dementia care		220	225			445
Community residential care		44	0			44
Geriatric evaluation and management	350		300	53		703
Home-based primary care	.....		72		70	142
Homemaker/home health aide		56			34	90
Home respite care		20				20
Hospice care		59	0			59
Skilled home health care	.....	602	0	211		813
Other noninstitutional	.....					.....
Institutional long-term care services:						
Alzheimer's/dementia care		28				28
Community nursing home care	64	178	48	20	73	383
Domiciliary care	247					247
Geriatric evaluation and management	7		3			10
Hospice care		10	14		6	30
Respite care	10	54	3		3	70
VA nursing home care	240	89	76		25	430
Other institutional	.....		4			4

Source: GAO survey of VA facilities.

Notes: Responses to our survey were submitted in September and October 2001.

Empty cells indicate that a facility did not report offering the service at the time of our survey. Dashes indicate that a facility reported the service but did not report the service's utilization.

[a] We did not calculate the total number of veterans receiving services at each facility because veterans may be authorized to receive more than one service. Some veterans may thus appear in several services at one facility.

Chairman ROCKEFELLER. Thank you very much. Jim Musselwhite.

Mr. MUSSELWHITE. I am available to answer questions.

Chairman ROCKEFELLER. You indicated that OMB is going to send over rules and regulations in a week. That does not mean that they are not going to be sent back for further revision. Why do you think really it has taken this long?

Ms. BASCETTA. It is difficult for me to answer that question. The focus of our work was on what was available and the condition of universality of these services across the networks and we spent less time in trying to figure out why the agency had taken so long to actually promulgate regs. Our understanding is that many of the issues they found to be understandably complex, perhaps particularly issues related to copayments, but we do not have the details of what went on between OMB and the department.

I would also point that even if there had not been issues with OMB, the rest of the Nation is also facing a pretty significant challenge in trying to figure out how to provide these services, so in other words, notwithstanding the interactions in Washington, I think the decisions about how best to provide care in the field are also difficult ones that need to be made.

Chairman ROCKEFELLER. But it is true, is it not, that the Department of Veterans Affairs is meant to be the best in terms of dealing with aging? In other words, that is why 50 percent of all medical students do their training at VA hospitals because that is where

they get geriatric training. I mean VA is meant to be good at this. This is not meant to be a discovery process on their part.

Ms. BASCETTA. That is correct. Certainly in geriatric evaluation and geriatric medicine, the VA is perceived as a leader. In terms of their provision of care in non-institutional settings, we have done less to have an opinion about how they stack up compared to other health care systems, but I can tell you that the task force found that they were pretty typical of the rest of the Nation, that the Nation is not doing as well as it could be in recrafting how to shift from institutional to non-institutional settings.

The task force also suggested that VA might want to look to some states that are farther ahead in providing non-institutional care.

Chairman ROCKEFELLER. Well, we are going to hear from those, and they obviously——

Ms. BASCETTA. Right.

Chairman ROCKEFELLER [continuing]. Were not bottled up by the inertia——

Ms. BASCETTA. That is correct.

Chairman ROCKEFELLER [continuing]. That was taking place in this and the past administration, and I am interested, if you know about those, and why it is that some are willing to move ahead irrespective of whatever consequences there might be and could not care less because they know what their mission is.

Veterans are much older than the general population. Here we have a really important medical mission, and all of a sudden everybody freezes up except a few people from whom we will hear.

Ms. BASCETTA. Right. You are right that there is this tremendous variability. We are hoping that in the study that we are conducting for you now, we will better understand what the reasons are for some of this unevenness, but clearly we have seen in the VA area as well as in some states that where there is a commitment it seems to unleash a great deal of creativity in being able to provide non-institutional services in a very cost effective way, but we are hoping to understand that much better over the next few months.

Chairman ROCKEFELLER. I will stop here, but I understand when you say there are many technical problems and the Nation is trying to figure out all of these things, but where there is a clear direction, where there is a clear sort of triumphantly conceived policy which speaks to such direct needs of veterans, it just does not occur to me that sort of the technical problem between OMB and VA or whoever is botching this thing up is a particularly compelling excuse.

Ms. BASCETTA. I agree.

Chairman ROCKEFELLER. I mean if you are talking about the Nation trying to figure it out, that is one thing. If you are talking about VA trying to figure it out, that strikes me as quite another.

Ms. BASCETTA. I agree, and as you point out, others have been able to proceed despite those kinds of problems.

Chairman ROCKEFELLER. Thank you. Senator Specter.

Senator SPECTER. Thank you very much, Mr. Chairman. Ms. Bascetta, how long have these regulations been languishing awaiting OMB approval?

Ms. BASCETTA. I am not sure I have the exact date. Do you know, Jim?

Mr. MUSSELWHITE. No, I do not.

Senator SPECTER. About 2½ years?

Ms. BASCETTA. I think that is probably about right.

Senator SPECTER. Why?

Ms. BASCETTA. As I said, I wish I had the details. I do not know.

Senator SPECTER. I am not asking you for details. I am asking you why 2½ years have elapsed and you still do not have OMB approval of these regulations. You are silent. Let the record show you are nodding. What action did the VA take to try to get the regulations promulgated?

Ms. BASCETTA. Dr. Roswell would be in a better position to answer that. I do not know how much interaction there was between OMB or VA. I do not know what their response is, what OMB's response would have been to the draft regulations, or whether they asked them to make revisions or the basis of those kinds of revisions.

Senator SPECTER. Well, what is the view of VA generally when Congress, by legislation, mandates—that word means requires—that VA do certain things? Maintain nursing home care capacity at 1998 levels, provide outpatient based long-term geriatric care services, adult day care, adult day health care, respite care, geriatric evaluations, to all VA patients in need of such care. Does the Veterans Administration—this may seem like an easy question—but does the Veterans Administration take seriously a congressional mandate?

Ms. BASCETTA. I certainly hope so.

Senator SPECTER. Well, then why is nothing done?

Ms. BASCETTA. Well, they do need to promulgate regulations and those do go through the Office of Management and Budget.

Senator SPECTER. Well, do you think the VA has some duty of diligence——

Ms. BASCETTA. Absolutely.

Senator SPECTER [continuing]. To push whoever is not promulgating regulations to do that?

Ms. BASCETTA. Yes, I do.

Senator SPECTER. I understand the VA has a series of excuses that might be called reasons, but was any effort made to come back to the Congress—to the relevant committees—to say these are our problems?

Ms. BASCETTA. Well, that is a good point, and I was going to say that if there were problems, it would have at least been beneficial certainly to us and to you to have an understanding of what those problems might have been.

Senator SPECTER. Well, we have a very important piece of legislation. We have a very strong stand taken by the Congress, and we have inertia, inaction, indolence, and disregard by the administration. What do you suggest that we do about it, Ms. Bascetta? Go to court, get a contempt citation, put somebody in jail?

Ms. BASCETTA. Having this hearing I think is an important, a very important signal, and the tone that Senator Rockefeller set in laying out these very clear expectations, which should have been

clear all along, is certainly an important step in moving this process along.

Senator SPECTER. How many hearings have we had on this subject, Ms. Bascetta?

Ms. BASCETTA. That I am not sure.

Senator SPECTER. Several. Well, we hope this hearing does some good, but there has been certain turnover in the VA, and it is easy to find excuses, but there are a lot of veterans out there who are not getting the services which Congress has decided, as a matter of public policy, ought to be given.

Ms. BASCETTA. That is correct.

Senator SPECTER. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Specter. Senator Graham, we welcome you. There is kind of a somber mood around here if you care to add to it. [Laughter.]

Senator GRAHAM. I think that, Mr. Chairman, you and Senator Specter have properly set the mood, and it is not necessary for me to contribute to that level of seriousness. Obviously representing a state with a very large population of veterans and an especially large population of older veterans, these issues of long-term care are extremely important, and I appreciate your holding this hearing and giving us an opportunity to both hear on the record what the status of implementation of the 1999 legislation is to date and to hear the recommendations such as those that Senator Specter just propounded as to what alternatives are before us.

Senator SPECTER. Mr. Chairman, Senator Graham may want to use our protocol when he convenes hearings on CIA failures.

Senator GRAHAM. No comment.

Senator SPECTER. It is too late now, Bob.

Chairman ROCKEFELLER. I just want to ask a question, and then, Senator Graham, if you want to do so. You know I think in your report, you say that 8 percent of dollars spent on VA long-term care were in non-nursing home settings. So people say resources are the excuse. My answer to that would be there may be some increase in workload on the part of an incredibly loyal work force in the VA, but you certainly cannot use cost as a reason, because non-institutional care is going to be a lot less expensive. Would you not agree?

Ms. BASCETTA. On a per person basis, yes, that is correct, it should be less expensive.

Chairman ROCKEFELLER. So any time I hear resources used as an excuse today, I am going to bear that very much in mind.

Ms. BASCETTA. Right.

Chairman ROCKEFELLER. Now, we do not wish to be—Senator Graham, did you have any questions?

Senator GRAHAM. No.

Chairman ROCKEFELLER. OK. We do not wish to be short with you in terms of time, but we want to move to some of these folks who are making this thing work, so we thank you very much for doing the work. I am extremely glad that you are both there, and I thank you for coming.

Ms. BASCETTA. Thank you.

Mr. MUSSELWHITE. Thank you.

Chairman ROCKEFELLER. OK. Panel two is our innovators panel, and they have programs that are already at work. So Gladys Dickerson, who runs a home-based program geared toward those with dementia, will be one of our witnesses.

Tom McClure and his Medical Foster Care Program will be another. Paula Hemmings, Network Number 2's geriatric and extended care service line manager, but with us today representing the Alzheimer's Association. And finally, Jennifer Moye. Who is a researcher and a psychologist with a great story to tell about what can be done in terms of geriatric mental health. We are so glad you are here. Right now you are not giving special time to your patients because you are away from them, and I apologize for that, but I think that you understand that we are talking here about the greater good. So I am very grateful that you are here, and why do we not start, Ms. Dickerson, with you on home-based dementia.

STATEMENT OF GLADYS DICKERSON, R.N., HOME-BASED PRIMARY CARE COORDINATOR, DALLAS VA MEDICAL CENTER

Ms. DICKERSON. Mr. Chairman and members of the committee, I appreciate this opportunity to speak before you today regarding alternatives to institutionalization for long-term care.

Hospital-based and Home-Based Primary Care—HBPC as it is referred to—and other programs associated with HBPC ensures that the right care at the right time in the right setting is available to veterans all over the nation. Programs such as HBPC, adult day care, telemedicine, advances in home-based primary care for end of life in advancing dementia, which is referred to as the AHEAD program, the senior companion program, in-home respite and assisted living ensures that veterans receive alternatives to institutional care.

These services can be provided at a much reduced cost to the VA system and keep the patients out of acute care beds and at home where they prefer. The number of veterans with long-term care needs is increasing as the population ages. Currently, we have an estimated 600,000 individuals with dementia alone within the veteran population. Dementia and similar diseases are progressive.

The victims are vulnerable to accidents, injuries which ultimately make them completely dependent in all aspects of their daily living. These diseases are projected to triple in the veteran population over the age of 65. The incurable nature of these diseases and long-term conditions, the suffering that they cause the patient and their families, and the cost of care, of managing diseases such as dementia, makes it a priority to find alternatives to institutionalization.

Home and community-based care allows the veteran to live at home rather than in an institution, making it a win-win situation for such programs as the HBPC program and the AHEAD project. Families are able to participate in quality of life issues with the veterans in the home environment and the cost of care is usually lower than the cost of skilled care nursing facilities.

Across VHA, the data indicates that families prefer to keep veterans at home, but they are unable to as the veteran becomes more impaired. The AHEAD project through HBPC focuses on the dementia patient's problems. Focus areas include earlier identifica-

tion, caregiver support, completion of advanced directives and symptom management.

The project allows the veteran to receive appropriate care in the location they prefer and help sustain caregivers in their vital roles. The AHEAD project took 20 VA facilities across the country and we completed a 9-month collaboration committed to improve the care of veterans with dementia who prefer to live at home.

These teams demonstrated notable success in early identification of dementia, symptom management, caregiver support and staff education. Home-based primary care is the most cost effective way to deliver interdisciplinary home care.

The HBPC program offers long-term patients the kind of alternative to nursing home placement. It minimizes the amount of followup that they have to go through in the ambulatory care clinic. It prevents premature admissions to the hospital by early identification and premature admission to long-term care facility. It also allows the patient the option of dying in the home rather than in an institution.

The purpose of the Community Adult Day Care Program is to establish functional impaired individuals with a supportive professional environment so that they can be nurtured; to facilitate the return of the older veteran to his home and to coordinate their long-term care; to maintain the older veteran at the highest level of function possible both physically, socially, and medically; and to provide the family and caregiver with professional support, enabling them to maintain the disabled veteran in the community.

The Senior Companion Program often makes the difference between living at home and in an institution. This translates into major health cost savings for the senior, their family, and the taxpayers. Nursing home costs is an average of $38,000 annually per patient per year. However, the cost of supporting one senior companion for an entire year is $3,850. Telemedicine technology also allows us to reduce costs, time, and efficiency and eliminates distance.

In conclusion, funding an expansion of HBPC programs will enable alternatives to institutionalization of long-term care veterans, which we need expanded programs, innovative approaches to long-term care, and this would mean a cost savings to the VA. HBPC keeps families together and this concludes my remarks, and I will be happy to answer any questions.

Chairman ROCKEFELLER. Thank you very, very much. Tom McClure.

[The prepared statement of Ms. Dickerson follows:]

PREPARED STATEMENT OF GLADYS DICKERSON, R.N., HOME-BASED PRIMARY CARE COORDINATOR, DALLAS VA MEDICAL CENTER

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to speak before you today regarding alternatives to Institutionalization in Long Term Care. Home Based Primary Care (HBPC) and those programs associated with HBPC; ensure that the right care, at the right time, in the right setting is available to veterans all over the nation. Programs such as HBPC, Adult Day Care, Telemedicine, Advances in Home Based Primary Care for End of Life in Advancing Dementia (AHEAD), Senior Companion, In-Home Respite, and Assisted Living ensure veterans receive alternatives to institutional care. These services can be provided at a much-reduced cost to the VA system and keep the patient out of an acute care bed and at home, where they prefer to remain.

NON-INSTITUTIONAL ALTERNATIVES TO LONG-TERM CARE

The number of veterans with long-term health care needs is increasing as the population ages. Currently, there are an estimated 600,000 individuals with dementia within the veteran population.

Dementia and similar diseases are progressive. Their victims are vulnerable to accidents and injuries that ultimately make them completely dependent in all aspects of daily living. These diseases are projected to triple in the veteran population over age 65. The incurable nature of most long-term conditions, the suffering it causes patients and their families, and the cost of care make managing diseases such as dementia and others a priority to promote non-institutional care for VA.

Veterans who receive the home and community based care that allows them to live at home rather than in an institution, makes this a "win-win" situation for such programs as the HBPC and AHEAD Project. The family is able to participate in quality of life issues with the veteran in their home environment. The cost of care is usually lower than care provided in a skilled care facility.

Across the VHA, data indicates many families prefer to keep the veteran at home but they are unable to, as the veteran becomes more impaired. The AHEAD project through HBPC focuses on the dementia patient's problems. Focus areas are, early identification, caregiver support, completion of Advance Directives, and symptom management. The project allows veterans to receive appropriate care in a location they prefer and helps sustain caregivers in their vital role.

In the AHEAD Project, 20 VA facilities around the country completed a nine-month collaboration, committed to improving care of veterans with dementia who prefer to live at home. These teams demonstrated notable success in early identification of dementia, symptom management, caregiver support, and staff education. It has been shown that the best place for veterans with long-term problems is in the HBPC Programs across the country. Home Based Primary Care is the most cost effective way to deliver interdisciplinary health care. This care is defined as accessible, comprehensive, coordinated, continual, accountable and acceptable.

The HBPC Program offers long-term patients this kind of care.

- An alternative to nursing home placement.
- Minimizes the amount of follow up in an Ambulatory Care Clinic.
- Prevents premature admissions to long-term care institutions.
- Maintains optimal physical, cognitive, and psychosocial functioning.
- Allows the patient the option of dying at home rather than in an institution.

The purposes of the Community Adult Day Care facilities are:

- To enable functionally impaired individuals to reside in a supportive home environment rather than nursing home care facilities.
- To facilitate the return of older veterans to their homes and to coordinate their long-term care.
- To maintain the older veteran at the highest level of functioning possible (physical, social and medical).
- To provide the family and caregivers with professional support, enabling them to maintain disabled veterans in the community.

The Senior Companion Program often makes the difference between living at home or in an institutional setting. This translates into major health care savings for seniors, their families, and taxpayers. Nursing home care costs an average of $38,000 annually per person. However, the cost of supporting one Senior Companion for an entire year is $3,850.

Telemedicine technology allows us to reduce travel time and costs, improves efficiency and provides better quality care.

In conclusion, funding and expansion of all HBPC Programs can ensure alternatives to institutionalization for the long-term veteran patient. With these expanded programs, innovative approaches to long-term care can be established with a cost saving to VHA, patients and their caregivers. HBPC keeps families together.

This concludes my remarks. I will be happy to respond to any questions you may have.

STATEMENT OF THOMAS McCLURE, LCSW, COORDINATOR, VA MEDICAL FOSTER HOME PROGRAM, LITTLE ROCK VA MEDICAL CENTER

Mr. MCCLURE. I appreciate the strong language from this committee because I think we need action, and I think I have some good news. I am here to tell you about a unique and exciting program that actually changes lives. The VA hospital in Little Rock

has taken the Medical Foster Home Program and the HBPC programs and formed a partnership that provides an extremely personal and comprehensive service that benefits not only our disabled veterans, but it benefits our communities and the VA hospital at a low cost.

This program has an excellent record of satisfaction among the veterans and their families. The secret, these homes provide a permanent home with private rooms. They provide 24 hour supervision, home cooked meals, a safeguard against abuse and neglect. We have never had a case of abuse in our program. We take sick, depressed veterans and turn them into grandpas, father figures. We turn them into family members.

We fatten them up and make them laugh. They bring their pets to these foster homes. They are allowed flexibility in their routine. They are treated with dignity and respect, because those are our standards. The Medical Foster Home Program also provides a valuable service to our community, and that is in the form of jobs and income. Also an opportunity to work at home.

But the reason I am successful at recruiting good homes is because this program provides a meaning and a purpose in these caregivers' lives. Our community, the everyday people, have defended our nation in war, they have run our factories, and they have built our homes. These people can also care for our frail elderly population if we support them. They can do it better and they can do it with less cost than any other alternative.

The program also provides a service to our VA hospital by giving the discharge planners an alternative to nursing home placement. Already, 50 percent of my referrals come from the VA hospital, and that is growing. 25 percent come from the community just by word of mouth. If I advertise this program, I would be overwhelmed.

Eight of our 44 veterans living in foster homes are 100 percent service connected. They or their family choose to spend their own money to live in a foster home rather than have VA pay for their care in a nursing home. The cost of these two programs, HBPC and the Medical Foster Home, in partnership is $37 per day per patient. That is compared with $155 per day for nursing home care. I got that in the April issue of the AARP national average.

The foster home staff consists of myself, a part-time secretary, one vehicle, one cell phone at $8 per day. I travel 15 to 2,200 miles per month. I am on call 24 hours a day, 7 days a week. But I have reached my limit. And we need action. I have added 44 patients to the HBPC case load, and now they have reached their limit. This is a win-win situation, and this is a solution. This concludes my statement but not my ideas.

[The prepared statement of Mr. McClure follows:]

PREPARED STATEMENT OF THOMAS MCCLURE, LCSW, COORDINATOR, VA MEDICAL FOSTER HOME PROGRAM, LITTLE ROCK VA MEDICAL CENTER

Mr. Chairman and members of the Committee:

My name is Tom McClure and I am a VA social worker at the Central Arkansas Veterans Healthcare System. I am honored to be here today because one of your staff, Kim Lipsky, heard me and a colleague present our Medical Care Foster Home Project at a recent national conference, and she thought you would be interested. We recently finished a pilot, funded by VA, and we are now disseminating our findings.

For 23 years I have been working in our Home Based Primary Care Program. I saw firsthand how hard veterans worked to stay in their own homes even though they had severe chronic illnesses and disabilities, unsuitable housing, and poor social supports. I often witnessed how difficult it was for elderly spouses to continue to care for their very disabled husbands. Time and time again I observed the unwillingness of veterans and their families to consider placement in a nursing home.

We wanted to try to find ways for these patients to continue to stay in the community and still get the care they needed. A few times I helped our patients make informal community arrangements to live in the home of a hired caretaker. These situations worked out well for the veterans. The Home-Based Primary Care (HBPC) team managed the medical care. Then we heard about our Central Office's "New Clinical Initiative Funding." We asked for and were given the resources to develop Medical Care Foster Homes for our veterans—$95,000 for each of 2 years. This money paid my salary so I could develop foster homes full time. It also paid for my half time assistant, travel costs and cell phone costs. We set about to recruit caring families and individuals in the communities served by our large HBPC program.

Now, 2 years later, we now have 35 foster homes and 45 patients. Our outside funding has ended, but the Medical Center chose to continue at the same level of funding. Eight of our Foster Care patients are 100 percent service connected; some of them came directly from a community nursing home to our foster home at their own expense.

Here is how our program works. When I recruit a foster home, I assess their motivation, attitude, life experience, and I explain the general needs of our disabled veterans. I check their references and do a criminal background check. Our safety engineer inspects the home environment. If everything checks out, we approve the home and can begin to match the home with patients who are interested in family living. We involve any family or friends of the veteran in the process of selecting a foster home. I encourage them to visit a few homes. I serve as an intermediary between the veteran and the foster home sponsors in agreeing on the monthly fee. This fee ranges from $1000 to $1800 per month depending on the care needs of the veteran. For this fee the veteran gets a private room, personal care, 24-hour supervision, meals, laundry, and activities. This is a permanent home. We do not uproot these veterans when they become terminally ill and place them in a nursing home. They remain in the foster home. It is understood that the VA will provide medications, supplies, and health care. All the veteran's needs are met.

The veterans pay for their Medical Foster Care with no funding from VA. They use their Social Security, private pensions, and VA pensions or service-connected disability compensation. Most have spending money in reserve. The veterans who qualify for non-service-connected pensions can have their pensions increased to cover the costs of the Medical Foster Care. We have a liaison in the Little Rock VA Regional Office that assists us in processing claims in a timely manner, but sometimes it does take several months.

Once in Medical Foster Care, the patients are visited regularly by the HBPC team members, who conduct an interdisciplinary geriatric assessment, develop a treatment plan, provide medications and medical equipment, and educate the foster family in the care of the veteran. Because of the close partnership between our Foster Care Program and HBPC, we safeguard against abuse.

So far we have recruited our Medical Care Foster Homes from persons in the community who are experienced in caring for the elderly, either former health care workers or those with experience caring for family members. Even though the income is important to foster home sponsors, we feel the most important factor is that the program instills meaning and purpose to their lives. This is why we can recruit good people. Also we help our Foster Home Sponsors. They have 24-hour access to us. We also offer respite 2–4 times a year so they can rest and reduce stress levels.

We believe Medical Foster Care/HBPC is humane care and affordable for VA and the Veteran. At our facility, with a census of 45 patients in foster care, the VA direct care costs are $29 per day for the HBPC portion of the care, plus $8 per day for the Foster Home Program, for a total of $37 per day.

The Central Arkansas Veterans Healthcare System has formed a partnership with the Medical Foster Care Program and the HBPC Program, permitting us to provide this unique care environment. Many states have adult foster care. But this program is just for veterans and VA healthcare providers are actively involved in caring for the patients and overseeing the homes. The most important feature of this program is that it improves the quality of life for our frail, disabled veterans in a family atmosphere. We take sick, depressed veterans from our wards, place them in a family environment and they become grandfather, uncles, and father role models.

Here at Little Rock, we are at capacity for the number of homes and patients can be managed with existing staff. HBPC's census of 180 is now 25 percent Foster Care patients and growing. With this program in its infancy, we are unable at this time to predict the limits of its growth.

I believe VA Medical Centers could develop Medical Care Foster Homes in conjunction with existing Home Based Primary Care Programs. It is not easy work, but it is important and gratifying work that would give our aging veterans a true alternative to institutional care.

This concludes my statement. I will be happy to respond to the Committee's questions.

Chairman ROCKEFELLER. Or the obvious and clear emotion just one inch below your words. You commitment is enormous.

Ms. Hemmings.

STATEMENT OF PAULA HEMMINGS, R.N., DEPARTMENT OF VETERANS AFFAIRS' VETERANS INTEGRATED SERVICE NETWORK NO. 2, GERIATRICS AND EXTENDED CARE LINE MANAGER, REPRESENTING THE ALZHEIMER'S ASSOCIATION

Ms. HEMMINGS. Mr. Chairman and members of the committee, thank you very much for giving me the opportunity to testify at this important hearing. I am the Director of Geriatrics and Extended Care Line for the Upstate New York Integrated Service Network. However, I am here this morning on behalf of the Alzheimer's Association and the views expressed do not necessarily reflect the views of the Department of Veterans Affairs.

The purpose of my appearance today is to explain how the VISN 2 located in upstate New York was able to implement the Chronic Care Networks for Alzheimer's disease project fully utilizing the continuum of VA institutional and non-institutional long-term care programs that are variable to the veterans.

In 1996, VISN 2 was the only VA network that was a member of the National Chronic Care Consortium. Membership in this organization reflects commitment on the part of VA Central Office as well as the executive support in VISN 2.

As members of the NCCC, the Alzheimer's Association and VISN 2 leadership made a commitment to partner in the CCN/AD project because of our strong belief that chronic care takes many resources to work.

In upstate New York, the partners recognized that they had a common goal. They also served the same target population, individuals with dementia and their caregivers and families. This recognition of commonality promoted pooling of experience, experience and resources. Both agencies also recognized that no one organization, no matter how complete its array of services and programs, is sufficient to successfully manage the chronic and progressive illness of dementia throughout its course.

VISN 2 is strongly motivated to partner with the community organization to better serve an aging veteran population with the prevalence of chronic illness. Nationally, the rate at which a veteran population is aging surpasses the general population. The 20 percent reduction in the overall veteran population is offset by the significant growth of very elderly veterans, thereby maintaining significant demand from health care services in the next 10 years.

The CCN/AD's primary project goals are: identification of individuals in the early stages of the condition; implementation of state-of-the-art comprehensive care guidelines; creation of a dual track

to support both a person with dementia and the family caregivers over time and across a continuum of needed services; and modification of the care for coexisting conditions with recognition of the underlying dementia and its effects.

As a selected CCN/AD site, VISN 2 is active in the development, piloting and demonstration of the model. Chapter and VA partners quickly identified training as a major component of the intervention. Primary care clinicians were targeted for initial and ongoing training. Staff of both partnering organizations was educated about the goals, protocols and their role in addition to dementia topics.

Once the initial piece of the project was accomplished, the role of the Dementia Care Manager became more important. This is a staff role unique both to this project and within the VA. These staff serve as a variety of diverse functions all designed to advance the goals of the CCN/AD initiative.

The dementia care managers work diligently to ensure that all veterans continue to have access to VHA resources and services when they need it. This is a good illustration of a model that strategically places VHA resources alongside numerous community partners to work in concert in meeting the needs of the chronically ill veterans.

Treatment and management of chronic illnesses such as dementia fundamentally challenge the way health care service delivery systems are currently delivered. Typically care delivery centers around brief episodic office visits with the primary care provider. The nature of the visit commonly focuses on the medical aspects of presenting problems. Chronic care management, however, presents fundamentally a different reality.

Chronic progressive illness, such as Alzheimer's, needs to be addressed over time and it must include the patient's family and caregivers. Plans often need to include access to a full range of non-institutional resources such as home-based primary care, the homemaker home health aide, adult day health care, and respite care, all service that the VA provides and coordinates.

Planning has to include caregivers who oftentimes are as old and as sick as the identified patients they care for, and yet they are so crucial to the success or failure of the management of the disease. Planning with them is important. VA chose to use a CCN/AD program as a springboard to help influence its medical model and culture of primary care to better accommodate the needs of veterans and patients with chronic illness.

It has expanded the provider's appreciation to where care is actually delivered. It is delivered in the home. It contributed to the provider's understanding that successful management of our patients with dementia care means addressing the needs of the family and patient as well. This project has taught us that we must reach out to our partners in the community who have common missions and work with them to offer our veterans and their family caregivers what they need, not just what we have. Thank you.

[The prepared statement of Ms. Hemmings follows:]

PREPARED STATEMENT OF PAULA HEMMINGS, R.N., DEPARTMENT OF VETERANS AFFAIRS' VETERANS INTEGRATED SERVICE NETWORK NO. 2, GERIATRICS AND EXTENDED CARE LINE MANAGER, REPRESENTING THE ALZHEIMER'S ASSOCIATION

Mr. Chairman and members of the Committee, thank you very much for giving me the opportunity to testify at this important hearing.

In my professional life I am the Director of the Geriatrics and Extended Care Line for the upstate New York Veterans Integrated Services Network (VISN 2). However, I am here this morning on behalf of the Alzheimer's Association and the views that I express do not necessarily reflect the views of the Department of Veterans Affairs.

The purpose of my appearance today is to explain how Veterans Integrated Service Network (VISN 2), located in upstate New York, was able to implement the Chronic Care Networks for Alzheimer's Disease (CCN/AD) project fully utilizing the continuum of VA institutional and non-institutional long-term care programs that are available to the Veterans.

In 1996, VISN 2 was the only VA Network that was a member of the National Chronic Care Consortium (NCCC). Membership in this organization reflects commitment on the part of VHA Central Office as well as executive support in VISN 2. As members of the NCCC, the Alzheimer's Association and VISN 2 leadership made a commitment to partner in the CCN/AD project because of our strong belief that chronic care takes many resources to work. There were seven sites selected from the NCCC applicants. VISN 2 and the upstate New York chapters of the Alzheimer's Association were among those selected. The importance of this project was recognized by the Robert Wood Johnson Foundation who heavily underwrote the evaluation component of the VISN 2/upstate New York Alzheimer's Association chapters site.

BACKGROUND ON CCN/AD PROJECT

The following is a detailed description of the CCN/AD initiative and VISN 2 and the upstate Alzheimer's Association chapters participation. VISN 2 and the four upstate New York chapters of the Alzheimer's Association formed a community partnership to participate in the CCN/AD initiative, a national demonstration project. In Upstate New York the partners recognized that they had a common goal. They also served the same target population, individuals with dementia and their caregivers and families. The partners strove to provide their clients with the best quality care their agency resources allowed. This recognition of commonality promoted pooling of experience, expertise and resources. The Alzheimer's Association chapters have a history and extensive experience providing support and education to diagnosed individuals, their caregivers and families. The VA brought to the partnership their clinical experience and expertise in the provision of an enviable continuum of chronic care services. Both agencies have much to offer individuals with dementia and their caregivers. Both agencies also recognize, that no one organization, no matter how complete its array of services and programs, is sufficient to successfully manage the chronic and progressive illness of dementia throughout its course. Partnership is essential. Partnering in CCN/AD meant that both organizations could provide better access for their clients to a wider arrangement of services. Also as important, the partnership in the CCN/AD initiative would establish the foundation for development of a disease management model of care in VISN 2. This model serves as a guide for providing services and support throughout the course of the disease at all care sites within the Network.

DEMOGRAPHIC PROFILE OF VISN 2

VISN 2 is an integrated health care delivery system composed of inpatient facilities, nursing homes, community clinics, non-institutional care programs provided through contracts, and community agency referrals. VISN 2 provides acute inpatient and nursing home care services at five locations: Albany, Western New York, Syracuse, Bath and Canandaigua, provides primary care at twenty-nine community-based clinics that are located throughout the region. The VISN serves an area of 42,925 square miles encompassing 47 counties in New York State as well as two in northern Pennsylvania, with an estimated 573,546 veterans (17.7% of those veterans were treated in FY 2000).[1] This is approximately the same area (minus counties in northern Pennsylvania) served by four Alzheimer's Association chapters. The

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

chapters and VA Medical Centers formed the partnerships based upon shared service areas.

VISN 2 was strongly motivated to partner with a community organization, such as the Alzheimer's Association, to better serve an aging veteran population with a prevalence of chronic illness. Nationally, the rate at which the veteran population is aging surpasses the general population.

Highlights of veteran demographics for upstate NY:

• Over 52% of veterans treated in FY 2001 were 65 years of age or older, with nearly one-quarter over age 75.

• Perhaps equally significant is that while our total veteran population decreases, the number of veterans over age 85 will nearly double in the same five-year period.

While veterans over age 65 historically use health care services at a higher rate than younger veterans, greater demand is profoundly more significant among those 85 and over, in all major care settings-acute inpatient, ambulatory and nursing home care. The 20% reduction in the overall veteran population is offset by the significant growth of very elderly veterans, thereby maintaining significant demand for health care services over the next ten years.[2]

These demographic data provided VISN 2 an incentive to participate in the CCN/AD initiative addressing Alzheimer's disease, a chronic illness whose prevalence increases with age. A disease which if left undiagnosed could interfere with the management of their medical care and cause them to be labeled as non compliant patients, possibly leading to their death because they were not taking their medications as prescribed.

In addition to the demographic challenges presented to us, VISN 2 was impelled by fiscal and budget realities to make effective changes, rapidly, and to look outside itself for agencies with whom to collaborate.

In VISN 2, Care Lines are structured along major program emphases. In my case, the major program emphasis is Geriatrics and Extended Care (GEC). In VISN 2, the Care Line Directors are given budgetary and operating authority over all relevant programs in this new organizational structure. Decisions about program operations are matrixed with the Directors of the major Medical Centers in upstate New York. This structure allows us to rapidly deploy and standardize the best, efficient and effective practices across all sites of care delivery within our Network. The Care Line organizational structure lets administrators in our Network focus and concentrate on all the pertinent issues and requirements relevant to aligning resources for efficient and effective service delivery. It also impacts the speed of implementation, in that, I can influence deployment across the entire Network catchment area, and not just at one Medical Center at a time. This structure allowed me to institute the CCN/AD initiative rapidly throughout all of upstate NY and hire and put in place Dementia Care Managers at each major site which I will talk about later.

CCN/AD PROJECT GOALS

The CCN/AD project's primary goals are: identification of individuals in early stages of the condition, implementation of state of the art comprehensive care guidelines, creation of a dual track to support both the person with dementia and the family caregivers, over time and across the continuum of needed services, and modification of the care for coexisting conditions with recognition of the underlying dementia and its affect. As a selected CCN/AD site, VISN 2 was active in the development, piloting and demonstration of the CCN/AD model.

Chapters and VA partners quickly identified training as a major component of the intervention. Primary care clinicians were targeted for initial and ongoing training. Other staff in both partnering organizations, were also trained in sessions specifically designed to meet their needs. A site wide curriculum was developed that outlined a basic introductory presentation with CME credit that the VA clinical director of the Initiative delivered at each sub site. The purpose was to assure that each location started with the same basic information. During the clinical director's travels to the sub sites he met with key personnel and along with dementia care managers recruited physician "champions" who would participate in or support future sessions.

THE ROLE OF THE DEMENTIA CARE MANAGER

Recognizing the varied resources and needs of each sub site, Dementia Care Managers and chapter coordinators determine future educational needs for the staff at their facilities using the curriculum as a guideline to identify target audiences and use a variety of methods. Faculty was recruited from within the VA and more fre-

[2] Ibid.

quently from universities, Alzheimer's Disease Centers and Alzheimer's Disease Assistance Centers. Staff at both partnering organizations were educated about the goals, protocols and their role in addition to dementia topics. A milestone occurred when demands for training came from numerous diverse staff themselves after hearing about or experiencing the quality of Alzheimer's Association chapter training sessions for direct care staff. Eventually, this led to use of Alzheimer's Association chapters for train-the-trainer programs and development of a plan to use those newly trained as instructors and dementia resource individuals in their unit. The implementation of that plan was the culmination of efforts to reach our goal to train the full range of staff at VA facilities.

Once the initial piece of the project was accomplished, the role of the Dementia Care Manager became more important. This is a unique staff role; unique both for this project and within the VA. These staff serve a variety of diverse functions all designed to advance the goals of the CCN/AD initiative. The Dementia Care Manager is there to respond to questions related to the tools after the education sessions and to collect the necessary data for the project. The other responsibility of the Dementia Care Manager is to work with the primary care provider to establish the psychosocial support system for the Alzheimer's patient in the community. Further these staff work with the family and the Alzheimer's Association to provide family/caregiver support.

The Dementia Care Managers like the other VISN 2 Geriatrics and Extended Care staff work diligently to insure that all veterans continue to have access to VHA resources and services when they need it. VISN 2 is one of the Networks nationally that met veteran resource, use reliance target levels for both our institutional Nursing Home programs as well as our non-institutional home care programs and services. But the needs, both in nature and kind of need, of patients with chronic illnesses and their families will always exceed the VHA's ability to directly provide for them.

PARTNERSHIP WITH THE ALZHEIMER'S ASSOCIATION

Faced then with increasing numbers of aging veterans in the upstate New York area and the competing healthcare budget needs previously mentioned, geriatric and extended care program planners in our Network factored in access to Alzheimer's Association community resources, as a necessary component to compliment services for veterans with dementia and their families. It is a good illustration of a model that strategically places VHA resources along side numerous community partners to work in concert to meeting the needs of chronically ill veterans.

THE CHRONIC CARE CHALLENGE

Treatment and management of chronic illnesses, such as dementia, fundamentally challenge the way healthcare service delivery systems are currently configured.

Medical care delivery within VHA, as is the case with most medical care systems, is well designed to manage health care problems of the general population. Typically care delivery centers around brief, episodic office visits with the primary care provider. The nature of the visit commonly focuses on the medical aspects of presenting problems. Patients are given prescriptions, advice on life style changes and follow up appointments if necessary to track progress of the condition for which they are being treated. At times, referrals may be made to specialty clinics and if warranted to treat acute illness, hospitalization. In addition, providers in these settings are busy. They have high patient volume and are daily pressed to complete their scheduled visits. As would be expected, resources in most health care systems are aligned to meet this mission and model of healthcare delivery.

Chronic care management, however, presents a fundamentally different reality. Chronic progressive illness, such as Alzheimer's, needs to be addressed in clinic, over time rather than episodically. Also managing these patients, who are typically frail and elderly, takes time. Time to plan access to a full range of non-institutional resources such as Home Based Primary Care, Homemaker Home Health Aide, Adult Day Health Care and Respite Care, all services that the VA provides and/or coordinates. Providers are trained and trained well to assess and treat on the medical level and patients with chronic illness need this care. But often simultaneously, these patients and families need assessment and care on several other non-medical dimensions as well. These other domains that require attention and often intervention and care planning include functional, social, financial, psychological, behavioral and environmental dimensions. Further adding to the complexity is the work that needs to be done with the family caregivers. Caregivers often times are as old and sick as the identified patients they care for, yet they are so crucial to the success or failure of the management of the disease. Their needs must be accounted for in

care planning. Finally, the nature of chronic progressive illness is such that it evolves, develops, and eventually deteriorates over time. Changes in condition and circumstance must not only be monitored but must be prepared for proactively. Patient's changes in physical, behavioral and functional needs require different mixes of supports, services and settings. Their caregivers' skills, aptitudes, as well as their own family and agency supports available to assist them need to be looked at as they progress through role changes and the changing demands that their loved ones chronic illness places on them. This is where the Dementia Care Managers come in and provide invaluable assessment, coordination and support.

To successfully address chronic illness management, the mindset, both clinically and in resource planning and deployment, needs to be fundamentally different than an uncritical reliance on a system of delivery designed to serve needs of a general population. The consequences of dependence on episodic care delivery as it's currently organized or premature reliance on costly institutional care for management of chronic illness is to squander precious resources that are and will be needed to treat the ever growing population of veterans with chronic illness.

REPLICATION OF THE CCN/AD PROJECT

Given the complexity of what is described above, it is impractical to think that any one agency, no matter how vast its resources, can unilaterally provide all the care patients and their families with chronic progressive illness will need. To begin to think like this, and coordinate with community partners and monitor care over time outside of the clinic encounter, is nothing short of a cultural change in healthcare delivery. To actively change medical care delivery culture, the endorsement and commitment from top leadership is required. VISN 2 chose to use the CCN/AD model as the springboard to help change it's medical model and culture of primary care and to influence it over time to better accommodate the needs of patients with chronic illnesses and their families. Over a five year period, the VISN deployed dedicated Dementia Care Managers to cover all the medical centers and major care sites within the VISN. These staff are able to take the time medical providers don't have to do detailed assessment of both patient and caregiver needs. They also are a direct contact point and portal of entry into the VA system and continuum of services. They are easily reached by their partners at the Alzheimer's Association and help sustain this inter-agency relationship. They collaborate with both VHA providers and Chapter staff and work to integrate into care planning relevant data about both patient and caregiver's current functioning.

CONCLUSIONS

CCN/AD created in VISN 2, over time, the reality of viable partnerships with community agencies such as the Alzheimer's Association. It imparted to our providers the importance of addressing caregiver needs and supporting them as they struggled to cope with their loved ones illness on a day to day basis. It reaffirmed that chronic care had to be managed across settings and over time. It expanded the providers' appreciation as to where care was actually delivered in the majority of instances. It contributed to the provider's understanding that successful management of our patients with dementia means addressing the needs of the patient's family caregivers as well.

Our veteran patients, whom we correctly refer to as our nation's heroes, who now come to us with dementia, along with their family caregivers, who are quiet, unsung heroes in their own right, continue to teach us. They teach us that to be true to our mission and obligation to "serve him who has borne the battle and his widow and orphan", we must continue to maximize our resources to serve the extended care needs of our veterans as they age, become frail and more heavily rely upon us. They teach us that to be successful in our mission we cannot be solely focused on our identified patient, the veteran. We must also focus on those in our veterans' lives who are most intimately caught up in the provision of their extended care needs. And finally, they teach us not to come to rely solely on VHA resources to achieve our mission. They have taught us that we must reach out to our partners in the community, who have common missions, and work with them to offer our veterans and their family caregivers what they need, not just what we have.

Chairman ROCKEFELLER. Thank you very much, Ms. Hemmings. Dr. Moye. And this will be geriatric mental health and your study about that.

STATEMENT OF JENNIFER MOYE, PH.D., DIRECTOR, GERIATRIC MENTAL HEALTH CLINIC/UPBEAT, BROCKTON VA MEDICAL CENTER, AND ASSOCIATE PROFESSOR OF PSYCHOLOGY, DEPARTMENT OF PSYCHIATRY, HARVARD MEDICAL SCHOOL

Ms. MOYE. Right. Mr. Chairman and Senator Graham, my name is Jennifer Moye. I am the Director of the Geriatric Mental Health UPBEAT Clinic at the Boston VA Brockton Campus, and I am an Assistant Professor of Psychology in the Department of Psychiatry at Harvard Medical School.

I am pleased to testify today on the Unified Psychogeriatric Biopsychosocial Evaluation and Treatment, or UPBEAT program.

I have worked as a psychologist with medically and neurologically frail older veterans with late onset mental health concerns for the past 10 years, and I speak today as a clinician. Our clinic was founded in 1995 as part of a 5-year, nine-site clinical demonstration project that evaluated the effectiveness of outpatient case management combined with mental health treatment for elderly veterans who have previously undiagnosed mental health problems in the context of serious medical illness.

This program is based on two research findings, one, mental health problems are underdiagnosed and inadequately treated in the elderly. These are fellows who are not going to say to their doctor, "gee, I have been feeling sad, could I talk to a psychologist?" They are more likely to sort of buck up and suffer, unfortunately.

And also, the second finding, elderly who have depression or other mental health problems have more complex medical management, have a more complicated recovery from illness, and are more expensive for our health care system.

In the UPBEAT program, patients 60 years or older admitted to medical or surgical inpatient services were screened for depression, anxiety or alcohol use. 1,687 veterans with these problems were randomly assigned to either a treatment group or a usual care group.

In the treatment group, those fellows got an intensive interdisciplinary assessment, followed by outpatient case management combined with mental health treatment.

In the year following enrollment, veterans in the treatment group had higher utilization of outpatient care, especially mental health and telephone encounters, costing 1,171 more dollars per patient per year than the usual care group.

However, that expanded outpatient cost was more than made up for by savings in inpatient costs of $3,027, resulting in a net savings on average of $1,856 per patient per year, or a total savings for all patients enrolled in the treatment group of approximately $1.5 million.

The savings were chiefly attributable to reduced length of stay when those veterans were rehospitalized. We are starting to look at other subgroups, and it looks like in specifically targeted subgroups, such as patients with circulatory conditions or more significant depressions, the savings may be even greater, up to $5,000 per patient per year.

Let me share with you an example to illustrate the program. One veteran in the UPBEAT program was enrolled at our site when he

was surgically hospitalized and he screened positive for depression. The depression was triggered in part because the current surgery he was having was reminiscent of the eight surgeries he received in 1945 after he was injured by shrapnel.

This patient participated in six combat jumps in Africa, Italy, France and Germany, including the Battle of the Bulge and the Anzio and Normandy invasions for which he received the Bronze Star for heroism.

Late in life when confronted with illness and vulnerability, he became overwhelmed with depression, to the point where he would retreat from everyone and stay in bed and then that would compromise his health.

He entered our program at the age of 75 participating at first very reluctantly, but eventually enthusiastically with the case management as well as the psychotherapy, and in this case some psychopharmacology to help him sleep. He was still having nightmares of the war.

With that treatment, he was able to manage his mood better when medically ill, and he successfully underwent a subsequent surgery without that excess disability caused by depression. Furthermore, as a result of speaking in psychotherapy about his war experiences for the first time ever, he began to also share these with his family.

None of his family members were previously aware of any of the details of his military service, and this newfound capacity for communication was tremendously appreciated by both the veteran and the family.

What does the success of the UPBEAT program tell us about outpatient case management programs? UPBEAT is a non-institutional program that reduces institutional care and reduces total cost of care. These findings are similar to other studies that find case management of these high risk geriatric patients can forestall a nursing home admission or other institutional care use and be cost effective.

Key elements of successful programs are: interdisciplinary teams, readily accessible primary care, home-based care, adult day health care, the things my panel members have described, integration of mental health treatment, case management to coordinate that optimal utilization of the health care system, and careful targeting of the patients to identify those most at risk for institutional care and most likely to benefit from such programming.

Patients with dementia require additional services including travel and caregiver support. The ultimate success of these programs will rely on appropriate case loads for clinicians and case managers, and I really want to second Tom's noting on how large the case loads are getting for the clinicians these days, and clear program goals and performance measures for clinicians and administrators.

In closing, I have felt very blessed to work with elderly veterans and very grateful for that opportunity. I am also grateful for the opportunity to speak with you today. Thank you.

[The prepared statement of Ms. Moye follows:]

PREPARED STATEMENT OF JENNIFER MOYE, PH.D., DIRECTOR OF THE GERIATRIC MENTAL HEALTH/UPBEAT, BROCKTON VA MEDICAL CENTER, AND ASSOCIATE PROFESSOR OF PSYCHOLOGY, DEPARTMENT OF PSYCHIATRY, HARVARD MEDICAL SCHOOL

Mr. Chairman and Members of the Committee:

My name is Jennifer Moye. I am the Director of the Geriatric Mental Health/UPBEAT clinic at the Boston VA, Brockton Campus, and an Assistant Professor of Psychology in the Department of Psychiatry at Harvard Medical School. I am pleased to testify today on the Unified Psychogeriatric Biopsychosocial Evaluation and Treatment (UPBEAT) program.

REVIEW OF UPBEAT MODEL

I have worked as a psychologist with medically and neurologically frail older veterans with late onset mental health concerns for the past ten years, and I speak today as a clinician. Our clinic was founded in 1995 as part of a nine site clinical demonstration project that evaluated the effectiveness of intensive outpatient case management and mental health treatment for elderly veterans with previously undiagnosed mental health problems in the context of serious medical illness. The program is based on previous research demonstrating: 1) mental health problems are under diagnosed and inadequately treated in the elderly; 2) elderly who have depression or other mental health problems have more complex medical management, a more complicated recovery from illness, and are more expensive for the health care system.

UPBEAT COST SAVINGS

In the UPBEAT program, patients 60 years and older admitted to medical or surgical inpatient services were screened for depression, anxiety, or alcohol abuse. 1,687 veterans with these problems were randomly assigned to a treatment versus usual care group. The treatment group received interdisciplinary assessment followed by outpatient care coordination and mental health intervention. In the year following enrollment, veterans in the treatment group had higher utilization of outpatient care, especially mental health and telephone encounters, costing $1,171 more per patient per year, than the usual care group. However this expanded outpatient cost was more than made up for by savings in inpatient costs of $3,027, resulting in a net savings of $1,856 per patient per year, or a total savings for all patients enrolled in the treatment group of approximately $1.5 million dollars. Savings were attributable to a reduced length of stay when re-hospitalized. Savings were even greater in targeted subgroups, such as those with circulatory diseases or more significant depression, estimated at $5,000 per patient per year. Additional analyses are ongoing.

UPBEAT CLINICAL EXAMPLE

One veteran in the UPBEAT program was enrolled at our site when he was surgically hospitalized and screened positive for depression. The depression was triggered in part because the current surgery was reminiscent of the eight surgeries he received in 1945 after being injured by shrapnel in World War II. This veteran participated in six combat jumps as a paratrooper in Africa, Italy, France, and Germany, including the Battle of the Bulge, and the Anzio and Normandy invasions during which time he received the Bronze Star. Late in life when confronted with illness and vulnerability, he became overwhelmed with depression, to the point of remaining in bed constantly, compromising his health. He entered our program at the age of 75, participating at first reluctantly, then enthusiastically in case management and individual psychotherapy with psychopharmacology. With treatment he was able to manage his mood better when medically ill, and he successfully underwent a subsequent surgery without the excess disability caused by depression. Furthermore, as a result of speaking about his war experiences for the first time in psychotherapy, he began to also share these with his family. None of his family members were previously aware of any details of his military service. This newly found capacity for such communication was tremendously appreciated by both the veteran and his family.

ESSENTIALS OF CASE MANAGEMENT FOR AT-RISK VETERANS

What does the success of the UPBEAT program tell us about outpatient based case management programs? UPBEAT is a non-institutional program that reduces institutional care and reduces total cost of care. These findings are similar to other studies that find case management of at-risk geriatric patients can forestall nursing home admission. Key elements of these programs are:

1) interdisciplinary teams;
2) readily accessible primary medical care;
3) home based care and support when indicated;
4) integration of mental health treatment;
5) case management to coordinate optimal utilization of the health care system; and
6) careful targeting of patients and interventions to identify those patients most at-risk for institutional care and most likely to benefit from such programming.

Patients with dementia require additional services including travel, caregiver support such as respite care, and adult day health care. The ultimate success of such programs will rely on appropriate caseloads for primary care clinicians and case managers, clear program goals, and performance measures for clinicians and administrators.

In closing, I have been most grateful to work with our elderly veterans, and I thank you for the opportunity to speak before you today.

ATTACHMENT

Kominski, G., et al (2001). UPBEAT: The impact of a psychogeriatric intervention at VA Medical Centers. Medical Care, 39, 500–512.*

Chairman ROCKEFELLER. Thank you, Dr. Moye. A little off-the-wall question here. None of you have particularly talked about—you, I think, Ms. Dickerson talked about savings—none of you have talked about the problem of resources that I assume VA would care to bring forward, and I am wondering if that has anything to do with the fact that some of you were told not to bring up the subject of resources by the VA?

Ms. DICKERSON. Particularly in my case, resources are readily available. Alan Harper in North Texas Health Care System is a very believer of HBPC, and he has seen the things that we have done. So we have been able to get the resources. What we did was that he transferred a lot of the nursing staff from the inpatient to the outpatient.

Chairman ROCKEFELLER. You found a way?

Ms. DICKERSON. Yes, we found a way.

Chairman ROCKEFELLER. And you found a way without fundamentally compromising the health care of others?

Ms. DICKERSON. Yes.

Chairman ROCKEFELLER. Because you cared to take the initiative?

Ms. DICKERSON. Yes. So we have transferred from inpatient occupational therapists, physical therapists, dieticians, social workers and nurses. We even have a physician and a physician's assistant that was transferred from other places in the hospital.

Chairman ROCKEFELLER. But it would be easy, it seems to me, for VA to come forward and say, well, we cannot do this because we do not have the budget that we have. I mean that is what Senator Graham and I say every year, and that is what VA says every year, and we are all right every year, and so they could come forward and say that.

And what you are saying is, yes, they can come forward and say that, but you, Ms. Dickerson, were able to undertake something without compromising the health care and other critical areas for the same population of veterans that we are all talking about and do just exactly what the long-term care law required.

[*The information referred to has been retained in the committee's files.]

Ms. DICKERSON. That is exactly right. We also maintained a $22 per day per patient for the last 5 years, so the cost has not increased.

Chairman ROCKEFELLER. And you also, as I think you indicated, know that as time goes on, you will be saving more money?

Ms. DICKERSON. Yes. We have also increased our patient load to over 200 patients.

Chairman ROCKEFELLER. So the patient load has gone up, the money can be handled, and the resources are not an excuse?

Ms. DICKERSON. Yes.

Chairman ROCKEFELLER. Anybody else wish to comment?

Ms. MOYE. I just wanted to comment on the issue I want people to appreciate the complexity of the older patients. As the GAO reported, we are seeing this tripling in the over 85-year-old veteran, and these are veterans who are already expensive to the health care system, and we are saying let us spend more money on them, so I cannot speak to fiscal issues. I am a clinician, but I want to emphasize how very, very complex these patients are, how they require more time to work in a preventative fashion.

Our primary care clinicians currently have case loads of 1,200 patients. We have a waiting list of about 500 patients. I know you have heard these things. That may be appropriate if you are working in an HMO setting and you have lots of young adults who you see once a year, but when you have very complicated 85-year old patients, we really need to look at the issue of directing resources to those needs.

Chairman ROCKEFELLER. And I do understand that, but Ms. Hemmings, who looks like she wants to say something, I want to say to you that one of the things I certainly remember about my mother in talking about complexities with older people is that particularly in Alzheimer's you go through stages where there is an enormous amount of violence, an enormous amount of just sort of following people around houses or outdoors or down streets. You are not quite sure where they are going to go.

They hit, they throw food, they scratch at certain points and they stop, and they will take it up again. Often a single caregiver if the person is larger in size cannot transport that person to a bathroom, for example, or to a tub, and so what Dr. Moye says becomes even more true, and that is that it is indeed very complex, and in your field and in others manifestly complex and yet you have handled it?

Ms. HEMMINGS. Well, I think the way it is handled, too, is that we all talked about having some form of case management, and I think that is really one of the real issues that we have used. The nurse or the social worker, depending on what site she is at, works with whatever level that patient is at. The issue is to try and identify it early and through some of the other medications and also give us a time to educate the family how to deal with some of these behaviors.

If you learn how to do some diversional therapy and some of the other things that are going to be coming up, you can also handle the patient better at home, but it also gives us much more time to work with the Alzheimer's Association to set up support systems for the family. The caregiver really needs a lot of support, and so

while we are supporting the medical needs of the veteran, the Alzheimer's Association provides support from the community in terms of helping the caregiver, who is usually a wife, cope with these things that are going on, learn more skills and then we from the VA will offer, respite care will offer homemaker home health aide.

So you are really combining the best of both worlds, because a veteran is not just a veteran. He is a member of a community, and his family is part of the community. So there is a lot of other community services that can be called upon to help with this relief and the support when it occurs. But I think the initial part of helping to educate—that is why it is so important to identify it early—helps the family then cope when it becomes more difficult. But then rely on things like home-based primary care when it becomes more difficult for the family, and eventually sometimes the patients are not able to stay at home anymore.

And then we use our VA nursing home, but in the meantime we have kept them out in the community with their loved ones as long as we possibly can and I think that is what really makes a big difference is that partnering.

Chairman ROCKEFELLER. If Senator Graham will forgive me, I just want to ask one more question to Tom McClure feeding off of what Dr. Moye said, and that is that the amazing complexity as people get to be 85 or older, and sometimes younger than that, and that is, you know, that is like saying that rain is wet. I mean that is inevitable.

I am not trying to play doctor here, but that is the fact, when you get to be that age, because there is an enormous range of things that work together and then some manifest themselves more than others. Some fit under the category of Parkinson's, Alzheimer's, dementias, mental depression, schizophrenia, stroke. But, I accept what you say, but that is manifestly true across all fields of medicine, I would think.

And so I would like to get your response, Tom McClure, to this general situation of resources and we just do not have the money to do this.

Mr. MCCLURE. Well, those eight service connected veterans that are 70 percent and above that are on my program, that is saving our hospital director about $320,000 a year. My budget is $95,000. That is not to speak of the VERA allocation on managing the medically complex patient of about 40 patients. I know that is not generating actual revenue, but it is bringing revenue into the VISN. But that is another good point about this, and we are managing medically complex patients.

Chairman ROCKEFELLER. And saving money?

Mr. MCCLURE. And I think the other thing to look at in a global view. Instead of just looking at the VA budget, if we can take veterans and place them in foster homes with that partnership, rather than into a nursing home, you know we are saving our national budget by managing them with a cost-effective program, not to speak of the VA budget. And I think we must look at the entire budget of this nation in planning these.

Chairman ROCKEFELLER. Thank you, sir. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. Again, thank you for holding this hearing. One of the observations that has been

made about these long-term care services, particularly the non-institutional services, is that they are uneven across the VA system.

Ms. Dickerson, you just gave a very persuasive statement about what you are doing in the Dallas area, as have each of you in your own particular VA centers. Why is not what you just described in Dallas or in Little Rock or among the Alzheimer's patients or among the geriatric mental health, why is that not the norm in VA as opposed to the exception?

Ms. HEMMINGS. I can answer in terms of the Alzheimer's project. I think we were the pilot for the VA, and so we have given this information in the beginning to everyone in long-term care via teleconference, and when the project is——

Senator GRAHAM. When did you provide that information?

Ms. HEMMINGS. Well, we told them we started the project when we did in like 1997. We are having an evaluation finishing up this year, and then we will go back to everyone with the results of the project. We are in the middle of something, so you kind of do not say it is successful until you finish it, but I think we are always trying to keep people informed of what we are doing. So some of this might be related to the fact that you are in the middle of doing a project.

Ms. DICKERSON. In my case, I do believe that these types of programs will be successful all over the Nation once they realize that the resources, you do not have to hire a lot of people to do this, you just need to transfer around, move people around from the inpatient to outpatient if that is possible in other facilities as it was in our facility, because that is simply what we did.

Senator GRAHAM. You say whether it is possible to move from inpatient institutional care to at-home community care. Is that a constraint of physical facilities of people or what are the limitations on making that transition?

Ms. DICKERSON. There should not be any. There should not be any limitations on moving people around where they are needed and what is most cost effective and what is better for patient care.

Senator GRAHAM. Mr. McClure, what about in the area of foster care?

Mr. MCCLURE. Foster care, of course, I placed my first veteran in a foster home in 1987 on an informal basis because I did not have alternatives. But the VA in which I work for the central office funded this program in the year of 2000 as a pilot project and we just completed that. Our director, as I said, has already put it in his budget, and I think now it is time to act, and this is my own personal opinion and not that of the VA, but this program should go nationwide and immediately.

Senator GRAHAM. Well, I agree with you, not only because it is humane, but also you made the case that it is cost effective, but even more fundamentally the people who are our particular concerns, the veterans of America, they did not defend Little Rock, they defended the United States of America, and there ought to be an expectation of an evenness of service whether you live in the far Northwest or the far Southeast of the United States. We have a national system, and it ought to be a national system in terms of benefits readily available.

Mr. MCCLURE. And I do expect that.

Senator GRAHAM. Dr. Moye, as you were describing your program, I was struck with the fact that while you have been conducting you say nine areas that you have centers that you have been doing your pilot work?

Ms. MOYE. It was at nine VA medical centers, yes.

Senator GRAHAM. That this is not an issue that is peculiar to America's veteran population. If you saw the front page of today's Washington Post, there is an article that the President has indicated that next week he is going to make an announcement in support of parity for mental health treatment.

To what degree is the information that you have gathered in your research applicable to the general American older population, and to what degree is it peculiarly relevant to the veteran population?

Ms. MOYE. That is a wonderful question. We know that mental health problems are underdiagnosed and undertreated in the current cohort of all older adults. For the reason I just suggested, I think there are stigma issues, there is lack of familiarity with, "OK, this is what depression looks like, and when I have it I need to share it with my physician, I need to get some treatment for it."

However, I think the problem may be somewhat worse in the veteran population. I think we do a good job of identifying and treating serious mental illness such as schizophrenia, but not these sort of low level, but clinically significant, depression, anxiety, oftentimes related to war experiences. We did a survey in our outpatient clinics. We interviewed veterans waiting to see their doctors who were not in mental health treatment. 40 percent had a combat trauma history; 15 percent were to this day having problems with intrusive memories and nightmares.

So I think when those things are also lurking and coming into the picture and then suddenly you are having illness and vulnerability and maybe a heart bypass surgery, that strains your coping resources and may make it more likely that you have some mental health issues arise.

Senator GRAHAM. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman, and I apologize. I had to go back and forth, and I missed your testimony, and Perry Lange was just giving me a summary of some of what you said, I think, and then I just was hearing Senator Graham's question of mental health.

First of all, I want to thank you. I think really, you know, you kind of light a candle and you show what we can do at the community level, and I guess the only obvious question, and I gather you maybe touched on some of this, is whether or not you have received the kind of support that you would like to have from the existing VA system, and if not, where do we need to fill the gaps here, and if so, in what ways? That is, I think, my only question, you know, asking for as honest an answer as possible.

I mean you should know what can be done. The question is are you getting the support from the existing VA system as is or not, and if not, you know, we do not have to get into acrimony, but where are the gaps? What do we need to start doing to make this

happen throughout the VA system in the United States of America?

Ms. HEMMINGS. Well, related to the Alzheimer's project, we received support by having us join the National Chronic Care Consortium, so we have been under support all along for this project, and then with our contacts with headquarters, when this is done, we will use that support to roll it out. So I think from that perspective, we have always had the support of headquarters in this project, because it has been something that we have identified as a real population need in our veteran population. And then the programs already exist in the VA. So that supported the types of home care that we needed.

Ms. DICKERSON. I feel in Dallas we have received the kind of support that we needed. When we wanted to start a Senior Companion Program, we were given the go-ahead to start a Senior Companion Program. We have 33 senior companions that, you know, this gives the seniors an opportunity to do a great service to stay with the veteran while the wife has a little respite.

We have also been able to start many other programs. The telemedicine program, we received the support to start that, and that just broke through all distances. We can go 100 miles or 10 miles.

Senator WELLSTONE. What are the critical elements of the support so that we can try to make these models be more and kind of apply system wide?

Ms. DICKERSON. I think system wide, the most important thing was you needed nursing service support. If you do not have the nurses who are the case managers, then your program cannot grow. So we had tremendous nursing service support. They closed beds in the hospital that were being underutilized and moved those resources to outpatient facilities, and then, of course, the director has to support what the nursing service chief wants, but I think the nursing service support was one of the biggest things that we had in Dallas.

Mr. MCCLURE. I would like to add to that I worked for 9 years as a social worker with the HBPC program. I used every resource I could find to keep them at home, and there is a point in time when these veterans have to be removed. We can at least keep them in a family setting-HBPC and foster care. Our caregivers are ill and exhausted, and I feel like we need at least to attach a foster home program to each one of our HBPC programs in the Nation.

Mrs. Dickerson, it is a wonderful program, they keep veterans at home as long as possible, but you can hire all the aides, have all the nurses that you can get, but there is a period of time where our veterans require 24-hour supervision. In Little Rock, I am taking those patients when HBPC cannot maintain them any longer, placing them in a capable foster home with the VA support, and we are managing them until they die.

Ms. MOYE. I spoke in my testimony about performance measures for clinicians, and one of the things that has been concerning for me is sort of, if I can come back to case load, sort of a blunt instrument about case loads, that we are under tremendous pressures to see as many patients as possible. And folks look at just absolute number of patients, and I wonder if it might be possible to develop some sophistication in this such as is done in chronic psychiatry

where patients are described as maybe sustaining, moderate, intense and end of life, and if you are working in the intense or end of life area, then your case load expectation would be lower to accommodate that, because we know it would pay off in the end, and it would be what the veterans want.

But it is hard to do that when the main pressure you are getting is see more people more quickly, you know, the absolute number of patients you see is the performance measure by which I am judged.

Ms. HEMMINGS. Can I just make one other comment? It is not related to VA support, but I think as a part of what realistically what is happening and why some things cannot be done. I run the total geriatric program in upstate New York, and from that perspective, sometimes it is not just what is available in the community, and the other piece in terms of trying to do some of these programs is the issue of getting health care workers.

It is not the money from the VA. It is what is available out in the community, and I think most of us that are in health care today are finding it more difficult to find the health care workers and the support that we need because people are not going into health care. So sometimes you cannot implement something you really want to implement just because the resources in the community are not there in which to pull from, and that is becoming extremely difficult for everyone in health care these days.

I think that is another piece of it that has to be looked at, because we are part of the community and we buy some of our services from the community, and it is very difficult. People want to do everything else but be a health care worker these days.

Senator WELLSTONE. Thank you.

Chairman ROCKEFELLER. Thank you, Senator Wellstone. I have other questions I want to ask, but I think in view of time constraints that I cannot or at least, I will not. And I want to point out that each of the four of you have made an enormous contribution. You have come from various distances, and you have made a great contribution to this, and you have raised the bar, I think, for our next witness, and for all of us.

Ingenuity is what has always separated invention, the willingness to not fear that if you try to do something which is new, and you work for some government bureaucracy, that you are not going to be retaliated upon.

And, fortunately, there are people who exercise that sense of ingenuity and risk taking. You might call it a model. You might call it a pilot or whatever. Nevertheless, you all are doing extraordinary things and helping people and loving it, and wanting to see it done for everybody. So I thank you all very, very much for taking your time to come.

Ms. HEMMINGS. Thank you.

Chairman ROCKEFELLER. Our final panel today includes Dr. Robert Roswell, who is the newly, and I need to say that, the newly confirmed Under Secretary for Health. He is accompanied by Marsha Goodwin, who is the Acting Chief Consultant for VA Geriatrics.

As I indicated earlier in the hearing, I broke with the usual protocol, to have Dr. Roswell not be the first but the last witness, and I wanted him to be able to listen to the testimony, both positive

and less than positive, so that we can talk about VA and what is the most vulnerable veteran segment in the future. So, Dr. Roswell, welcome back. I am very glad you are here, and we look forward to your statement.

STATEMENT OF ROBERT ROSWELL, M.D., UNDER SECRETARY OF HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MARSHA E. GOODWIN, R.N., M.S.N., ACTING CHIEF CONSULTANT, GERIATRICS AND EXTENDED CARE, AND DIRECTOR, GERIATRICS PROGRAM, DEPARTMENT OF VETERANS AFFAIRS

Dr. ROSWELL. Well, thank you, Mr. Chairman. It is a privilege to appear before you as the Under Secretary for Health, and I appreciate your support in facilitating my confirmation. Mr. Chairman, Senator Wellstone, it is a pleasure to be here, and I want to thank both of you for calling attention to what I truly believe is a tremendous problem that we simply must do a better job in facing, and I salute you for your efforts in convening this hearing.

You talked about deviations, and to allow a dialog I will not be making a formal statement, although I would ask that my statement by included in the record.

Chairman ROCKEFELLER. It will be done.

Dr. ROSWELL. I have several concerns. You asked about OMB. The interim rules for the three services that were specified were actually published last year. The final rule will be published in the Federal Register next week, so admittedly this is too long, but those rules will be published very shortly, and we will have that implemented.

I think this morning we have seen some truly wonderful examples, not only of compassion and commitment to the needs of veterans, but also in innovation in how we meet those needs. The four examples we have just heard are heart-wrenching really because there is such a great need, and there are many other examples as well throughout the country, tremendous innovation across our system.

It is clear that we need a full continuum of services to meet the broad range of long-term care needs of America's veterans. Just as no two patients are alike, no two set of circumstances associated with long-term care are alike, and it is important that we maintain a full continuum of care, and nurture innovation in meeting and developing a full continuum of care.

The cost of care per patient per year in long-term care services can vary from as much as $140,000 a year per patient in a VA staff nursing home bed to as little as $2,500 a year for home care programs using interactive technology.

The Millennium Health Care bill focuses on our need to provide that long-term care, but with all due respect, Mr. Chairman, the one capacity that is measured is the most costly on that continuum, and that is the institutional long-term care, at an average cost of $140,000 per patient per year when the average cost of non-institutional care is only $10,000 per patient per year, meaning that we could serve 14 patients in a non-institutional setting for the cost of one patient in an institutional setting, and yet the Mil bill man-

dates that we maintain our 1998 VA staff nursing home capacity at historical levels.

We have submitted from the department a request for legislation that would ask you to consider looking at the three levels of VA nursing home care—VA staffed nursing home care, state nursing home beds, and contract community nursing home beds—in meeting that obligation for commitment.

I think that truly the most important part of this is making sure that we can deploy the resources in a way that meets the broad needs of our veterans. There are concerns now with tremendous growth in the users in our system, lengthy waiting times for access to care, and a statutory requirement which admittedly we have not yet complied with, but hope to comply with by 2004 to maintain the VA staff nursing home bed capacity.

Those are the constraints that cause competition for the dollars. The 2003 budget request submitted earlier this year, however, would provide over $100 million for additional long-term care services and would add staff to the 75 Home Based Primary Care Programs like the ones Gladys Dickerson spoke of throughout the country.

It would also add 30 additional of those programs so we are committed to long-term care. We are committed to innovation. We are looking at ways to provide the needs in new and less costly ways, but more importantly that meet the needs of the veterans in a less restrictive environment that allow better quality of life and greater functional independence.

I would be happy to answer any questions you might have.

[The prepared statement of Dr. Roswell follows:]

PREPARED STATEMENT OF ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee:

Thank you for inviting me to discuss non-institutional alternatives to long-term care provided by the Department of Veterans Affairs (VA).

VA has a long history of providing high quality geriatric and extended care to chronically ill elderly veterans and is nationally recognized as a leader and innovator in the care of older persons. Today one of our greatest challenges is to find ways to meet the increasing demand for extended care services in the most appropriate settings and within available resources.

As you know, veterans prefer to receive care in their homes and communities when it is possible to do so. These programs are highly cost effective in comparison to institutional care and allow VA to provide care to a greater number of veterans than would be possible through increased reliance on institutional programs. However, our ability to expand these programs may be impacted by the interaction between competing requirements.

VETERANS MILLENNIUM HEALTH CARE AND BENEFITS ACT

Since Public Law 106–117, the Veterans Millennium Health Care and Benefits Act, became effective in November 1999, VA has focused on implementation of the extended care provisions of that law. To date, the following provisions have been implemented:

- Mandatory nursing home care for veterans rated 70% service-connected and above and for any service-connected veteran who needs nursing home care for a service-connected disability;
- Three pilot programs evaluating different models of all-inclusive care for the elderly (VA as sole provider, at the Dayton VAMC; VA/community partnership, at the Denver VAMC; and VA as care coordinator, at the Columbia, SC, VAMC); and
- An assisted living pilot initiated in VISN 20 at all VA facilities in Alaska, Washington, Oregon, and Idaho.

VA anticipates publication of final regulations on the medical benefits package and co-payments for extended care next week. The regulations—to be effective 30 days from the date of publication—add three non-institutional extended care services, outpatient geriatric evaluation, adult day health care, and respite care, to VA's standard benefits package. Other important extended care services, e.g., home care, hospice/palliative care, and inpatient respite care, were already in VA's standard benefits package. Also last October the Veterans Health Administration (VHA) issued a policy directive requiring provision of these non-institutional services. Access to these services is not currently uniform throughout the VA system, but work is ongoing to determine what barriers to access exist and to develop plans for addressing these barriers.

The requirement to maintain staffing and level of extended care services in VA facilities no lower than the 1998 level is being met for non-institutional care (VA home-based primary care and VA adult day health care) but not for institutional care (VA nursing home care and VA domiciliary). Plans are in place to be in full compliance by 2004. The Administration has recently proposed legislation to implement the President's FY 2003 Budget that would revise the requirement for maintaining levels of extended-care services to veterans.

VA LONG TERM CARE STRATEGY

As the VA health care system has redefined itself in the last six years as a "health care" system instead of a "hospital" system, VA's approach to extended care has further evolved from an institutionally-focused care model to one that includes a complete continuum of home and community-based extended care services in addition to nursing home care.

In its 1998 report, VA Long Term Care at the Crossroads, the Federal Advisory Committee on the Future of Long-Term Care in VA, made 20 recommendations and 4 related suggestions on the operation and future of VA long term care services. These recommendations served as the foundation for VHA's national strategy to revitalize and re-engineer long term care services. One of the major recommendations of the Committee was that VA should expand home and community-based care while retaining its three nursing home programs (VA, contract community, and State home).

VA is making progress on that strategy. Between 1997 and 2001, VHA average daily census (ADC) in home and community-based care increased from 11,500 to 16,150. VHA has a Budget Performance Measure calling for an ambitious 34 percent increase in the number of veterans receiving home and community-based care compared to FY 2001. We plan continued increases each year to achieve a level of 34,500 ADC in home and community-based programs in FY 2006. To achieve these goals, we will expand both the services VA provides directly and those we purchase from affiliates and community partners. We will meet most of the new need for long-term care through home health care, adult day health care, respite, and homemaker/home health aide services.

The piloting and evaluation of new models of care will be important. One example you have heard about today is VA's Advances in Home-Based Primary Care for End of Life in Advancing Dementia (AHEAD) quality improvement project, which was initiated in 2001 with 20 VA teams from 15 networks. AHEAD II is now underway to include a wider variety of primary care settings that serve community-dwelling veterans with dementia.

VA also must explore utilization of new technologies, such as telemedicine, to expand care of veterans in the home and other community settings. We have shown that by using interactive technology to coordinate care and monitor veterans in the home environment, we are able to significantly reduce hospitalizations, emergency room visits, and prescription drug requirements, while improving patient satisfaction with the care they receive. Use of technology not only reduces the need for institutional long-term care, but also provides veterans with a more rewarding quality of life and greater functional independence. For example, in FY 2000 VISN 8 developed an innovative alternative to institutional care known as the Community Care Coordination Service (CCCS). CCCS provides care coordination of groups of clinically complex, high cost, chronically ill patients. With the use of technology, CCCS has improved their quality of life and their perceived functional status, thus allowing them to remain both independent and at home. A recent survey of these patients showed that 41 percent would be in a nursing home if not for enrollment in this program. An Odds Ratio Analysis has shown that these patients were 77.7 percent less likely to be admitted to a nursing home than a similar group that did not participate in the program. The innovative use of technology has also improved communication and clinical relationships with the State veterans domiciliary in Lake City,

FL, and has increased access to assisted living facilities. A care coordinator has become the primary communication link between the domiciliary and the local VA medical center. This enhanced communication has reduced unscheduled clinic visits by veterans in the State home by 29 percent.

To the extent that we can do so within the existing programmatic resources, VA's plans for long-term care are as follows:

- achieve an integrated care management system that incorporates all of the patient's clinical care needs;
- provide more care in home and community-based settings as opposed to inpatient settings, when appropriate;
- achieve greater consistency in access to and quality of care provided in all settings;
- achieve greater consistency across the system in assessing patients for extended care and in managing care, including post institutional care;
- continue to emphasize VHA research and educational initiatives that will improve delivery of services and outcomes for VA's elderly veteran patients; and
- continue to develop new models of care for diseases and conditions that are prevalent among elderly veterans. You have heard testimony today about VISN 2's participation in one such initiative to find better ways of caring for veterans with severe dementia. To help find better ways of caring for these veterans, VHA is participating in a multi-site demonstration project on Alzheimer's disease and care management, which is co-sponsored by the Alzheimer's Association and the National Chronic Care Consortium (NCCC).

CONCLUSION

VA has made considerable progress toward organizing a geriatrics and LTC system that can respond to shifts in demand and to changes in local healthcare market characteristics, and provide seamless care. We have launched major national initiatives to improve end-of-life care and pain management for veteran patients. We are in the process of implementing an aggressive home- and community-based care strategy.

Mr. Chairman, this concludes my prepared remarks. For information purposes, I have included two attachments to my statement. The first addresses veteran demographics and population projections; the second discusses VA's geriatric and extended care programs. I will now be happy to address any questions that you and other members of the Committee might have.

ATTACHMENT A.—VETERAN DEMOGRAPHICS AND POPULATION PROJECTIONS

Between 2000 and 2010, the veteran population is currently projected to decline by 17.7 percent (from 24.3 to 20.0 million). However, this projection may change due to the current armed conflicts. Over the same time period, the percent of veterans over the age of 65 will decline only by 9 percent (from 9.3 million to 8.5 million), while those 75 and older will increase 12 percent (from 4 to 4.5 million), and those over 85 will increase by 208 percent (from 422,000 to 1.3 million). To continue to provide the appropriate and needed service to veterans, this "demographic imperative" must be addressed.

At present, about 38 percent of the veteran population is over 65, compared to about 13 percent of the total U.S. population. Over 51 percent of veterans who have service-connected disabilities or are poor are over 65. The number of veterans over age 65 peaked at 9.3 million in the year 2000, when 66 percent of all American males aged 65 and over were veterans. A second but smaller peak is expected to occur in 2015, with the aging of Vietnam-era veterans. The projected peak in the number of elderly veterans during the first decade of the 21st century is well in advance of the general United States population (which is expected to peak in the year 2030). This is one of the driving forces behind VHA's current efforts to find high quality, affordable extended care solutions for meeting the needs and preferences of veterans.

The most vulnerable of our older veteran population, those over 75 and particularly those over 85, will continue to increase into the next decade. This is notable since these persons are especially likely to require institutional care and to need healthcare of all types. Also of importance is the fact that current VA patients, compared to the general population, are not only older, but they also generally have lower incomes and no health insurance, and they are much more likely to be disabled and unable to work. While it is important to maintain our nursing home capacity to serve the post-acute rehabilitation, respite, geriatric evaluation and hospice/palliative care needs of older, chronically disabled veterans, it is equally impor-

tant to expand our home and community-based extended care options wherever possible and appropriate.

ATTACHMENT B.—CURRENT VHA GERIATRIC AND EXTENDED CARE PROGRAMS

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

State Veterans Homes. A significant part of VHA's long term care strategy is effected through one of the longest existing Federal-State partnerships, the State Home Grant program. Through this program, the Department provides grants to states for the construction and support of state veterans homes to provide long term care for frail, elderly veterans. The construction grant program provides up to 65% federal funding to states to assist in the cost of construction of new nursing home and domiciliary facilities, or expansion or remodeling of existing facilities. VA's per diem program, part of the Medical Care account, assists states in providing domiciliary and nursing home care for veterans through partial payment of per diem costs. Most recently, regulations have been published on per diem payments for provision of adult day health care in State homes. In FY 2001, over 16,000 veterans on any given day were provided nursing home care in state veterans homes. While this program dates back to the post-Civil War era, it has grown dramatically over the past 10 years. The state home program substantially augments VHA's capacity to provide a continuous residence for veterans in need of long term care, especially for veterans in rural areas.

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

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

Geriatric primary care clinics have been expanding in VHA over the past few years with the move from inpatient to outpatient care and expansion of primary care throughout the system. These clinics provide geriatric evaluation services and on-going primary care for geriatric patients.

Nursing Home Care Units (NHCUs). VA nursing homes provide skilled nursing and related medical services through an interdisciplinary approach to meeting the multiple physical, social, psychological and spiritual needs of patients. Most also provide sub-acute and post-acute care. In general, these units are co-located with or are an integral part of the VA medical center. In FY 2001, 41,934 veterans received care in VA's 135 NHCUs.

Community Nursing Home Care. VHA contracts with approximately 2,800 community nursing homes to provide nursing home care for veterans making a transition from the hospital to the community. Each community nursing home is evaluated and inspected by VHA staff prior to selection as a contract facility, and VHA staff provides follow-up visits to assess the progress of veterans admitted to the facility and to monitor the overall quality of care.

In order to improve access to community nursing homes and reduce the administrative cost associated with maintaining hundreds of individual contracts, VHA has recently developed contracts with multi-state nursing home providers. In 1996, six multi-state contracts and one single-state contract were awarded to corporations for quality community nursing home care in 1,053 facilities. These seven contracts together span 43 states and added nearly 600 nursing homes to VHA's existing contract community nursing home program. Since 2000, VA has 11 Regional Contracts

(replaced multi-state), which include 8,000 facilities. In 2001, nearly 28,800 veterans were treated in community nursing homes at VA expense.

Adult Day Health Care (ADHC). This therapeutically oriented program provides health maintenance and rehabilitation services to veterans in a congregate, outpatient setting. VHA operates 14 ADHC programs, which had an average daily attendance of 446 patients in FY 2001. VA also contracts with an estimated 480 non-VA agencies for ADHC, which provided services to an average of 804 veterans each day in FY 2001. The contract program has been established by 66 VA facilities.

Alzheimer and Other Dementia Care Programs. Approximately 52 VA medical centers have developed specialized programs for the care of veterans with dementia. These programs include inpatient and outpatient dementia diagnostic programs, behavior management programs, adapted work therapy programs for patients with early to mid stage dementia, Alzheimer's special care units within VA nursing homes and transitional care units, and a model inpatient palliative care program for patients with late stage dementia. Programs for family caregivers of dementia patients include support groups and caregiver education, as well as respite and adult day health care services for the patient that allow "free time" for the caregiver. Many of these specialized programs for patients with dementia have been developed by VHA's Geriatric Research, Education and Clinical Centers (GRECCs). Seven of the current 21 GRECCs have a primary or secondary focus on Alzheimer's disease and related dementias. These GRECCs have made significant contributions to both the scientific understanding of dementia and improved models of care for dementia patients.

Home-Based Primary Care. This program is operated at 75 VA facilities across the country to provide in-home primary medical care to home-bound veterans with chronic diseases, as well as to patients with a terminal illness. The patient's family provides the necessary personal care under the coordinated supervision of an interdisciplinary treatment team based at the VA facility. The team plans and provides for the needed medical, nursing, social, rehabilitation, and dietetic regimens and trains family members and the patient in supportive care. In FY 2001, comprehensive primary care was provided in the home by VHA staff to an average of 7,803 patients on any given day.

Contract Home Health Care. VHA also arranges with community home health agencies to provide skilled home care services for veterans. Under this program, VA pays a per-visit rate to the agency providing the service, similar to what is done under the Medicare program. In FY 2001, 3,273 veterans were provided these services on any given day.

Domiciliary Care. Domiciliary care is provided in VA domiciliaries, as well as State homes. VA domiciliaries provided care to 24,931 in FY 2001. Nearly 5,000 of those veterans were homeless and admitted for specialized care. In addition to services for the homeless, the domiciliary provides other specialized programs to facilitate the rehabilitation of patients who suffer from head trauma, stroke, mental illness, alcoholism, early dementia, and a number of other disabling conditions. Although the average age of veterans overall in VA domiciliaries is 59 years (43 years for those in the homeless program), increased attention is being focused on older veterans who reside in VA domiciliaries. For example, elderly domiciliary patients are encouraged to become involved with programs in the community such as senior centers and Foster Grandparents. These activities have facilitated continued community involvement as well as reintegration into the community. Many of the domiciliaries in state veterans homes provide similar services, although patients in the state home domiciliaries tend to be older. In FY 2001, 47 State Veterans Home domiciliaries in 33 states served more than 6,400 veterans.

Community Residential Care/Assisted Living. This program provides room, board, personal care, and general health supervision for veterans who, because of health conditions, are not able to live independently and have no suitable family or social support system to provide needed care. A multidisciplinary team of VHA staff inspects private homes that provide residential care/assisted living services prior to including the home in VHA's program and annually thereafter. Payment for services provided in a residential care home is the responsibility of the individual veteran. In FY 2001, 7,055 veterans received residential care on a daily basis in homes approved and monitored by VHA.

Homemaker/Home Health Aide (H/HHA). This program enables selected patients who meet the criteria for nursing home placement to remain at home through the provision of personal care services. The H/HHA services are purchased by VHA from public and private agencies in the community. Case management is provided directly by VHA staff. During FY 2001, 120 VA facilities purchased these services for approximately 3,824 veterans on any given day.

Respite Care. Another program that enables the chronically ill, disabled veteran to live at home longer than would be otherwise possible is respite care. This program is available at nearly all VA facilities and is designed to reduce the caregiving burden from the spouse or other caregiver by admitting the veteran to a VA hospital or nursing home for planned, brief periods, totaling no more than 30 days per year. During the inpatient stay, patients are also provided with evaluative and treatment services needed to maintain or improve functional status, thus prolonging the veteran's capacity to remain at home. A formal evaluation of this program, concluded in 1995, found a high level of satisfaction among family caregivers and a high level of enthusiasm for the program by VHA staff delivering the care. In FY 2001, nearly 700 veterans were receiving respite care on any given day. Home respite was authorized under P.L. 106–117 and programs have been initiated at a number of VA facilities, utilizing contract services and piloting the use of volunteers to provide the respite services.

Hospice/Palliative Care. A number of VA medical centers have an interdisciplinary hospice/palliative care consultation team that is responsible for planning, developing and arranging for the local provision of hospice care, directly by VA or through contract or referral to community programs. Hospice/palliative care programs offer pain management, symptom control, and other medical services to terminally ill veterans or veterans in the late stages or chronic disease process, as well as bereavement counseling and respite care to their families. System-wide education and training was provided in the early 1990's to facilitate the incorporation of hospice/palliative care concepts into each VA facility's approach to the care of veterans at the end of their lives. New education programs are being planned to reinforce the concepts for current staff. Approximately 42 percent of VA facilities have inpatient hospice/palliative beds but nearly 38 percent of facilities have neither inpatient beds nor consultative services. The majority of VA facilities refers or contracts for hospice services through community-based agencies. Hospice and palliative care initiatives are currently being intensified throughout VHA to improve end-of-life care for veterans. Specific strategies to increase the availability of these services to veteran patients are currently under development.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO ROBERT ROSWELL, MD

Question 1. Do you believe the VA should work with private home health care providers to meet its obligations to provide veterans with long term care opportunities?

Answer. Collaboration with private home health care agencies is integral to VA's success in meeting the home health and long-term care needs of veterans. Through the VA Community Health Nurse Coordinator program, VA works with private home health agencies in providing needed care to veterans. The majority of the effort in this program involves referrals by VA staff of those veterans who choose to use their Medicare eligibility to home health care (HHC) agencies. Additionally, VA maintains arrangements with over 500 HHC agencies for the provision of care at VA expense. In FY 2001, approximately 3,300 veterans were enrolled in skilled private HHC, and another 3,800 were enrolled in homemaker/home health aide services at VA expense on any given day.

Question 2. Without Medicare reimbursement, home health agencies cannot survive, despite an infusion of VA funds. How can we address the inequities in funding that may force many home health care providers to leave?

Answer. Home Care expenditures from all payers totaled $32 billion in FY 2000 (latest available data). In that year, private funds covered 47.8 percent of all HHC spending ($15.5 billion), and public, non-VA funds (Medicare and Medicaid) covered 51.9 percent ($16.8 billion). VA's expenditures of $108 million for skilled HHC and home health aide services in FY 2000 represent only 0.3 percent of home care spending. VA's current and planned efforts for purchasing home care services do not indicate a major presence in the marketplace. This Department has no opinion on the larger issues of Medicare reimbursement.

Question 3. Has the VA carefully considered access for all veterans, regardless of where they live, when developing options to nursing home care?

Answer. VA's planning model for long-term care (LTC) services, both nursing home (NHC) and home and community based care (H&CBC), is based on the enrolled veteran population, rather than the total veteran population. To the extent that veterans who live at a distance from a VA Medical Center are enrolled in VA for their health care, then their needs for LTC are addressed. In this regard, nursing home care is mandated for veterans with a 70% or more service-connected dis-

ability. Veterans with less than a 70% service-connected disability receive care on a resource available basis.

One of the advantages of contracting or purchasing home care is that VA can address veterans' HHC needs without attempting to provide it directly in geographic locations where demand for care could not justify an efficient VA-operated program. At the same time, VA has been successful in establishing Home Based Primary Care (HBPC) Programs at VA clinics located at a distance far from the host VA medical center. The HBPC Programs at Hot Springs, Arkansas and Joliet, Illinois are the best examples of VA-operated satellite home care efforts.

Access to nursing home care for veterans is provided through VA's three programs: VA nursing home care units (NHCU); contract community nursing homes (CCNH); and State veteran nursing homes. There are currently 135 VA NHCUs, contracts with 2,800 CCNHs and 11 regional contracts, and 102 State nursing homes. Increased demand for nursing home care will primarily be met in CCINIH and State nursing homes. Construction of new State home beds, with VA providing up to 65 percent of the cost, is based on veteran population need in each geographic area.

Chairman ROCKEFELLER. OK. I want to just deal, Dr. Roswell, with your statement you have made. You are correct that Congress has said that VA must not reduce nursing home beds, and on the other, that VA must increase its efforts of non-institutional long-term care. You would like to be relieved of one to do more of the other.

Unfortunately, both are necessary elements to long-term care. So you are not going to get that wish under the laws of health care. Some people just do not stay in the community, cannot stay in the community, should not stay in the community. So you have asked for relief from VA staffed nursing home beds requirement.

I am willing to entertain the possibility of some change. I think we must be assured that VA retains sufficient capacity to provide institutional long-term care for those who need such services, and I want you to talk about those who do need such services, and if you do not do it, then I will get Dr. Moye to come back to do it.

So far, VA has not been able to do this in the area of specialized services, and so I do not know how I am meant to react to what you just said. In a sense you gave a reason why you cannot comply—because it costs $140,000 per patient for institutionalized care—knowing full well as you said that that that is also going to continue and has to.

You said that the rules and regulations are going to be out in a week. I hope, I assume that is to provide me with some sense of comfort or a mission well done. Again I recognize you have just been on the job, so I am talking more to predecessors of yours, but I am talking to you, because you are now responsible and you took the oath.

And so that is sort of a nice little wrap-up that you do more of what the four folks were talking about, and that they are wonderful. You have also got this other little burden, which you and I know that you cannot get rid of, because all people cannot go back to the community for long-term care.

So, I guess what I want to say is are you trying to kind of slide by me on this one? And point out your problems? You have not used resources. Others were told not to use resources, but that was the first thing that came out of your mouth—I would but I cannot—because these other institutionalized are too expensive.

And is that, in terms of the outcome for the veteran, unacceptable? I guess I cannot accept it, and if Ms. Dickerson can find ways

to do things and you are the second-largest agency in the entire Federal Government outside of the Department of Defense with over 200,000 people, I believe, there must be some ways that you can say something other than relieve me of this one and I will do the other. Care to comment?

Dr. ROSWELL. Yes, Mr. Chairman, I appreciate the opportunity to comment. First of all, I do agree with you. We must maintain our institutional capacity. There is no question that many veterans at some point will need institutional care. We think we can delay that in many cases, put that off until later stages of a disease process and in some cases avoid it altogether, but there is no question, the institutional capacity will be needed.

All I was suggesting is that our institutional capacity is split across VA staff nursing home beds, which we own and operate at an average cost of $380 per day, contract community nursing home care, which we procure for veterans in an institutional setting in the community at an average cost of $185 a day, and skilled nursing home care in homes operated by the states through the state grant program that provides skilled nursing home care at an average cost to the VA of $50 per day.

There are three levels or three different types of institutional long-term care, and I am suggesting that if we aggregate the total amount in 1998 between those three, that we be held accountable to the 1998 level of capacity for all of our long-term care institutional beds as opposed to just the skilled beds operated only by the VA.

Now, having said that, finding resources, yes, we have to do both. We have to look at non-institutional programs as we meet that institutional commitment. My point is that there is a fierce demand for resources now as our system has grown, and this year we will have over six million veterans enrolled with over 4.3 million veterans using the system, reaching levels that we have never ever attained in our history.

When we look at non-institutional care, we find that many programs are being developed, and people are finding resources just to——

Chairman ROCKEFELLER. Can I interrupt for a second?

Dr. ROSWELL. Certainly.

Chairman ROCKEFELLER. I apologize. You see that is what I call sliding by me and Senator Wellstone. Because, of course, there are endless requirements in health care, and of course you have budget constraints which you have quickly brought up, and of course you have the responsibility, and of course there is a war on terrorism, and of course there is homeland security, and of course we have gone from a $5.6 trillion surplus to $100 billion deficit for a variety of reasons.

And, of course, you must do your duty and you shall take care of these people. So I am not predisposed to say that because you have so many veterans who are getting older and their problems are getting more complex, that you take what can possibly be identified as the most obvious and clearly the fastest growing health care problem that you do and will face, and say, well, we cannot comply.

Either VISN 2 is an anomaly or you set up some experiments which you are going to keep as experiments, so that there is always something good to say about what VA can do. Those regs will be in effect in a week, but none of that gives me confidence that you are going to actually go ahead and do it. And I guess that is what Senator Wellstone and I are looking for is that you are going to go ahead and you are going to do these things, and you are going to be like Ms. Dickerson.

You are going to move ahead, and you are going to understand what Dr. Moye says that things are going to get much more complicated as patients get older. There is not only a law and a mandate here, but it is one which seems to take kind of a primacy among health care problems that the veterans face.

I mean it just sort of stands out and hits you, so to speak. So I am just inpatient with your answer because I am not sure what is going to come of it. We have hearings, and somebody said these hearings are very useful. These hearings can be very useful. They can also be a wonderful opportunity for us to say things, sometimes in goodwill, sometimes in less goodwill. Hearings always end. And people from the Federal Government are extremely accustomed to handling them; some of them handle them extremely well. They know exactly what answers to give. Sometimes they tell witnesses what answers not to give.

But in any event, the hearings pass, yet in many case the problems persist. And what I think Senator Wellstone and I want to know is that you are going to be doing something about this on a broad scale and that your nursing home problem is going to be right there, and you are still going to find a way around it.

Dr. ROSWELL. Yes, Mr. Chairman. We have actually submitted a plan to be fully compliant with the Mil bill requirements for institutional VA long-term care capacity.

Chairman ROCKEFELLER. To whom?

Dr. ROSWELL. To Chairman Smith of the House Veterans Affairs Committee, because he requested it. That would bring us into compliance with that requirement by the end of fiscal year 2004, reaching the 1998 VA staff census of 13,391. But that is not enough.

Chairman ROCKEFELLER. I mean is a point by point plan or is it a series of generic goals? Plus I would like to have a copy, if that would not be inconvenient?

Dr. ROSWELL. We can provide you with that.

Chairman ROCKEFELLER. That would be very nice.

Dr. ROSWELL. The plan basically allocates an average daily census to each of the 21 VISNs to be achieved this year, and then an interim average daily census next year to bring us back to that level. It will be at a cost of an additional $161.2 million to be able to get there, and that is money that will have to come from somewhere, but, yes, it is a statutory requirement, Mr. Chairman. I respect that. I honor that. We are committed to it.

But there is a cost associated with that, but we will do everything we can to move toward that statutory requirement. I think the hearing—I wanted to focus, I think you wanted to focus, on non-institutional care.

Chairman ROCKEFELLER. Right.

Dr. ROSWELL. And that is——

Chairman ROCKEFELLER. But I got very hung up when you started dangling that $140,000 nursing home cost per year, because I felt——

Dr. ROSWELL. Well, for example, as you know, I came into my current position from being the VISN director in VISN 8. That is a VISN I can talk greatly about. Our assigned ADC to increase this year is 109 patients. That will cost probably in excess of $10 million in additional staff to be able to move the census to that level.

Two and a half years ago, I shared the concerns you have echoed this morning and some of our panelists have echoed. I took $5 million out of the VISN 8 budget because I found a way to find those resources to create a program to meet long-term care needs. With less than $5 million a year, we now operate a community care coordination service.

The director is sitting here in the gallery today. That community care coordination service provides care in a home setting using interactive technology to over 1,300 patients. Now the average cost per patient is $2,500 per year. Many of those patients are at great risk for nursing home placement and would only be in a home care environment were it not for this particular program.

That is important to me. Would I like to expand that? Yes. Which is a greater cost? Meeting our average daily census requirement in VA staffed nursing home beds is a greater cost to add 109 patients than it would be to double or to triple the 1,300 patients receiving home care services.

Chairman ROCKEFELLER. Paul, just forgive me, and then I will be quiet and go to you.

Senator WELLSTONE. I may have to leave anyway. You go ahead. I may have to leave.

Chairman ROCKEFELLER. I do not know why it was that I did not leap up when you said we are going to have this all in effect by 2004, because my instinctive reaction is that, No. 1, this is 2002, and the bill was passed in 1999. So that is a nice long chunk of time.

You do not have to go; do you?

Senator WELLSTONE. Actually I have people outside to go to see. That is OK. You keep going.

Chairman ROCKEFELLER. Then you go ahead and ask a question.

Senator WELLSTONE. No, no, no.

Chairman ROCKEFELLER. No, you go ahead.

Senator WELLSTONE. Just tell me when you are done and I will come right back in. I will do that.

Chairman ROCKEFELLER. OK. I am not going to tell him when I am done. [Laughter.]

Dr. Roswell, are you going to wait until 2004 and then all of a sudden the firecrackers go off? I mean is the upper New York model going to be replicated all over the place? I mean you said you did it yourself, and you seem pretty happy about it. So are we going to wait until 2004, or?

Dr. ROSWELL. No, it is a ramp up. Our current average daily census is 11,000. Marsha can you help me. 11,506 approximately.

Ms. GOODWIN. Yes; 11,506.

Dr. ROSWELL. So we have got to go from that number, 11,506, to hit an end census of 13,391 by September 30, 2004. Obviously, to

staff those beds does not meet the statutory requirement. The statutory requirement is that the patients in the staff beds be at 13,391. So over time we will place patients as we add staffing and identify patients that are suitable candidates for VA staff nursing home care.

In the spirit of disclosure, though, it is important that this committee understand that VA staffed nursing homes provide a very high level of skilled rehabilitation care. 70 percent of the people who receive care in VA staffed nursing home beds are discharged to home. That is a remarkable statistic.

But it reflects not so much our clinical outcome as the fact that the beds are used primarily for the rehabilitation of acute medical and surgical problems, and it is truly not end-of-life long-term care. That type of care is much more compassionately and cost-effectively provided in State home beds, the State Department of Veterans Affairs home beds, where we have had a major growth over the last several years, and I would hate to deter that growth in the State home program, because it provides an ideal setting for veterans who have continuous stay long-term care requirements and are not suitable for care in the home environment.

Chairman ROCKEFELLER. Secretary Rumsfeld did something recently which I kind of liked. He sort of replaced some generals who fought wars the way they used to be fought, with generals who can fight wars the way they are going to have to be fought. I have to assume that he took a lot of criticism for that, and I do not know how deep it reaches. I have no idea what he had to go through in order to do that.

The point of my question obviously is that if you go from fighting land-massed wars to the kind of wars that we are now fighting, you have to change what you do. Now, I am not on the Armed Services Committee. I did not have a chance to ask him how you get people to redirect their thinking.

But this is a war that is not waiting for you, and you have raised problems. You have to change the culture of bureaucracy, and I do not know that you have to change generals, but you might, and I am interested in how you personally arrive at how you implement this by people who will have to, let us say unlike Ms. Dickerson, who is dealing with a specific situation.

I mean you are dealing with old roles and with people who have been doing this for 30 years, and by golly, they are not going to have some guy who has just come in as head of health and tell them what to do. And so your battle plan for attacking that and implementing all of this by 2004 ramped up or not?

Dr. ROSWELL. You know you make an excellent point, Mr. Chairman. A lot of the way we approach long-term care is in traditional models. Now, the 1,300 patients I spoke of in Florida are not even counted in our long-term care count because they do not fit a traditional model. They are not institutional care. They are not adult day health care. They are not home-based primary care. So they do not fit in any of our traditional categories, and we do not even count them. so they are not in our total workload capacity.

One of the things I will clearly be doing with the leadership in the geriatrics and the extended care part of VHA will be working to develop new programs, to develop new models of care, to use

field-based clinicians, like the talented people you heard this morning, to define new programs, new approaches to care, so that we can have a broader continuum of care and we can define how that care is provided, and that will lead us to replicate that across that system in a cost-effective manner.

Chairman ROCKEFELLER. OK. Look, I am interested in results. I am also interested in Senator Wellstone coming back to ask his question. [Laughter.]

And then I am going to dismiss the hearing, and here he is.

Senator WELLSTONE. Gee, I forgot. Actually I think, Dr. Roswell, I think I do not find myself, it would not surprise you, in disagreement with the chairman. I mean I think, you know, I feel exactly the same way about it. The one thing that also occurs to me, and it is just sort of one comment which is in the form of a question, and react any way you want to, is also I think there is, you know, look above and beyond our saying come on, we are inpatient with the slowness, make this happen. We have got models, let us do this. I also think, though, that this debate about, Senator Rockefeller, about how much it is institutional care versus how much is it going to be home-based care.

You know what I worry about are these sort of zero sum games that we are going to have to play. In other words, it is a false choice, I mean if we have the resources, and I also look at other parts of our health. In our region, we are seeing some pretty darn severe strains right now.

We do not have the adequate funding. So the other thing I want to say to you is, you know, if you do not have the resources, you got to say it. I mean you got to come up here and say to us, listen, we need to do both. We cannot like cannibalize, you know, nursing home care for the sake of doing home-based care, but home-based care makes a lot more, but there is a lot of people that could benefit from that, and then there are other needs as well, and you all need to give us the resources we need.

So my appeal to you would be, you know, you have to say it. And I frankly think you should. I mean I think a number of us are going to work on a supplemental bill. We are going to argue we need more resources. Now, Senator Rockefeller is going to say there is lots of ways you can get your priorities right and deliver some of this care right now, but I also think—I personally think you got a big resource problem, and I think the VA needs to be bolder in telling us that we need to step up to the plate with the resources that you need, but I cannot tell you what you need unless you tell me what you need. That is the only thing I would add.

Dr. ROSWELL. Well, Senator Wellstone, thank you. I appreciate your comments and I appreciate your support. In his letter to Chairman Smith, Secretary Principi indicated the plan to get there, and I do not know that he specified the exact cost. He did. He identified that the cumulative shortfall to meet the Mil bill requirements is $161.2 million.

That is an operational shortfall in our budget right now to be able to meet the statutory requirement of the Mil bill just as it applies to the VA staffed inpatient nursing home requirement of the 1998 capacity at 13,391.

Senator WELLSTONE. That is on top of the $400 million shortfall he identified last November as well?

Dr. ROSWELL. It is on top of the $142 million for priority seven. Now, the $400 million included management efficiencies that are being sustained by the various 21 VISN's, but that information, Senator, I will be happy to leave is detailed in that letter.

I guess my concern is that it is so much more than institutional long-term care. There is so much we need to do. We need to have VA staffed nursing home beds, but we need State home beds, more State home beds. We need to use contract community nursing home beds, because each meets a different need. We clearly need to develop and nurture the innovation and the commitment that was seen on the previous panel.

We need to develop models that allow greater functional independence that offset the need for institutional care, to preserve the quality of life as long as we possibly can.

Senator WELLSTONE. Well, I just want to interrupt you and finish. I like what you are saying. I just think that, and, you know, look, this is not the VA. I just would love for the VA to be a model for the Nation, and I mean we have the same issue with the population at large. We have, I think, Senator Rockefeller, that we have our collective heads ducked in the sand when it comes to the demographics of our country and the number of people that are going to live to be 80 and 85, and how are you going to have people staying at home in as near normal circumstances as possible living with dignity that way, and then when they can—I had a mother and father with Parkinson's.

We lived all of this, and then we cannot, then there will be good care, you know, high quality care, which we do not have in our nursing homes right now, and so it is not just VA, but I think the whole point of this legislation was for us to sort of lead the way; am I correct? And that we are not doing. But we can and you are committed to it, so I just would finish up again and say let us make this happen, and at the point at which I think you are trapped by your budget, I think frankly veterans health care, quality veterans health care is on a collision course with the tax cuts.

I think we cannot do everything. And we have to be honest about how much tax cuts and how much revenue, and I think that is part of what is facing you. But I am with you. I will work with you.

Dr. ROSWELL. Thank you very much for your support.

Senator WELLSTONE. With you, too. I want to work with you.

Chairman ROCKEFELLER. You may be more with him than I am. [Laughter.]

Let me conclude with these comments. I think VA loves to think of itself as being recognized as a national leader in the care of the elderly. And the truth of the matter is that it is within those who observe VA and health care, but elsewhere it is not recognized as such. It gets an occasional burst and a little bit here and there, but it is not. And it needs to be. That is point No. 1.

Point No. 2, you know you have sort of General Motors and you have the Federal Government, and sometimes I am not sure if there is really any difference in the way they are run, and this goes back to, I think, two points. One is that you cannot give any testi-

mony or Secretary Principi, and I assume yourself that has not been previously cleared by OMB.

That ought to infuriate you as a health care professional. Now, the deal, of course, is that everybody has to be on the same page of the song. There have been those who have decided not to be. Some have paid a price for it. I think Secretary Derwinski could probably tell you something about that. Jesse Brown used to be told by President Clinton what the budget was going to be, and he said, oh, yeah, and then he would fight for more money.

In other words, I am not making any Republican/Democratic comparisons here. What I am saying is that the one main question I asked Tony Principi when he came here for confirmation, was, are you willing to go head to head with the President if you do not get the budget you want? That is what I care about more than anything else, that you will go to him, demand time and argue your case, whether he likes it or not. Just bull right past Andy Card. I mean he is bigger. You are bigger than Andy Card. Just bull right past him. In your case, you are an Under Secretary.

And I do not know Mitch Danielsvery well, but I encourage you to sort of adopt that kind of mentality, because if you mean what you have been saying this morning, then you are obviously going to have to fight along with us.

And where everybody is concentrating on other issues which have to do with national security and homeland security, which is exactly what our first constitutional responsibility is. In the meantime, a thousand veterans are suffering. How are they dying and under what conditions? What is VA doing?

So that what I like to refer to as face time, and that is putting yourself on the line, because ultimately that is what we do here, if we are doing our jobs. There comes a time when you simply have to put yourself on the line, and then you lose sometimes, but if you put yourself on the line, people know that you mean it. People know if you put yourself on the line, if you have put your job at risk, if you have not been afraid to offend somebody who is superior in position, then suddenly they know that you mean it and all of a sudden you are listened to more.

And that whole dynamic and the absence of its practice in Washington is thoroughly not understood by the American people who choose but sometimes wisely to ignore Washington all together thinking that not much of anything happens here.

I happen to think a great deal happens here, and I happen to know that an enormous amount happens here and only happens here that affects long-term care and veterans. So that was not just generally directed at you. It was an expression of frustration on my part, but it is partly directly at you. At some point people take stands, and, for heaven sakes, if you go into public service, that is one thing. If you go into health care, I mean you do that—for how long to become a doctor?

Dr. ROSWELL. Four years of medical school.

Chairman ROCKEFELLER. Yes.

Dr. ROSWELL. An average of 4 to 5 years of residency, yes.

Chairman ROCKEFELLER. So I mean, in other words, there is sort of a large commitment in your life to doing health care right, and

I would like to see that work for the advantage of long-term care in the Department of Veterans Affairs.

Dr. ROSWELL. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. And I thank you, and this hearing is adjourned. Also, without objection, the written statement of Senator Murray will be made a part of the record.

[The prepared statement of Senator Murray follows:]

PREPARED STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Thank you Mr. Chairman for calling this hearing. Like you, I'm very concerned that veterans still do not have universal access to the additional long term care benefits we provided for in the 1999 Millennium Health Care Act. I hope this hearing will help us move the process forward quickly so that our older veterans can get the care they need.

I'm also concerned that veterans are losing long-term care options because of some of the larger changes that are taking place in health care. In Washington State, nursing homes and home health care agencies are closing their doors, in part, because of unfair Medicare and Medicaid reimbursement rates that punish providers based on their geographic location. It's an issue we've got to address to ensure that veterans and all seniors have access to long-term care.

As I mentioned, in 1999, we passed the Millennium Health Care Act to add extended care services to the VA benefits package. But the VA has been extremely slow in making those benefits available to veterans.

As the chairman knows, the GAO recently found that:

> "Two years after the passage of the act, VA has not completely implemented its response to the act's requirement that all eligible veterans be offered adult health care, respite care, and geriatric evaluation."

The report goes on to say that: "access to these programs was far from universal in the VA."

I understand the VA has gone back to OMB for a third time trying to get the final regulations approved so that they can comply with the Millennium Act. Frankly, I don't understand why it's taken so long to implement the Act. The VA has a legal and a moral obligation to our veterans to ensure access to quality long-term care. Of course, today, long-term care means much more than just nursing homes. It includes home health care, adult day care, adult homes, and respite care.

When you look at the growing need for long-term care, it's clear the VA is going to have to work with private health providers.

According to the GAO, in FY 2001 the VA spent about $3.1 billion on long-term health care and the amount is likely to increase. It's projected between the years 2000 to 2020 the US population over the age of 85 will increase by 37%, and the veteran population will nearly triple. I find these statistic particularly troubling when you consider that VA nursing homes beds are very expensive, costing as much as $50,000 per year for a veteran. That's nearly $20,000 dollars more expensive than the national average.

Given these statistics, it's clear that the VA will have to contract with private health care providers to meet the needs of our veterans.

As the VA has done for ensuring access to nursing homes, we will have to turn to private providers, like home health care agencies, to help cover the full commitment to our veterans. Unfortunately, the VA has committed very few resources to non-institutional settings. In fact, of the $3.1 billion the VA spent on long-term care in 2001, only 8% was devoted to non-institutional settings.

There is no question that this Issue is resource driven. However, it only makes sense to devote more resources to non-institutional health care settings to increase our ability to provide for all veterans. Home health care offers quality care that allows veterans to stay in their home, with their family, in the community. It offers a sense of relief as well for family members who are not equipped to handle the health care needs of the patient, but who don't want to see their loved ones in a nursing home.

As we have seen with Medicare, home health care offers real solutions to acute care and long term care. Home health care providers are well trained and can provide a wide range of highly skilled care to veterans with special health care needs. However, for veterans in Washington state, home health care may not be an option to nursing homes.

Currently, Washington state ranks 45th in average per beneficiary costs in comparison to other states. We are well below the national average. For example, pro-

viders in Florida or Texas can receive almost twice as much per home health visit than a provider in Washington state.

This inequity, coupled with the scheduled 15% reduction in home health care under Medicare, could cripple home health care in Washington state. We've already seen agencies closing or scaling back their home health care delivery areas. Hospitals that once actively participated in home health care are leaving. This is quickly becoming a crisis situation.

Medicare is penalizing home health care agencies, like doctors and hospitals in Washington state for providing more cost effective care. Over the lifetime of a Medicare beneficiary, this can mean thousands of dollars less spent on their care in Washington state.

This inequity is already forcing many doctors to leave and causing severe health care professional shortages in hospitals. Our hospitals cannot compete with hospitals in other states that can pay more because they receive significantly more from Medicare for providing the exact same service.

These regional inequities have resulted in vastly different levels of care and access to care. For example, in Florida many Medicare beneficiaries have access to prescription drugs and prescription eyeglasses in the Medicare+Choice program.

In Washington state, there are no plans available that offer prescription drug coverage much less eyeglasses. I don't want to see the same thing happen to our veterans.

Veterans, regardless of where they live, deserve access to quality nursing home options. Unless the VA plans on creating competing home health care agencies in Washington state for veterans only, there may be limited access to this option.

It's unfair and unjust to provide vastly different levels of care for veterans depending upon where they live.

I urge the VA to work with CMS to ensure that home health care agencies in all states are stable and affordable. Home health care must be an option for veterans. With the advances in medical research and the aging veteran population, the VA has to explore and invest in alternatives to nursing homes. In many cases, these alternatives provide a more appropriate level of care.

I've been supportive of efforts to address these inequities, and I'll continue to work on it. I again want to thank the Chairman for holding this hearing and for helping to ensure our veterans have options when they need long term care.

Chairman ROCKEFELLER. Thank you. The hearing is adjourned.
[Whereupon, at 12:20 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO

Thank you, Mr. Chairman, for holding this hearing today. I look forward to hearing from the panelists regarding the VA's efforts to provide alternative long term care services.

In my meetings with veterans from Colorado, one of the issues of greatest concern is health care. The vets want to know that they will be able to get quality care when they need it.

I am encouraged that in recent years, Congress has invested substantial resources to improve the quality and accessibility of VA medical care and to make that care available to more veterans. As I understand, the number of individual veterans served by the VA has increased by 65% in the last 7 years. But, nearly all of that increase has been in primary care provided by outpatient clinics.

Now, as the age of the our veterans population rises, we are looking at services needed by older patients. In the 106th Congress, under your leadership, Mr. Chairman, we enacted legislation directing the VA to expand its geriatric services to include nursing home care, assisted living arrangements and home care options.

Today, it is time to look at those programs to determine how we are doing. Are our elderly and disabled veterans being offered the options we have promised them? Are they able to choose home care rather than institutional care? Can they find adult day care services? Are their family caregivers able to find relief services?

Speaking as a veteran, I believe we need to do all we can to help those who have so honorably served all of us.

Mr. Chairman, again, I thank you for holding this hearing and look forward to hearing details of how the VA is addressing the long term care needs of our vets.

PREPARED STATEMENT OF THE ALZHEIMER'S ASSOCIATION

Mr. Chairman and members of the Committee:

The Alzheimer's Association appreciates the opportunity to submit the following statement to the Committee on Veterans Affairs for the hearing entitled "Options to Nursing Homes: Is VA Prepared?"

The Alzheimer's Association is the premier source of information and support for the four million Americans with Alzheimer's disease. Through its national network of chapters, it offers a broad range of programs and services for people with the disease, their families, and caregivers and represents their interests on Alzheimer-related issues before federal, state, and local government and with health and long-term care providers.

Over the past few years, the VA has embarked on several exciting projects to improve care for veterans with Alzheimer's disease and other dementias. Our comments in this statement will focus on two specific projects currently underway within the VA system.

ADVANCES IN HOME BASED PRIMARY CARE FOR END OF LIFE IN ADVANCED DEMENTIA (AHEAD)

Advances in Home Based Primary Care for End of Life in Advanced Dementia (AHEAD) is a rapid-cycle improvement project intended to help VA staff identify problems in dementia care, implement clearly defined steps to address them, and evaluate outcomes. The first group of AHEAD sites included teams of 3–5 VA staff members from Home Based Primary Care units at 20 Veterans Integrated Service Networks (VISN's). The teams worked from January-September 2001, and focused on four areas of improvement: early intervention, symptom management, staff edu-

cation, and caregiver support. Outcome data show improvements in each of these areas at many of the sites. A second group of AHEAD sites is now underway.

CHRONIC CARE NETWORKS FOR ALZHEIMER'S DISEASE (CCN/AD)

Chronic Care Networks for Alzheimer's Disease (CCN/AD) is a longer-term project that is being implemented in the VA's upstate New York network (VISN 2). CCN/AD is a 7-site national demonstration project that is jointly sponsored by the Alzheimer's Association and the National Chronic Care Consortium (NCCC). It is intended to provide coordinated health care and supportive services for people with Alzheimer's disease and other dementias by linking Alzheimer's Association chapters and health care systems. VISN 2 is the only VA participant in the national demonstration. Since 1997, it has worked closely with four local Alzheimer's Association chapters to coordinate care and improve outcomes for veterans with dementia.

VISN2 leadership and staff have strongly and consistently supported the development and implementation of CCN/AD. While the VA central office and individual networks and medical centers have previously provided extensive resources and leadership in Alzheimer's research and demonstration projects to improve Alzheimer's and dementia care, this is the first time VA and Alzheimer's Association chapters have worked together at this level and with this intensity. The Alzheimer's Association believes that the change and improvement in Alzheimer's and dementia care in VISN 2 are truly impressive.

With the support of the Senate Committee on Veterans Affairs and the VA central office, AHEAD and CCN/AD could be replicated in other VA networks across the country, and the benefits of these innovative projects could be extended to many more veterans with Alzheimer's disease and other dementias. The Alzheimer's Association is especially enthusiastic about the potential for replication of CCN/AD because of the value of coordinated medical care and supportive services for people with these conditions, and the remainder of our statement focuses on this project. We would point out, however, that the experience and knowledge developed by VISN 2 in its work with Alzheimer's Association chapters over the past five years could provide a valuable basis for similar working partnerships between VA facilities and other community agencies. Such partnerships could improve the care available to veterans with other chronic conditions, which, like Alzheimer's disease, require both medical care and non-medical, community-based services.

THE VISN2—ALZHEIMER'S ASSOCIATION PARTNERSHIPS

In upstate New York, CCN/AD has been implemented through VA/Alzheimer's Association partnerships at the network and VA medical center levels. VA staff at the Albany, Bath, Canandaigua, Syracuse, and Western New York VA medical centers have worked closely with the four Alzheimer's Association chapters that serve the same geographic areas. Overall policy has come from the network level, but detailed procedures for training, referrals, assessments, and joint care management have been developed at the medical center/chapter level.

The creation and maintenance of these working partnerships has involved each partner learning about the organizational structure, practices, and available services of the other. VA staff have learned about training programs, informational materials, family educational workshops, and support groups provided by the Alzheimer's Association chapters. Chapters have learned about the wide array of institutional and non-institutional services provided by the VA. VA medical centers have designated a single point of contact for referrals from the chapters. Likewise, if veterans and their families agree and give formal, informed consent, VA staff can fax their names and contact information to the chapters so that the chapters can reach out to them with supportive services.

THE CCN/AD MODEL

The CCN/AD model was developed by physicians, other health care professionals, and Alzheimer's Association chapters from the seven participating sites, including VISN2 and the upstate New York chapters. It is intended to address common problems in the care of people with Alzheimer's disease and other dementias in VA and non-VA settings and to meet the needs of the person as a whole, not just his/her Alzheimer's disease or dementia.

The model includes recommended procedures and tools for identification of people with possible dementia, diagnostic assessment, ongoing care management, and family support. It is available from the National Chronic Care Consortium's website at www.nccconline.org.

IMPLEMENTATION OF CCN/AD IN VISN2

CCN/AD was first implemented in Syracuse, with the Syracuse VA Medical Center and the local Alzheimer's Association chapter functioning as the pilot site for VISN 2. The Robert Wood Johnson Foundation provided a one-year $100,000 grant to support the pilot test.

Once the pilot test was completed successfully, the Foundation provided an additional $700,000 grant for two years of full implementation to be completed in October 2002.

Over the past three years, extensive training has been provided, first in Syracuse and then in the other medical centers. Hundreds of VA staff members have received training about Alzheimer's disease, dementia, and effective approaches to care. As the project has matured in the main medical centers, training has also been offered in some of VISN 2's community-based outpatient centers (CBOCs), e.g., in Elmira, Rochester, and Rome, NY.

VA staff throughout VISN 2 have been trained to recognize the warning signs of dementia and to refer veterans with possible dementia for a diagnostic evaluation and possible enrollment in CCN/AD. As of April 2002, more than 450 veterans have been enrolled. Some of these individuals are in the early stages of Alzheimer's disease or another dementia, but others are in later stages and have simply not been identified previously. Available data indicate that nationally, only 20–40 percent of people with dementia have received a diagnostic evaluation. The numbers were probably somewhat higher in VISN2 even before CCN/AD because some of the medical centers already had diagnostic clinics. Still, however, many veterans with dementia had not been identified and diagnosed. CCN/AD procedures and tools are helping to address this problem. In addition to efforts by VA staff, the local Alzheimer's Association chapters have begun asking callers whether they are a veteran or a family caregiver of a veteran. If they are, the chapter is able to make an expedited referral into the VA for that individual or family.

Diagnostic assessment is occurring in all of the medical centers and CBOCs. The CCN/AD model includes a recommended assessment that not only supports the diagnostic process but also provides valuable information about the veteran and his/her family that can be used for care planning. Each VA medical center has made adaptations to the model to fit with pre-existing practices at that center, available staff, and other resources.

At each of the five main medical centers, VISN 2 has created a new dementia care manager position. These five VA employees provide and coordinate training, encourage, assist with, and oversee the CCN/AD identification and assessment procedures, and work with Alzheimer's Association chapter staff to develop project procedures and eliminate barriers to better care.

Ongoing care management for veterans enrolled in the project is provided by the dementia care managers, other VA specialists and primary care providers, and chapter staff. The dementia care managers and chapter staff talk frequently with each other about the needs of particular veterans and their families and how those needs can be met. Both the dementia care managers and chapter staff make referrals to other community agencies. Occasionally, in particularly difficult situations, the dementia care manager and a chapter staff member have made joint home visits. More often, however, one or the other is able to solve the problem and obtain the needed care for the veteran.

In VA medical centers were there is a dementia clinic, ongoing medical and non-medical care management has been provided in the dementia clinic. Over time, as the number of enrollees has increased and primary care providers have become more knowledgeable and comfortable with Alzheimer's and dementia care, these functions are being shifted to primary care. In medical centers where there is no dementia clinic, CCN/AD project staff have worked with VA primary care physicians, physician assistants, nurse practitioners, and others from the beginning to provide medical and non-medical care management.

In each of the five medical centers, resource rooms have been set up with print and video materials about Alzheimer's and dementia for veterans, their families and VA staff. Print materials are also available in racks in public areas of the VA, and chapter staff contact veterans' families to offer educational materials and other chapter services. Support groups are provided at the medical center and in the community by chapter staff or VA staff that have received training from the chapters.

OUTCOMES

The evaluation of CCN/AD will continue for another year with funding from the Retirement Research Foundation and the Robert Wood Johnson Foundation. Thus, final results are not yet available. Responses to mail surveys of VA physicians,

nurses, social workers, and others show positive attitudes about the project model and the partnership with the Alzheimer's Association chapters. Survey responses also show general agreement that implementation of the CCN/AAD model and participation in the partnership with chapters will lead to earlier identification of dementia, improved communication between VA staff, veterans with dementia, and their families, and greater awareness of needed treatments and services. Preliminary findings from telephone interviews with veterans who are still able to respond and their families indicate high satisfaction with the care they are receiving through the project.

Information about CCN/AD enrollees' use of VA and chapter services will eventually be available to analyze the cost impact of the project. Since there is no control group, cost information from the project will only be suggestive, although it is possible that data from other VA networks could be used for general comparison.

Many people with Alzheimer's disease and other dementias also have serious coexisting conditions such as heart disease, diabetes, and cancer. Available data show that these coexisting medical conditions increase the cost of care for people with Alzheimer's and dementia. Likewise, Alzheimer's and dementia increase the cost of coexisting medical conditions. Thus, a person with Alzheimer's disease and diabetes is likely to have higher medical costs than a person with only Alzheimer's or only diabetes. Greater attention to the management of coexisting Alzheimer's, dementia, and other serious medical conditions could improve outcomes and reduce costs of care. Little work has been done in this area thus far, primarily because of lack of knowledge about Alzheimer's disease and dementia and widespread failure to identify and diagnose these conditions in most health care systems. By increasing staff knowledge about Alzheimer's and dementia and ensuring identification and diagnosis of veterans with these conditions in VISN 2, CCN/AD has laid the necessary groundwork for future projects to improve management of coexisting medical conditions, with likely positive effects on both quality of care and costs.

POTENTIAL FOR REPLICATION IS OTHER VISNS

The CCN/AD model is available for use by any health care system. The model was originally designed to be flexible enough to work in the diverse, real world settings of the seven participating sites. As noted earlier, some adaptations to the model have been made at each of the VISN2 medical centers, thus creating a rich array of procedures and tools that could be adopted by other VA networks. The site has a project manual that includes the CCN/AD model and tools, site policies, work plans, budgets, timelines, and data collection instruments. Training curricula are also available. Perhaps as valuable as these formal products is the extensive experience VISN 2 has accumulated in partnering with Alzheimer's Association chapters. These partnerships are essential in providing coordinated care for people with Alzheimer's disease, dementia, and many other chronic conditions, and VISN 2's knowledge in this area is a potentially valuable resource for other VA networks.

For the Alzheimer's Association, the CCN/AD project in upstate New York has provided opportunities to reach physicians, other health care professionals, veterans with dementia, and family caregivers we would not have reached otherwise. We are impressed with the dedication and skill of VISN 2 clinical and administrative staff, and we are grateful for the time and resources the network has devoted to this project. We hope the project will continue to grow in VISN 2 and that other VA networks will want to replicate it in their health care systems.

RECOMMENDATIONS

The Alzheimer's Association recommends that the Senate Committee on Veterans Affairs and the Veterans Health Administration (VHA):

1. encourage and support replication of the AHEAD and CCN/AD projects in VA networks and medical centers across the country. Both projects require significant staff time and other resources, but the VA is already serving huge numbers of veterans with Alzheimer's disease and other dementias, including many whose conditions have not yet been identified and diagnosed. AHEAD and CCN/AD are vehicles for improving care for these veterans. CCN/AD creates partnerships with Alzheimer's Association chapters that can facilitate non-institutional, community-based care and augment the efforts of VA staff.
2. Given the groundwork already created by CCN/AD in VISN 2, the Alzheimer's Association also recommends that the Committee and the VHA encourage and support research and demonstration projects to improve the management of coexisting medical conditions in people with Alzheimer's disease and other dementias. As noted earlier, this is an important next step in improving quality and reducing cost of care for veterans with these conditions.

The Alzheimer's Association commends the Committee on Veterans Affairs for calling this important hearing on non-institutional long term care issues in the VA. Under Chairman Rockefeller's stalwart direction, the Committee on Veterans Affairs has worked consistently to improve the quality of health care and to develop a long term care system for our nation's veterans that provides options for care at home, in the community and in good care facilities.

In addition, the Association sincerely appreciates Chairman Rockefeller's particular commitment to veterans with Alzheimer's disease, not only in the area of long term care but also in raising awareness about the need for increased research funding both at the National Institutes of Health (NIH) and in the private sector. Through the Blanchette Rockefeller Neurosciences Institute at the West Virginia University Health Sciences Center, fundamental neurosciences research is underway to find practical solutions to Alzheimer's disease and other cognitive impairments.

Thank you again for the opportunity to submit this statement for the record.

PREPARED STATEMENT OF JAMES R. FISCHL, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

As an advocate for veterans and the nation's largest veterans service organization, The American Legion feels compelled to submit, for the record, its views on the subject of your most recent hearing—Alternatives to Nursing Homes—Is VA Prepared? With the ever-growing aging veteran population, it is critical that the Department of Veterans Affairs (VA) position itself in such a way as to be able to adequately take care of all the needs of these veterans to include long-term care.

With the VA health care system transforming itself from a "hospital" system to an "integrated health care" system, so too has VA's approach to long-term care evolved from an institutional setting to a non-institutional, community based and home based setting.

The enactment of Public Law (PL) 106–17, the Veterans Millennium Healthcare and Benefits Act, marked the first step down the long road to ensuring, mapping out and implementing a comprehensive long-term care plan for veterans.

While conceding that this legislation was complex, the VA has allowed nearly two years to go by without fully implementing the provisions of the law. The law requires that all eligible veterans be offered adult day health care, respite care, and geriatric evaluation. To date, VA has instituted only three of the provisions of the law:

- Mandatory nursing home care for veterans rated 70% and above and for any service-connected veteran who needs nursing home care for a service-connected disability;
- Pilot programs to evaluate varying models of all-inclusive care for the elderly; and
- An assisted living pilot to evaluate that particular program was initiated in the Pacific Northwest.

It will take two to three more years for the pilot programs to be fully evaluated as to whether they are a cost-effective means of providing long-term care (LTC). In the mean time, veterans continue to struggle to obtain LTC by the VA.

LTC within VA is a continuum of care provided over a period of time to veterans who suffer from severe chronic service-connected disabilities and conditions of aging and/or the disease process. Within VA, long-term care includes:

- home health care;
- adult day care;
- community residential care;
- specialized rehabilitation care, including Alzheimer's and Dementia care;
- psychogeriatric care;
- domiciliary care;
- assisted living;
- hospice and respite care;
- geriatric assessment and management;
- skilled and unskilled care;
- nursing home care; and
- Geriatric Research, Education and Clinical Centers (GRECCS).

One of the more innovative approaches to LTC within VA has been the use of telemedicine. Telemedicine technology allows VA to reduce travel time and costs while improving efficiency and providing better quality of care. The Senior Companion Program is another example of saving money, yet keeping LTC in the home of the

veteran. The Advances in Home Based Primary Care for End of Life in Advancing Dementia (AHEAD) program is yet another alternative to institutional care that the VA is evaluating. While all of these programs sound great, they are only offered to a small portion of the veteran population in need of LTC.

VA's plans for long-term care include:

• achieve an integrated care management system that incorporates all of the patient's clinical care needs;

• provide more care in home and community-based settings as opposed to inpatient settings, when appropriate;

• achieve greater consistency in access to and quality of care provided in all settings;

• achieve greater consistency across the system in assessing patients for extended care and in managing care, including post institutional care;

• continue to emphasize Veteran Health Administration (VHA) research and educational initiatives that will improve delivery of services and outcomes for VA's elderly veteran patients; and

• continue to develop new models of care for diseases and conditions that are prevalent among elderly veterans.

These plans are honorable; however, the caveat to achieving these plans is that it must be done within "existing programmatic resources." In essence, VA can only do so much and then the money runs out. When it does, the bill payer becomes the veteran.

The evolution of LTC from an institutional setting to a non-institutional setting brings with it many issues that need to be addressed. One of those is accountability of the patient and for that matter, whether the veteran is informed and understands exactly what is going on with his or her care. Another, of course, is quality of care being provided by non-VA staff and how is this being monitored.

Finally, The American Legion strongly contends that veterans, who are accepted into the health care delivery system provided by VA, must remain the responsibility of the Department. VA's charge includes providing quality improvement oversight for LTC provided by the Department or through private contract. If a veteran is accepted as a long-term care patient, no matter when or under which existent provision of a law, he or she remains the responsibility of the VA medical care system regardless of their medical condition.

Congress and the Executive Branch must recognize that it is incumbent upon them to provide VA adequate resources for the purposes of providing LTC to the nation's veterans. VA must continue to meet the demand veterans will undoubtedly place on the health care system in the next 30 years. The reality of quality LTC for veterans requires a financial commitment on the part of the legislative and executive branches of this government, and a coordinated treatment effort on behalf of VA.

We can never forget the commitment ". . . to care for him who shall have borne the battle, and for his widow and his orphan."

Thank you for allowing The American Legion an opportunity to express its views on this critical issue.

PREPARED STATEMENT OF ARLENE DAVIDSON, VICE PRESIDENT, PLANNING AND DEVELOPMENT, EVERCARE, A UNITEDHEALTH GROUP AFFILIATE

Mr. Chairman and Members of the Committee:

Evercare is pleased to have the opportunity to provide testimony for the record of this Committee hearing on long term care alternatives for veterans. Evercare is a division within the Ovations business segment of UnitedHealth Group. UnitedHealth Group is a diversified health care company that provides a broad spectrum of resources and services to help people achieve improved health and well-being through all stages of life. United is comprised of five major business segments: Ovations, UnitedHealthcare, Ingenix, Specialized Care Services and Uniprise. United has been operating since 1974 and currently serves nearly 35 million Americans in all 50 states. The Ovations business segment, of which Evercare is part, is dedicated to serving vulnerable individuals including the frail elderly, chronically ill, disabled and low income families.

Evercare is dedicated to meeting the long term care needs of this nation and we have on several occasions in the past offered testimony in support of the development of new long term care options for veterans. Our mission is to optimize the health and well being of aging, vulnerable and chronically ill individuals. Evercare was started in 1987 in Minnesota by two nurse practitioners and with its acquisition of Lifemark Corporation in 2001, has grown into a diversified award-winning

healthcare organization participating in government programs in over 15 states. During our 18 years in the long term care market, we have seen the emergence and maturing of many Medicaid, Medicare and other government programs. Our demonstrated ability to address complex health care needs and to provide customized services has consistently resulted in exceptional customer satisfaction, improved clinical outcomes, and increased efficiency. Some of these results are discussed in a recent article published by Robert L. Kane, MD in the April 2002 issue of the Journal of the American Geriatrics Society. We applaud and offer support to this Committee's efforts in examining new models to address the long term care needs of veterans and seeking effective ways to deliver quality long term care services.

Recently, Evercare was awarded a contract by the Southern Arizona Veterans Administration Health Care System (SAVAHCS) for a pilot case management program for veterans living in the community and in need of long term care services. This pilot, targeted to veterans living throughout the State of Arizona, is one example of how the Evercare care management approach can be applied to offer new long term care alternatives to veterans. In this testimony we provide not only an overview of our care management approach but also some examples of long term care program models in which our approach has been effectively applied. It is our hope that this testimony will help define options for future program development.

OUR CARE MANAGEMENT PHILOSOPHY AND MODEL

Central to any of the long term care program models in which we operate is Evercare's approach to care management. Our approach for aged and disabled individuals is a client-centered model that encourages the involvement of the client, their family, caregivers, physicians or primary care provider and our care manager in a collaborative effort. It is a holistic approach, designed to maintain the highest quality of life and functional status of the individual while minimizing reliance on services that are traditionally more restrictive and less effective in containing costs. This inclusive philosophy supports an overall goal of coordinating timely, quality, and appropriate health services while addressing medical, social, behavioral, environmental and financial considerations in each care plan. Our care managers achieve this goal through collaboration with the enrolled individual and his or her family to create a care plan that maximizes the individual's self-determination and respects individual wants and interests. In the coordination, facilitation and implementation of the full spectrum of acute and long term care needs, Evercare's care managers strive to maintain, and if possible, increase each enrollee's level of independence, individuality, choice and health status.

Evercare care managers work with the individual, his or her family, the primary care provider (PCP), our internal clinical experts, and other providers as partners on a team to design, coordinate, and manage the plan of care that achieves the results specified by the individual's goals. Care managers additionally identify the full range of health care resources and medical coverage available to each client, including Medicaid, Medicare, or private long term care insurance policies. This design and approach allows care managers to react immediately to changes in a client's condition, proactively intervene, coordinate care and service needs, and manage any necessary changes in the individual's plan or setting of care. In addition, the care manager assists the individual and his or her family in identifying attainable health and functional status goals, and provides education and supportive services on preventive medicine, healthy choices, and self-care techniques as appropriate.

COMPANY OVERVIEW

Our continuum of product lines includes Medicaid and Medicare health plans, government contracts, and a nationwide information, consultation, care management and referral service, all designed for frail, elderly, disabled or chronically ill individuals. Through these businesses we serve over 658,000 individuals, including providing comprehensive care management for approximately 150,000 individuals through publicly funded and managed care contracts. In addition, more than 2.5 million people have access to our nationwide information, referral, consultation, and care management services.

Evercare has experience coordinating long term care services through the following program models:

- Stand alone care and disease management programs offered in a fee-for service environment with reimbursement for administrative costs on a per participant per month basis;
- Eldercare consultation and referral services provided on an as needed, fee-for service basis through an insurer or payer as part of a greater long term care benefit package;

• Care management services delivered as part of a long term care single entry point (SEP) and/or primary care case management (PCCM) program administration contract;
• Capitated long term care health plan models designed to coordinate with traditional Medicaid acute care coverage; and
• Full-risk health plans (health maintenance organization or preferred provider organization) integrating acute, behavioral, and long term care funding.

In addition to the overall program model type, other important program design issues include whether participation is mandatory, how program eligibility is defined, what delivery settings are included, and the referral/outreach processes used to identify and enroll eligible individuals. Differences among our existing programs are described in the examples that follow.

Arizona Case Management Services for Veterans

CUSTOMER/CLIENT: Southern Arizona VA Health Care System
COMPANY/PRODUCT LINE: Lifemark Corporation, Evercare Connections
START DATE: January 2002

Through Evercare's Lifemark division, we provide care management services to referred veterans statewide with reimbursement for administrative costs on a per participant per month basis. Program participants, referred through local Contracting Officer Technical Representatives (COTRs), must require a nursing home level of care and reside in community settings. Care management services include initial assessment, care planning, maintenance of a statewide home and community based provider referral network, periodic reassessment, and ongoing management with regular communication with VA providers and other personnel. Our approach to cost containment includes a strong emphasis on coordination of benefits with other payor sources, improving access to care in rural areas, introducing appropriate social services and decreasing fragmentation of care delivery.

OUTCOMES: Since the program is new (January 2002), no outcome data is yet available.

Arizona Medicaid/Elderly and Physically Disabled Long Term Care Management

CUSTOMER/CLIENT: Arizona Health Care Cost Containment System (AHCCCS), Arizona Long Term Care System (ALTCS)
COMPANY/PRODUCT LINE: Evercare of Arizona, Evercare Select
START DATE: January 1989

Evercare of Arizona, through its Evercare Select product, has been an ALTCS program contractor since the inception of the program in 1989 through the Federal Medicaid Section 1115 waiver program granted to the State of Arizona. As ALTCS' largest private contractor, Evercare has demonstrated that services can be integrated cost effectively in a managed care environment through incorporating sound principles of intensive care management, utilization management, and quality assurance.

Evercare's care managers work with the enrollee, the enrollee's family or guardian, and his or her Primary Care Provider (PCP) in order to blend and deliver services to assist the enrollee in maintaining the highest level of functioning through the most appropriate, cost effective plan of care. Evercare enrollees have choices within a wide array of primary care, acute care, ancillary services, behavioral health services, nursing home placement, and home and community based services (HCBS). Evercare" strong HCBS network allows our enrollees to have access to a full continuum of services, including adult foster care, assisted living homes, assisted living centers, adult day health centers, attendant care services, emergency alert systems, group respite, home health services, personal care, homemaker services, respite care, hospice care, home delivered meals, and home modifications.

OUTCOMES: Independent evaluations have shown increased consumer satisfaction, cost savings and decreased rates of institutionalization as a result of this program. Evercare has increased its HCBS population from five percent participation of all clients in 1989 to 51 percent in 2001, significantly decreasing institutionalization. Other financial and utilization outcomes for this period showcase its strength in cost effectiveness. During this period we reduced the hospital length of stay from seven to five days and decreased nursing home expenses from $1,424 to $1,110 per member per month with an estimated overall medical cost savings of over $2.5 million. By offering a breadth of HCBS services through a highly developed network, Evercare has been able to develop a program that has improved access, financing, service delivery and follow-up while eliminating fragmentation, duplication of services, and unnecessary utilization. These findings have been substantiated by a 1996 Evaluation of Arizona's Health Care Cost Containment System Demonstration report by Laguna Research Associates. In addition, an October 2000 report by the

AHCCCS showed that consumers are very satisfied to satisfied with their long term care services.

Texas STAR+PLUS Medicaid Long Term Care Health Plan

CUSTOMER/CLIENT: State of Texas Department of Human Services
COMPANY/PRODUCT LINE: Evercare of Texas/HMO Blue STAR+PLUS
START DATE: January 1998

Since 1998, Evercare has provided administrative services and care management for HMO Blue STAR+PLUS. The STAR+PLUS Medicaid long term care program is designed to foster care coordination for individuals dually eligible for Medicare and Medicaid, and elderly and disabled people eligible for Medicaid-only. STAR+PLUS bundles Medicaid covered services into one integrated coordinated care program designed to control health care costs while improving access and coordination of services to enrolled individuals. STAR+PLUS provides incentives for dual eligibles to enroll in Medicare+Choice plans to further integrate health care services. For all Medicaid enrollees, including dual eligibles, Evercare is at-risk for the cost of home and community based services that are covered by Medicaid. In addition, Evercare provides a seamless transition along the continuum of health care services by coordinating acute care services reimbursed under the Medicare program. We have applied to become a Medicare+Choice program to assume risk for these services, to complete the integration. This care management function enhances continuity of care and the enrollee/care manager relationship. The Evercare program includes assignment of care managers to match the cultural and language aspects of Houston's diverse population (i.e., Vietnamese, African American, Asian American, Russian, and Hispanic).

OUTCOMES: Independent evaluations of the STAR+PLUS program have also shown increased consumer satisfaction, cost savings and improved quality. Evidence of our success in managing the STAR+PLUS population is demonstrated by an internal cohort study of 310 enrollees in the program, who experienced, over a two-year period, a decrease in inpatient days and days per thousand of 43 percent, and a decrease in paid claims of 22 percent. Furthermore, a 1999 study by the Public Policy Research Institute of Texas A&M University (STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality and Cost-Effectiveness) found that this waiver program saved the State of Texas over $6 million without impeding access to care or quality of care. Furthermore, a 1999 overall enrollee satisfaction survey conducted by the Texas Health Quality Alliance showed results of "seven or higher on a scale of zero to ten", where ten is most satisfied and zero is least satisfied.

Florida Diversion and Long Term Care Programs

CUSTOMER/CLIENT: Florida Department of Elder Affairs and Agency for Health Care Administration
COMPANY/PRODUCT LINE: Health and Home Connection; ElderCare
START DATES: 1998 (Health and Home Connection); 1987 (ElderCare)

Evercare operates two separate Medicaid programs in Florida aimed at assisting frail elders and disabled individuals to live in the community. Health and Home Connection is a Florida Diversion Project serving enrollees over the age of 65 in Osceola, Orange and Seminole counties under a 1915(c) waiver and monitored by the Department of Elder Affairs. These complex health care individuals require assistance with activities of daily living, have dementia or some other chronic illness or degenerative disease requiring daily nursing intervention. There are currently 446 voluntary enrollees whose health care needs are managed through our extensive care coordination programs and services. ElderCare is a similar program in South Florida (Dade and Broward counties) funded by the Frail Elder project and monitored by the Agency for Health Care Administration. ElderCare is for persons over the age of 21 at risk of institutionalization due to chronic illness, disability and/or in need of assistance with activities of daily living. There are 3,700 voluntary enrollees.

OUTCOMES: Estimated savings for the State of Florida from the Office of Program Policy Analysis and Cost Accountability are $18 million per year for the Diversion Project. ElderCare has potential savings estimated at $8.6 to $25.7 million per year. The savings are estimated for diversion of enrollees from institutionalization to more cost-effective community-based settings enabled by our comprehensive care management approach. A November 2001 study by the Department of Elder Affairs found Health and Home Connection had the highest average rating of satisfaction with our care managers and highest satisfaction (89 percent) with overall long term care services when compared to other participating contractors.

New Mexico LTC Link Single Entry Point Administration

CUSTOMER/CLIENT: New Mexico Human Services Department/Medical Assistance Division

COMPANY/PRODUCT LINE: Evercare Connections

START DATE: July 2001

LTCLinkNM© is an information and referral service specializing in long-term care services for disabled, elderly, chronically ill and vulnerable individuals of any age within the State of New Mexico. The service was implemented and is managed by Evercare's comprehensive national database of long term care providers, which includes both institutional and home and community based providers. The State of New Mexico created this program in July of 2001 to help eliminate the need for individuals to make numerous calls or trips to various organizations in the hopes of finding appropriate resources. Through this information service, Evercare assists individuals and other concerned parties in locating services to maximize their independence and quality of life.

This type of centralized information system is used by states to simplify the process for individuals as they access publicly funded programs for medical or social services. Other states, such as Colorado, rely on similar providers (in Colorado, called Single Entry Point Agencies, or SEPs) to provide initial screening and ongoing case management and assessments. A program such as this may be particularly beneficial for the VA, due to the intricacy of the benefit structure and the complexity of the care needs of many veterans. Evercare is capable of providing care management services coupled with single entry point administration.

Nationwide Medicare+Choice Long Term Care Demonstration Project and PPO

CUSTOMER/CLIENT: Centers for Medicare and Medicaid Services (CMS)

COMPANY/PRODUCT LINE: Evercare, Evercare Choice

START DATE: January 1987

Since 1987, Evercare has operated a Medicare program, called Evercare Choice, serving the frail elderly in institutional settings. This program has been operating under a CMS demonstration since 1995. Through a unique care management program that utilizes teams of nurse practitioners and primary care physicians, the Evercare model coordinates care for nursing home residents with an emphasis on areas such as prevention, early detection, collaboration with the primary physician, and communication with families and nursing staff. This geriatric clinical model seeks to avoid costly and traumatic transfers to the hospital and improve enrollees' quality of life. As a result of clinical success and superior cost effectiveness, Evercare Choice has expanded to include sites in six states, including participating in the Minnesota Senior Health Options program for dual eligibles and has led to the development of additional Medicare+Choice (M+C) plans reaching a total of over 23,000 individuals. Last year, Evercare opened the nation's first M+C PPO in Ohio. This year, Evercare will launch a new M+C HMO product for community-based dual eligibles in Texas and further expand the PPO model to additional states. Over 70 percent of the enrollees in Evercare Choice are dual eligibles, the average age our enrollees is 85 and 85 percent suffer from some form of dementia.

OUTCOMES: Evercare is one of the most successful Medicare demonstration projects and has produced impressive results in reducing hospitalizations, improving quality of care and family satisfaction. The success of the nurse practitioner model of care coordination is highlighted in studies conducted measuring affects on hospital admissions, clinical outcomes and enrollee satisfaction. Specifically, Kane discusses in the JAGS article higher satisfaction among Evercare enrollees when compared to a control group. The project has demonstrated 26–50 percent reduction in hospital admissions with a slight decrease in mortality while improving clinical indicators and consistently achieving 95 percent satisfaction rates with the families of this frail population. Excluding deaths, the disenrollment rate for enrollees in this program is less than one percent, data further underscoring the overall programmatic excellence.

Nationwide Eldercare Consultation, Information and Referral

CUSTOMER/CLIENT: The Lutheran Brotherhood

COMPANY/PRODUCT LINE: Evercare Connections

START DATE: July 1997

The Lutheran Brotherhood contracts with Evercare Connections to provide elder consultation, information and resources to their long term care insurance policyholders on a nationwide basis. This contract has been in place since July 1997 and over 50,000 Lutheran Brotherhood policyholders currently have access to this valuable service.

Under the terms of this agreement, Lutheran Brotherhood policyholders may call a dedicated toll-free telephone number and speak with an Elder Care Specialist who assists in determining the type and availability of services necessary to support their elder care needs. The Elder Care Specialist will offer multiple provider or service options in the desired geographic location drawn from Evercare Connections' provider database. This national database contains detailed information on over 90,000 long term care providers and community based services. The policyholder will receive an information packet that contains information relevant to their need. This information packet contains detailed provider profiles and other helpful information such as educational brochures and guides to assist in evaluating a provider. If desired, the Elder Care Specialist may assist the policyholder by scheduling provider appointments or implementing services.

SUMMARY

Evercare has experience in operating a number of different long term care program models tailored for the unique needs of veterans, Medicaid, Medicare and/or fee-for-service individuals. We provide service to government and private entities that are based on the care principles of a client-centered approach, integration, and the least restrictive and safest setting. Our experience and expertise in implementing and managing these programs can serve as a best practices resource to the Veterans Administration. We are thankful for the opportunity to present our capabilities and ideas to the Senate Committee on Veterans Affairs and look forward to future opportunities to collaborate with the Committee and the VA on the development of new long term care alternatives for veterans.