

**VA LONG-TERM CARE: WHAT'S WORKING, WHAT'S
NOT, AND HOW TO BEST SERVE OUR AGING
VETERANS**

**FIELD HEARING
Camarillo, California**

BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
SECOND SESSION

MONDAY, JULY 30, 2018

Serial No. 115-73

Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: <http://www.govinfo.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

WASHINGTON : 2019

COMMITTEE ON VETERANS' AFFAIRS

DAVID P. ROE, Tennessee, *Chairman*

GUS M. BILIRAKIS, Florida, <i>Vice-Chairman</i>	TIM WALZ, Minnesota, <i>Ranking Member</i>
MIKE COFFMAN, Colorado	MARK TAKANO, California
BILL FLORES, Texas	JULIA BROWNLEY, California
AMATA COLEMAN RADEWAGEN, American Samoa	ANN M. KUSTER, New Hampshire
MIKE BOST, Illinois	BETO O'ROURKE, Texas
BRUCE POLIQUIN, Maine	KATHLEEN RICE, New York
NEAL DUNN, Florida	J. LUIS CORREA, California
JODEY ARRINGTON, Texas	CONOR LAMB, Pennsylvania
CLAY HIGGINS, Louisiana	ELIZABETH ESTY, Connecticut
JACK BERGMAN, Michigan	SCOTT PETERS, California
JIM BANKS, Indiana	
JENNIFFER GONZALEZ-COLON, Puerto Rico	
BRIAN MAST, Florida	

JON TOWERS, *Staff Director*

RAY KELLEY, *Democratic Staff Director*

SUBCOMMITTEE ON HEALTH

NEAL DUNN, Florida, *Chairman*

GUS BILIRAKIS, Florida	JULIA BROWNLEY, California, <i>Ranking Member</i>
BILL FLORES, Texas	MARK TAKANO, California
AMATA RADEWAGEN, American Samoa	ANN MCLANE KUSTER, New Hampshire
CLAY HIGGINS, Louisiana	BETO O'ROURKE, Texas
JENNIFFER GONZALEZ-COLON, Puerto Rico	LUIS CORREA, California
BRIAN MAST, Florida	

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

Monday, July 30, 2018

	Page
VA LONG-TERM CARE: WHAT'S WORKING, WHAT'S NOT, AND HOW TO BEST SERVE OUR AGING VETERANS	1
OPENING STATEMENTS	
Honorable Neal Dunn, Chairman	1
Honorable Julia Brownley, Ranking Member	2
WITNESSES	
Katy Krul, Acting Executive Director, Oxnard Family Circle ADHC	4
Prepared Statement	31
Mike McManus, County of Ventura Veterans Service Officer	6
Prepared Statement	32
Thomas Martin, Assistant Deputy Secretary, Homes Division, California De- partment of Veteran Affairs	8
Prepared Statement	34
Dr. Teresa Boyd, D.O., Acting ADUSH, for Clinical Operations and Manage- ment, Veterans Health Administration, U.S. Department of Veterans Af- fairs	10
Prepared Statement	35
Accompanied by:	
Dr. Scotte Hartronft, M.D., Chief of Staff, VA Greater Los Angeles Healthcare System, Veterans Health Administration, U.S. Depart- ment of Veterans Affairs	
STATEMENT FOR THE RECORD	
Dr. Bernard Salick, M.D., Chairman & Ceo, Salick Comprehensive Diabetes Centers	38

VA LONG-TERM CARE: WHAT'S WORKING, WHAT'S NOT, AND HOW TO BEST SERVE OUR AGING VETERANS

Monday, July 30, 2018

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:00 a.m., at the Ventura County Office of Education, Salon B and C, 5100 Adolfo Road, Camarillo, California, Hon. Neal P. Dunn [Chairman of the Subcommittee] presiding.

Present: Representatives Dunn and Brownley.

OPENING STATEMENT OF NEAL DUNN, CHAIRMAN

Mr. DUNN. So it is great to be here.

The Committee will come to order.

Thank you all for coming here and joining us today. I am Congressman Neal Dunn. I represent Florida's Second Congressional District. I am honored to serve as the Chairman of the Committee on Veterans Affairs' Subcommittee on Health. As a veteran and a doctor, ensuring the VA is providing for those who have borne the battle is one of my deepest commitments in Washington.

I would like to begin by thanking Subcommittee Ranking Member Congresswoman Julia Brownley, whose district we are sitting in, for her hard work on the Subcommittee and her devotion to the betterment of our Nation's Veterans. I also thank you for giving me the opportunity to visit this beautiful part of the country.

During today's hearing we are going to take a closer look at the Department of Veterans Affairs long-term care and how it can be improved to best serve our aging Veterans. The title of the hearing is "VA Long-Term Care: What's Working, What's Not, and How to Best Serve Our Aging Veterans."

The average age in veteran population has increased over the last few years and as has a number of Veterans who qualify for VA support of long-term care. That means the VA is now facing the largest demand for long-term care in its history.

With this in mind, I have questions about how various VA long-term care programs work together, what the eligibility requirements are for these programs and how the VA will manage this increasing demand and what services Veterans would like to have available to them as they age. I also want to hear from our wit-

nesses about what is and is not working for the VA and the private long-term sector care providers here in Ventura County.

Understanding the good, bad, and the ugly on a microscopic level can help us see and get the big picture and address some of the national long-term care issues. I was, as I am sure many of you were, disturbed by recent articles in USA Today that alleged poor quality of care at the VA Community Living Centers in different parts of the country. Though the VA has briefed the Committee on the Department's quality ratings, I remain concerned about the quality of the care being provided to Veterans in this VA community and others in our living centers and in our other systems.

The three closest Community Living Centers to Ventura are in Sepulveda, Long Beach, and Los Angeles. Fortunately all three of these facilities earn quality ratings of at least four stars, which is I think a credit to the good work being done by the staff there.

I hope the VA will be able to speak to these ratings and what might be working well here in Southern California and that might not working as well in other facilities around the country, as well as how they plan to sustain and improve the quality of care provided to the aging Veterans in this community. And I am grateful to all of the witnesses for being with us this morning to discuss this important issue.

With that, I now yield to the Ranking Member, Ms. Julia Brownley, for any opening statement that she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Dr. Dunn. And first and foremost, I want to thank you for traveling out west to be here in my district and to help us all to understand the concerns of Veterans here in Ventura County and certainly across California and the Nation. I appreciate the time you are taking out of what I know to be a very, very busy schedule to come and visit and I hope you enjoy your time here in the most beautiful district in all of California.

Your commitment to this Subcommittee and the Veterans we serve is undeniable and your medical acumen on the Committee has been proven to be extremely vital, and we appreciate your willingness to hold this hearing on VA long-term care services here in Ventura County. So welcome to you and to everyone here today.

As a housekeeping note I just wanted to point out while typically we don't have questions from the audience during Congressional Committee hearings, but please know that I and my staff are here to help however we can and are very open to your ideas to improve any of these programs that we discuss today.

Today's hearing will hopefully raise awareness, provide you with critical information and if you have follow-up questions, follow-up questions or issues to resolve we will be here as a resource.

During this Congress the Committee has held a number of hearings on the caregiver support program and these hearings led us to realize that VA long-term care services have somewhat flown under Congress's radar for far too long. Overall Americans are living longer so we must be prepared for how to care for them, and this is especially important at the VA as more than 12 million Veterans across the country are over age 65.

I was proud to vote to expand the caregiver program as part of the Mission Act, however, this program will not meet all of the needs of our aging veteran population. This hearing is meant to be the first step in ensuring VA's long-term care services are designed and implemented in a manner that ensures Veterans receive the care they need in a manner that reflects their preference.

Not only will this promote the quality of care Veterans receive but it will allow the VA to better allocate its resources. Outside of VA, we have seen a significant shift from institutional care such as nursing homes to noninstitutional care such as medical foster homes. However, as in the case of medical foster homes, many of these new innovative types of noninstitutional care require the veteran to pay as the VA lacks the ability and resources to do so. Just last week the House of Representatives passed a long-term care Veterans Choice Act that allow VA to pay for up to 900 Veterans per day to access medical foster homes.

Now we must look towards other programs such as home health aides and assisted living facilities, among many others, that VA offers to aging Veterans and those with disabilities. We must ask are there gaps in eligibility, are the programs affordable for Veterans, does VA have the resources it needs to ensure Veterans are aware of and able to access the programs that best fit their long-term care needs.

In preparing for this hearing I was impressed with the number of different programs within VA that are meant to support its aging and disabled Veterans.

However, I am unsure that both VA employees and Veterans are fully aware of these programs, their eligibility requirements, or how they interact with programs outside of the VA.

By turning a congressional eye towards VA's long-term care services, I am hopeful that we can bring more attention to these programs, the areas in which they excel and the areas in which they may need a little or perhaps a lot of help. Obviously, the best way to do this is to speak with Veterans, veteran service organizations, VA experts, and my colleagues on the Committee. Today's hearing is an effort to establish the lines of communication between each of these stakeholders so that as we move forward, we are fully informed.

I appreciate each of today's witnesses for their willingness to engage in this conversation and to spread more life on these programs and the Veterans they serve.

I look forward to our discussion today, and Mr. Chairman, I yield back.

Mr. DUNN. Thank you very much, Representative Brownley.

Before I introduce our witnesses, I want to remind everyone that today's hearing is a formal congressional hearing, just as if we were holding it on the Hill, but we brought it here to you. So we have a routine.

What we are going to have is one panel of witnesses, and only those invited to testify will be permitted to speak. Each panel will have 5 minutes for their opening remarks, and I respectfully ask that our panelists keep an eye on the timers in front of you there which these we brought from Washington. These are authentic. I have to live under this pressure as well as you.

We have had some very thoughtful submissions for the record for this year from local experts in long-term care such as Dr. Bernard Salick of Salick Comprehensive Diabetes Centers and Julian Manalo, who is also with CalVet.

Mr. DUNN. I encourage those watching this hearing to read these submissions, which are included as part of the record for this hearing and will be available online at our Committee's Web site, which is www.Veterans.house.gov.

There will be an opportunity after the hearing for those of you in the audience to come up and speak with myself, Representative Brownley, our staff members, if you have questions, comments, suggestions, if you need further assistance.

Joining us this morning on our first and only panel is Katy Krul, Acting Executive Director for the Oxnard Family Circle, an adult day health care; Mr. Mike McManus, County of Ventura Veteran Service Officer, the Veteran Service Collaborative; Mr. Thomas Martin, Assistant Deputy Secretary, Homes Division for California Department of Veterans Affairs; and Dr. Teresa Boyd, the Acting Assistant Deputy Under Secretary for Health for Clinical Operations and Management within the Department of Veterans Affairs, who is accompanied by Dr. Hartronft, Chief of Staff of the VA Los Angeles—Greater Los Angeles Healthcare System.

So welcome all of you to here. Thank you so much for being here.

And, Ms. Krul, we are going to begin with you. You are recognized for 5 minutes.

STATEMENT OF KATY KRUL

Ms. KRUL. Oxnard Family Circle Adult Day Healthcare is a medical model day program that provides care for Veterans in our community. The Veterans who receive care are at risk for skilled nursing placement if they do not receive services at the center. They are frail, elderly individuals who require intervention from registered nurses, rehabilitative services, and assistance with personal care needs including toileting, feeding, and bathing. We provide transportation for Veterans from their homes to the center, meals, stimulating daily activities, social work case management services and psychological counseling, massage services, and podiatry care. The center also has a specialized memory care unit that we developed in conjunction with the Alzheimer's Association.

Many of the spouses or other family members of our Veterans are overwhelmed with the day-to-day responsibility of caring for their veteran. We find that the caregivers are at risk of experiencing a decline in their physical and mental health condition. Our program is the resource for vital respite care for many families as it offers day-long extended services for five days per week.

[KK1]Oxnard Family Circle provides care to Veterans who have served in World War II, Korea, Vietnam, and Iraq war periods. Essential benefits for Veterans in our program are camaraderie, the sense of social belonging, and connection to a group that is unique to their shared military experiences.

We develop an individualized treatment plan for each veteran that focuses on the specific medical, dietary, and psychiatric needs of that person.

Specialized programming that is provided includes an Equine Therapy program, outings that facilitate integration into the community, psychological groups, one-on-one counseling services, music and memory activities, art therapy, support groups for family members, educational events in conjunction with the Disabled American Veterans, Alzheimer's Association, Public Health and Ventura County Area Agency on Aging.

Our setting allows the Veterans to function with a sense of dignity. In the home setting, they often feel diminished as their loved ones assist them with basic activities of daily living, including toileting, bathing, having assistance with transfers and walking. Many of our Veterans are uncomfortable and resistant to family members providing this level of assistance. Veterans and their families benefit from the personal care assistance that is provided by Oxnard Family Circle's professional staff.

Oxnard Family Circle works closely with the Department of Veterans Affairs to coordinate the care needs of Veterans. Referrals for adult day health care services may be received from the local VA Outpatient Clinic. Many Veterans reside in our community who may not be connected with the VA Healthcare System. Our staff educates Veterans as to the types of benefits that they may receive and assists them with enrolling in the health care system.

We also refer Veterans and families to the Ventura County Veterans Services Office for assistance with financial benefits. We maintain close communication with the veteran's physician and VA social workers during the time that the Veterans are enrolled in our program. When a veteran's care needs increase so that adult day health care services are no longer appropriate, Veterans may be referred to the VA Community Nursing Home Program or VA hospice services. Aid and attendance may be applied for to pay for care in the veteran's home setting or an assisted living facility.

All Veterans who are VA health care eligible may be appropriate for adult day health care services, as long as the veteran has been determined to have the following clinical conditions: first, three or more activities of daily living dependencies; or second, significant cognitive impairment; or third, require community adult day health care services as adjunct care to community hospice services; or, fourth, two activities of daily living dependencies and two or more of the following conditions; veterans has dependencies in three or more instrumental activities of daily living; has been recently discharged from a nursing facility or upcoming nursing home discharge plan contingent of home and community-based care services; is 75 years-old or older; has had high use of medical services defined as three or more hospitalizations in the past year and/or utilization of outpatient clinics, emergency evaluation units 12 or more times in the past year; has been diagnosed with clinical depression; and lives alone in the community.

We are particularly appreciative of the support and advocacy that has been provided to us by Congresswoman Julia Brownley's office.

Thank you for allowing me.

[THE PREPARED STATEMENT OF KATY KRUL APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much, Ms. Krul. Thank you for thoughtfully including the admissions criteria for your program. That is helpful for us as well as coming into the situation.

Mr. McManus, you are up next for 5 minutes.

STATEMENT OF MIKE MCMANUS

Mr. MCMANUS. Good morning, Chairman Dunn and Ranking Member Brownley. Thank you for the opportunity to provide some information to the Committee regarding long-term care options to Southern California Veterans.

My name is Mike McManus, and I am the County of Ventura's Veteran Services Officer. My staff and I connect fellow Veterans, their dependents, and survivors with Federal and State benefits and local resources. One of our primary responsibilities is connecting Veterans with VA disability compensation for such things as post-traumatic stress, traumatic brain injury and for conditions resulting from physical and psychological injury while in the military. We also assist Veterans who enroll in VA health care and refer them to local and regional care resources.

My office has five accredited individuals who interview Veterans, file the appropriate benefit claim and advocate on behalf of the veteran and make needed referrals to other service providers. We also have support staff that enable us to meet our client needs.

The Veteran Services Office has conducted a variety of outreach activities to inform the veteran community about their benefits, including VA health care. The office currently operates out of the main office and 10 field offices. We have a variety of partners through the Veteran Collaborative of Ventura County that also helps us reach Veterans.

And just as an example in fiscal year '12-'13 my office saw 3,572 people. However, our last fiscal year, the one that just ended in June we saw 6,764 people. So we are encountering a lot of Veterans, briefing them on the benefits, connecting them where we can. However, there is, obviously, a lot of work that can be done because there are 40,000 Veterans in the county.

I myself am a retired Air Force Senior Master Sergeant. I did nearly 20 years or spent just over 20 years, ended up as First Sergeant with one deployment for Operation Iraqi Freedom. As a First Sergeant I was involved with briefing the commander on anything that had to do with the enlisted members of the unit, including physical and mental health.

I have been the Veteran Services Officer for over eight years.

Ventura County since January of 2010, and it is an honor to continue to serve our Veterans. So there are a variety of Veterans benefits that are eligible for Veterans when it comes to long-term care. Usually the veteran will start by seeing their primary care provider or social worker at the Oxnard Community Based Outpatient Clinic.

As I alluded to earlier, Ventura County has over 40,000 Veterans, thousands more National Guard, Air National Guard and Reserve personnel who may over time be eligible for VA long-term care. Approximately 22,000 Ventura County Veterans served in World War II, Korea, and Vietnam and their age ranges from 65 on up. In addition to the typical ailments of aging, over 4,100 of

these Veterans also have chronic injuries from military service. Those are individuals that have filed disability compensation claims. So you can anticipate that there is an unmet need there because many Veterans have not yet filed those claims.

In essence, we have tens of thousands of Veterans in Ventura County and many of those will need some form of long-term care. I feel there is a large unmet need in the community due to misperceptions on the part of Veterans and the lack of information from the VA. My staff and I have spoken with countless Veterans who thought that Medicare, TriCare, or the VA will provide for their long-term care needs. They aren't aware that Medicare provides very little in terms of long care—long-term care, TriCare even less, and the VA only if the veteran is eligible, typically 70 percent service-connected or higher. And, of course, based on clinical need.

As outreach to the military veteran community increases from organizations such as my office and those that are members of the Veteran Collaborative of Ventura County. The number of Veterans seeking services increases and we need to be able to better educate them on their realistic options.

In addition to veteran misperceptions, there is a lack of information provided to Veterans regarding VA long-term care. Now, in Ventura County, and I am just going to run down through some of the options that I am aware of that my office helps connect Veterans to; first we will learn more about the VA nursing home on the campus of the Greater LA Medical Center campus; the VA also has three Community Living Centers or what we used to refer to as nursing homes in Ventura County, Coastal View Health Care Center in Ventura and Shoreline Care Center is in Oxnard; and I recently learned of Maywood Acres also in Oxnard.

Typically a vet has to be 70 percent service-connected or higher, and I bring this up is because for those individuals that are service-connected in Ventura County, only 4 percent are 70 percent or above. Now, of course, it also means that where there is an option for Veterans that are enrolled in VA health care that require hospice and nursing home could also be eligible for a VA nursing home care, but I just want to be able to illustrate that 4 percent are 70 percent or higher. So what about the rest of our Veterans? So in some cases maybe they turn to Medi-Cal, you know, there is also Home Health Aides which are very important.

Mr. DUNN. Finish real quickly if you can.

Mr. MCMANUS. All right. I was already self-editing there.

So a veteran's primary care provider, they are usually where this starts, especially when it comes to Homemaker and Home Health Aide Care programs, which basically the VA contracts for someone to come into the veteran's home and provide care for the veteran and respite for the family care member.

Katy already touched on Oxnard Family Circle which is a vital service to the county. There are several hospice providers that also play a part in this long-term care, Livingston Memorial Visiting Nurse Association and VITAS are a couple in the county that have routinely received positive comments.

And I also just want to briefly comment everything we have talked about is on the VHA or the Veterans Health Administration

site but on the Veterans site there is also aide and attendance on the VPA side of the house. We can certainly connect them. But again, there are eligibility requirements. The vet needs someone to come in and provide assistance with some essential activities of daily living, maybe the veteran, is a patient in a nursing home or they have some visual acuity issues.

I can certainly go on but my time is up so I would just like to thank the Chairman and the Ranking Member Brownley for this opportunity.

[THE PREPARED STATEMENT OF MIKE MCMANUS PPEARS IN THE APPENDIX]

Mr. DUNN. Thank you, Mr. McManus. I do appreciate the inclusion of some of your organization's structure and the quantification of some parts of your budget. In general more quantification of these things is helpful to us in Washington. So that quantification is good going forward.

I will tell you that in Washington you would have been cut off, like, a minute and a half ago.

Mr. MCMANUS. I appreciate your indulgence.

Mr. DUNN. Mr. Martin, you are now recognized for 5 minutes.

STATEMENT OF THOMAS MARTIN

Mr. MARTIN. Thank you for the opportunity to be here today and facilitate this conversation amongst us. Projecting future health care needs is a top priority for CalVet at the moment. So this is a very good time for us, and I think it is a good opportunity for more communication and collaboration between the State and Federal Government and also private providers.

So first let me start with some background information on our program. CalVet operates eight Veterans Homes located throughout the States; each offers a range of care options, so independent living, assisted living, skilled nursing and skilled nursing secured-memory care units. The homes vary in size from 60 to 900 beds, and we are very proud to say that all of our homes, all of the Medicare-rated homes are at four or five stars.

In total, we care for about 2,400 Veterans and spouses and as Congresswoman Brownley knows we have the Ventura Veterans Home nearby. It is a state-of-the-art 60-bed assisted living facility, and it is a personal favorite of mine, but don't tell the other homes.

So to be eligible for admission applicants need to be former active duty military personnel. They must age or disabled. They must be California residents and they must qualify for long-term care from the VA. And we also admit spouses for certain situations.

We also have priority admission for Metal of Honor recipients, former prisoners of war, homeless Veterans, and Veterans with high service-connected disability ratings.

So the Veterans homes are closely connected to the VA in four primary areas. The VA annually certifies and surveys our Veterans Homes to ensure residents receive quality health care in a safe living environment; second, the VA also pays a per diem for all of our qualified Veterans. It ranges from, give-or-take, \$50.00 to \$500 or more depending on location, the service-connected-disability rating, and the care needs of the Veterans; third, the VA funds up to 65

percent of construction costs for approved projects, to include the Ventura home nearby; and finally, of course, many of our residents continue to receive specialty services and other forms of services from the VA.

So I understand that one of the goals of this hearing is to discuss strategic planning for veterans' long-term care, which as I said this fits quite well with what we are working on at the moment.

We know there are clear generational differences between each generation of Veterans. Our residents right now are World War II vets, Korean war Veterans, and Vietnam era Veterans, and with what we have seen now there are clear—again, there are clear differences in how late they wait to apply for long-term care which means they tend to come in older and with more significant health care issues. There's differences in the level—the type of community environment they want to be surrounded in, the level of privacy they want, and the type of activities they are interested in.

So again, at the moment CalVet has undertaken a census state-wide needs assessment to identify this generational change both in terms of the demands of the generation and also in terms of the level of support that is going to be needed for them. Our intention is to take this data and to translate it into really what we should look like in the future, and obviously this means we need a good sense of what resources are available beyond just the veteran's homes and how we connect into that.

It is pretty clear that there is going to be a high demand for skill nursing in the future, there is going to be sustained need for secured memory care units for dementia patients, and we also expect more demand for mental and behavioral health programming that focuses on post-traumatic stress, substance abuse, and other conditions that, frankly, don't fit the model of a long-term care patient in the classical sense.

And finally, most importantly, we hope to better understand how the VA, Veterans Homes, and nonprofit organizations and private facilities are or aren't equipped to meet these needs, to meet these challenges and how we can best bridge the gap to ensure that Veterans get the full spectrum of care that they have earned.

So with that said, I think the most important thing I can say is that there really is no single provider that can offer everything for every veteran. If there is one thing to take away from that, I think that is the most important thing.

So we certainly look forward to the VA's leadership in outlining where they expect providers to be, and again, I would like to thank you for this opportunity to be here today and for setting this up for us.

[THE PREPARED STATEMENT OF THOMAS MARTIN APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you for being here and thank you for your testimony, and you mentioned taking the census, or I took note of you saying it, you said you will have some data and data is what we run on. So please include Representative Brownley and our Committee in that report, if you would, please.

Dr. Boyd, you are now recognized for 5 minutes.

STATEMENT OF TERESA BOYD, D.O.

Dr. BOYD. Good morning, Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee. I appreciate this opportunity to discuss VA long-term care for Veterans and their choices for care as they age or face catastrophic injuries or illnesses.

I am accompanied today by Dr. Scotte Hartronft, Greater Los Angeles Healthcare System's Chief of Staff.

The VA's Office of Geriatrics and Extended Care or GEC is committed to optimizing the health and well-being of Veterans with multiple chronic conditions, life limiting illness, frailty, or disability associated with chronic disease, aging, or injury.

GEC's programs maximize each veteran's functional independence and lessens the burden of disability on Veterans, their families, and caregivers, as in the case of the 77-year-old World War II veteran, airplane mechanic, and retired country physician diagnosed with debilitating Parkinson's whose care is delivered by occasional admissions to a community nursing home, assisted in the home by Homemaker Home Health Aide, and the support of his spouse with respite care; or the 69-year-old Vietnam veteran, West Point grad, with devastating diagnosis of metastatic lung cancer who is able to spend his final days in his home under hospice care with family; and finally, the 32-year-old Navy veteran with a life-long medical diagnosis who no doubt will rely heavily on our VA system of care as he ages with a chronic disease.

As Veterans age, approximately 80 percent will develop that need for long-term services and support.

The aging of the veteran population has been more rapid and represents a greater proportion of the VA patient population than observed in other health care systems. GEC's programs include a broad range of long-term services and supports, one of which is home and community-based services.

This program supports independence by allowing the veteran to remain in his or her own home for as long as possible by using one or more of these services, including adult day health care, home-based primary care, Homemaker Home Health Aide, palliative and hospice care, respite care, skilled health home care, telehealth, and veteran-directed care.

In addition to improving care for Veterans, home and community-based services reduces costs for the Department. VA financial obligations for nursing home care in the fiscal year 2017 reached \$5.7 billion. The number of Veterans with service-connected disabilities rated 70 percent or more for whom VA is required to pay for nursing home care when indicated is projected to double from 500,000 to 1 million Veterans between 2014 and 2024.

Therefore, if nursing home utilization continues at the current rate among veteran enrollees without even considering inflation, the cost to VA for providing nursing home care for enrolled Veterans can conservatively be estimated to reach more than \$10 billion within the next decade.

There is an urgent need to accelerate the increase in the availability of these services since most Veterans prefer to receive care at home, and the VA can improve quality in a lower cost by providing care in these settings.

States have found that through their Medicaid programs they have been able to reduce costly nursing home care by balancing their expenditures for long-term services and supports between institutional and home and community-based settings. VA's spectrum of home and community-based services include adult day health care. This is one of the strongest sources of caregiver support and respite and is greatly valued by Veterans and their family caregivers who rely on this program to help the veteran to remain at home as long as possible.

While VA does not have sufficient data regarding the cost benefit of this program, the Medicare program for all-inclusive care of the elderly is based largely on this program and has demonstrated strong success in helping frail older adults at highest risk for nursing home placement to instead remain living at home.

Nursing homes are settings in which skilled nursing care is available 24 hours a day. All Veterans receiving nursing home care through the VA must have a clinical need, as mentioned, for that level of care. VA strides to use nursing hoecake when a veteran's health care needs cannot be safely met in their home.

VA also maintains strong working relationships with the States in the oversight and payment of Veterans care through State Veterans Homes. There are currently 156 State Veterans Homes across all 50 States, including one here in Ventura, California. We recognize and appreciate the commitment of all of our partners here today.

VA's various long-term care programs provide a continuum of services for older Veterans designed to meet the needs as they change over time. Together they have significantly improved the care, well-being, and dignity of our Veterans, including that 77 year-old World War II veteran, that was my father; the 69 year-old Vietnam veteran, he was my eldest brother; and the 32 year-old Navy veteran, he is my stepson.

The gains and the long-term care provision of care would not have been possible without consistent congressional commitment in the form of both attention and financial resources. Your continued support is essential into providing high quality care for our Veterans and their families present and future.

Mr. Chairman, this concludes my testimony. My colleague and I are prepared to answer any questions. Thank you.

[THE PREPARED STATEMENT OF TERESA BOYD APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much, Dr. Boyd.

And we will start the questioning now.

I want to comment that your testimony was very nationally based, which is, of course, what you do. We are here in Ventura County. We are hoping to get kind of a granular view of Ventura County or at least maybe bring it down to the VISN 22 level. So if even in your position cannot drill down to a specific visit or county, we can't do it either. So we are hoping that we can find out how things work on a county level.

I will now yield myself 5 minutes. So I will have to restart that clock since I was editorializing. So I will now yield myself 5 minutes for some questions.

Let me start out, if I may, with you, Dr. Boyd. Mr. Martin made a great comment about a census and data gathering and looking at shortcomings and what do we need in the way of data, what are we going to need in the future to treat our Veterans. Is this being done throughout all the VISNs or all the States and if not, should it be.

Dr. BOYD. So that is a good question. We are currently at the national level looking at this, because as I mentioned in the testimony and also in the written testimony, we are very concerned about this coming upon us now.

We can drill down to individual VISNs and regions by looking at our forecasting models as well, so you can be assured that this is being done. What we do with that and how we parse it out to the different programs is yet to be decided, but we are definitely very concerned and are on top of that.

Mr. DUNN. So while we are talking, your written statement referred to 20 centers of excellence in the VA. What are these centers of excellence and what do they do? What is their role?

Dr. BOYD. So the 20 centers of the excellence actually help us. We can have a whole hearing on this but in a nutshell, they really help us with our innovations and what we can do in moving forward.

I do believe that we have it right here with VISN 22, and Dr. Scotte Hartronft can do a little bit of bragging about that site, but in essence they help us with looking at the world of the possible and how we can implement changes and actual clinical practice in the field. So with your permission I would like Dr. Hartronft to discuss a very good program here within the GLA area.

Mr. DUNN. That may be a conversation for another time.

Somebody mentioned—I think it was you, Mr. Martin, or maybe Mr. McManus—was the hospice care, and that is a subject near and dear to my heart. I think hospice care is underutilized. I think it is an important part of medical care and I think it is a very compassionate and helpful thing to do.

Surely Medicare reimburses whatever program is providing hospice, whether it is VITAS Oxnard or a VA program. Has the VA filed against Medicare insurance for the hospice care that they provide to Veterans?

Dr. HARTRONFT. It is my understanding, no.

Mr. DUNN. No? Is that your understanding?

Mr. Martin, CalVets, do you know that.

Mr. MARTIN. I am not aware—

Mr. DUNN. Why wouldn't they?

Dr. BOYD. Hospice care is available to any enrolled veteran.

Mr. DUNN. It is also available to any Medicare patient. I got out over my skis there.

So on the subject of telehealth, I was interviewing a doctor in another city, another visit, and he said that by far and away the most efficient that he gets is in the telehealth. He was saying he sees 30 to 35 patients a day in telehealth versus 12 to 14 if he is in a clinic.

First of all, that is a very low number for a clinic, I happen to know, but also maybe we should do more telehealth. And I am not sure who should address that. Maybe Dr. Hartronft?

Dr. HARTRONFT. Locally telehealth has come a long ways and one thing we are finding out is how to—because as you imagine telehealth is only as strong how you are able to get the communication to both sides, and now currently we have had a lot of success with having specialties that could be at West Los Angeles that could then have care out into our smaller community clinics, but now we are also, like with mental health, they are developing a way to send a link to the veteran by e-mail and they can actually use that as a way to do tele-mental health to their home. So we are—

Mr. DUNN. He was actually Skyping or the version of Skyping that you are in the V.A.

Dr. HARTRONFT. Yes, sir. So we are evolving with telehealth. I think actually the easiest we make it for the patient, the veteran in their home the more acceptable and accessible it will be.

So I think we have already overcome having to have somebody go to their homes and removing the technological challenge to now where you can send them a link that they click on and then go through email, and you can imagine. So I think the telehealth is becoming a much more robust, and as you said being able to provide mental health in their home and other services is going to be the key.

Mr. DUNN. Let me say that the VA is in a unique position to develop this capability because we don't rely on the State Boards, State medical examiners.

So with that, I am going to yield to Representative Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Dr. Boyd, I wanted to drill down a little bit with you on this issue of institutional versus home or community-based services or care, and certainly over the past couple of decades Federal financing and delivery of long-term care, particularly for the largest Federal pair of long-term services, which is Medicaid—we say Medi-Cal here in California—has shifted to toward the provision of care at home and community-based settings rather than institutional care.

I think I read somewhere in the briefings prior to this meeting that Medicaid/Medi-Cal is roughly around 50 percent and the VA is roughly around 31 percent. So if you could speak a little bit to what is the right proportion that you see across the Nation in terms of where the VA is and if we are not there yet, what are we doing to get there.

Dr. BOYD. Thank you. Great question. And you are absolutely right, we can learn a lot from our State partners in various States as well. We do need—as a VA we do need to move upstream and not wait for institutional care, and we are learning that.

There are many programs, as we mentioned, that are not just in the community. We have some programs in the home and community-based settings that are dual based, whether the VA may provide some of it or we buy some and purchase some from our community partners, but we need to focus on more of that, and whether that means reaching out and developing those partnerships either through contracts and with some of the new legislation with regards as Choice fades away, we will have contract negotiations as well.

So that in our mind is where we need to be, moving it back to the left so that our Veterans can stay safely at home with caregivers or supplementing those needs, whether it be the adult day health care during the day and in the evenings or the weekends they have Homemaker Home Health Aide and respite care.

But you are absolutely right, we have lessons learned and we are moving in that direction so our Veterans can choose to age gracefully and safely at home.

Ms. BROWNLEY. Thank you for that. I know in Washington we talk a lot about this, and we spent a lot of time back in Washington talking about the caregiver program and the Committee has worked towards expanding the caregiver program post-9/11 Veterans where it was previously just pre-9/11 Veterans. But I think we all agree that in the long-term it is a win-win situation because Veterans prefer to stay in their home generally, and I believe also that many of these in-home services or community-based services at the end of the day is less expensive in the long run than institutionalized care is. And we know this bubble is coming through, you know, we call it the gray tsunami coming through, and I think we just got to make sure that we have clear and articulate plans on how we are going to address that so as our aging community ages no one is falling through the cracks.

I wanted to also ask, I think there is perhaps some confusion and certainly in terms of reading the materials prior to the meeting, you know, I was also getting a little confused as well. And this is really about trying to understand, we are—and you listed most of them, I think, Dr. Boyd, in your testimony of all of these long-term care options, and some, as Mr. McManus mentioned, require a veteran to be 70 percent disabled or higher in order to be recipients of some of these services.

But there are a lot of these programs that are based on physician's decision and clinical needs. So if you could kind of break down for me, and I think that is important for certainly our Veterans here in Ventura County to understand what the programs are, and certainly Mr. McManus who spends his days, that is all he does is help and assist Veterans in our community, to understand where, you know—I think that there are less programs that require the 70 percent disability requirement than there are just simply clinical decisions. So if you could break that down a little bit.

Dr. BOYD. Yes, I will. Thank you. And I did make note of that when Mr. McManus was giving his oral testimony.

It dawned on me, Congresswoman Brownley, that we need to do a better job of getting that information out, and I specifically wrote that down, what are we doing and how can be better at that and being a push instead of a pull organization with regards to information.

But you are absolutely right, and please, Dr. Hartronft, let me know if I stumble here, but really the 70 percent service-connected or greater really falls into our—are to provide for those Veterans in our CLCs are provided nursing home care.

Beyond that, most of the other—and the State Veterans Homes has their eligibility as well—but beyond that, the other long-term

services and supports, you are an enrolled veteran, you are eligible for those if you meet the clinical need.

And many times I start a conversation not only with the veteran but with the family, with their caregiver, with their support system as well to get the complete picture, and early on even, although it doesn't go directly to the eligibility part, it goes to the veteran's preferences. So we start very early in our partnership with our Veterans, is that relationship in discussing goals of care; so where do they want to be and what is most important to them.

And so again, that is where we fit around those services that they are eligible for as enrolled Veterans. So I hope that helps a little bit.

Ms. BROWNLEY. Thank you. I have exceeded my time. Mr. McManus and I are both in trouble, but I yield back.

Mr. DUNN. A stern note will follow.

So that actually was exactly where my first question was going to go.

I think that you mentioned that it is a hard time for people to know what they are eligible for, but this Committee, Members of this Committee who care about this, it is hard for us to understand what is available nationally, let alone in the granular level each county, each VISN, each locality may have certain things that available that aren't available anywhere else. And so if we don't know how to use it, if our staff doesn't know how to use it, how in the world are the Veterans going to know how to use it.

I have actually seen some early programs that are, again, coming from outside the VA, not inside, that are trying to organize that approach based on the location, the geolocation of the veteran, and I am going to be bringing more of that into the Committee as we go forward back in Washington.

But that would be a great thing to have, a flow sheet. And I guess actually I should say start with a national flow sheet and then fill in the location, even the geolocation you are in and what additional support is available for Veterans through that. So that is a commentary that is very, very, very important that we should meet on back in Washington.

Dr. Boyd, in your testimony you said 80 percent of Veterans will develop a need for long-term services. What percentage of those Veterans meet the criteria for VA paid nursing home care nationally? So that is a national question. Should be in your wheelhouse.

Dr. BOYD. So the question is with regard—

Mr. DUNN. So if 80 percent of all Veterans are going to need long-term services as they age, what percentage meet the VA nursing home 70 percent disabled criteria or the necessary critically ill criteria?

Dr. BOYD. I don't have that national number for you, but I will get it for you.

Mr. DUNN. It is an important thing for us to consider since we are talking about \$100 billion a year, right. So we need to know what that comes up at.

Dr. BOYD. Absolutely.

Mr. DUNN. Also, let me address if I can the foster homes. Representative Brownley talked about that.

The medical foster homes to us, to the people who have come to us in Washington to testify, seem to be very popular options and they are very cost-effective. So what are our plans for expanding that program, Dr. Boyd or Dr. Hartronft, whoever? I think it is Dr. Boyd.

Dr. BOYD. So yes, the medical foster home is actually a very good program for many of our Veterans. It is not for everyone. We do have about 1,000 enrolled—

Mr. DUNN. Which is a pretty small number.

Dr. BOYD. It is a small number. It is a very small number. There are over 700 medical foster homes, caregiver sites involving most States, although we do know that this is expanding in many others.

The average cost is about \$2,400 per month, and that is on the veteran. What we do know—

Mr. DUNN. There is no hope for the veteran's benefits if they qualify for certain benefits, that that money couldn't be paid to the foster home?

Dr. BOYD. If that is an authority that would be—

Mr. DUNN. We just passed that authority.

Ms. BROWNLEY. The President hasn't signed it yet, but we did pass that.

Mr. DUNN. It is coming.

Dr. BOYD. I will be glad to talk about it next time.

Mr. DUNN. I am a little ahead here again, but I think that is a popular—the Veterans are telling us they like it. It saves us a bunch of money. It saves the taxpayer. I think we ought to be able to lean into this as soon as we get the signature on the final document.

Mr. McManus, one of your primary roles is to assist Veterans enrolling in the health care system. Can you walk us through that enrollment?

Mr. MCMANUS. Sure. So basically it is going to start with discussing, reviewing their DD 214 or their discharge document to see if they are in need. You have some basic eligibility, and they have actually got that form; and then, of course, there is a 10-10EZ, which is the application form used by the VA. They then take both their DD 214 and that application to the Oxnard CBOC and they talk with either Dan or Scott and they review their DD 214 to make sure they have got the qualifying length of service or maybe a campaign medal if they are a recent Iraq or Afghanistan vet just discharged from service then they will enroll them. And then there is a vesting physical that will come where the veteran provides blood, urine, and then they eventually meet with their primary care doctor to review those results as well as whatever might be on the veteran's mind.

The veteran could also go online and enroll online and then ultimately be contacted by the Oxnard CBOC and be scheduled for that vesting appointment.

Mr. DUNN. So I know that the online—and I will end this very quickly—but I know that the online system has gotten better over the last few years, but I tried to use it to enroll just to get a card four years ago and I am still waiting.

I yield to the Representative Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman.

So, you know, we are, and Dr. Boyd reviewed many of the programs within her testimony in terms of services, noninstitutional care services and institutional long-term care services and it goes from home-based primary care, community residential care, medical foster homes, generic evaluations, palliative care, Homemaker Home Health Aide, noninstitutional respite, skilled home care, home hospice, Veterans-directed home and community-based services, adult daycare, those are the noninstitutional ones.

Institutionalized ones are the Community Living Centers, which I understand we have one both in Los Angeles and in Sepulveda, and community nursing homes, State Veterans Homes, which we know very well here in Ventura County. But that is a lot. That is a lot.

And going back to Mr. McManus's point, and Dr. Boyd, you have already said we have got to do some better training here, that we have much more in a pull situation than actually making sure that our Veterans and people like Mr. McManus have the information, not to mention that our CBOC here in Ventura County is a contracted-out facility, so I even wonder how well the physicians within the CBOC are trained to understand exactly what programs are available to them.

So while we are here in Ventura County I just want to get a firm agreement from you, Dr. Boyd, that we can bring some professionals, VA professionals into the county so that we can have a roundtable discussion or whatever to inform our Veterans to inform our physicians and certainly inform Mr. McManus and the county who are tremendous partners in all of this. So—

Dr. BOYD. Absolutely.

Ms. BROWNLEY. Very good. Very good.

The other thing I just wanted to briefly hit on in terms of institutional care, it is stated by the VA that institutional care—Veterans can receive institutional care if they are nonservice-connected Veterans if there is room, the caveat of if there is room.

So what percentage are we talking about in terms of Veterans who are in nursing homes, the VA is, I presume, is paying for it but are nonservice-connected.

Dr. BOYD. So I do not know the national numbers on that, but I can tell you this, that the Veterans that are not 70 percent or greater service-connected are the majority of Veterans. So I don't know the national numbers. I will get that to you when I get back with you about the other promise for the eligible.

And about the resources available, so if there is a clinical need and there is a bed within the VA CLC, we absolutely will bring that veteran in. If there is not but there is still a clinical need and there is no other option, a safe option for that veteran, then we do look to the community; although there is a I think 180-day cap on the VA paying for that, but in that interim they have tremendous coordination case and care management with the family and the veteran to see what is the next step, and they don't do it on day 180, they do it on day one to help with that transition.

Ms. BROWNLEY. Very good. So just in terms of we are using CLC, for the audience that is a Community Living Center which is like a nursing home, but they are associated with medical centers

across the country. So if you are in the hospital in L.A. or getting care from Sepulveda, this is used you go there for rehabilitation and other kinds of things. It is not necessarily a very long term. Everybody that is there, it is assuming that they are going to recover and go home in that sense.

But the question is, do we have the appropriate number of Community Living Center beds across the country? I certainly, you know—again, back in Washington we talk about nimbleness and following where the demands are across the country, and Ventura County is a perfect example of large demand, we have increased our CBOC but are we going to increase services here in Ventura County like Community Living Centers and like some of these other services that we have been talking about.

Dr. BOYD. So with regards to overall—and I apologize for not mentioning what CLC meant earlier to the audience here—with regards to the actual number, I don't foresee in the near future building more Community Living Centers. What we need to do, though, is look at rightsizing our Veterans that we have that need, the institutional care, and again, use the opportunities to work with our partners in the community and move that upstream.

Ms. BROWNLEY. But do we have wait times for people to get into these beds?

Dr. BOYD. To my knowledge we do not have wait times for the combination of Community Living Centers and—excuse me—CLCs and the nursing homes.

If we have a 70 percent or greater service-connected veteran who needs care and we do not have an available bed, say, it is going to be available in 10 days or 15 days or whatever, we will take care of that veteran in a community, in a contract nursing home that the patient and the family agree to. So we will take care of that.

Ms. BROWNLEY. Thank you. I yield back.

Mr. DUNN. So that last question that Representative Brownley asked, particularly about the wait times, is there a long wait time, significant wait times to get into these beds? I am going to direct that question to Mr. Martin. I think he might have a better feeling for it locally.

Mr. MARTIN. I can't speak to CLC facilities. I can speak to our Veterans Homes. So we do have wait times for most levels of care.

Mr. DUNN. Roughly.

Mr. MARTIN. It varies depending on location and the level of care.

Mr. DUNN. On average days.

Mr. MARTIN. So Ventura, it is probably a matter of handful of months at the smaller facility here. But we do something similar to them. We can refer them to other facilities that can take them pretty quickly depending on level of care.

Mr. DUNN. Did I hear you say months?

Mr. MARTIN. Correct. Yes.

Ms. BROWNLEY. This is a very popular one. This one in particular is very popular but it only has 60 beds.

Mr. DUNN. That actually gets into another question I had, and I was intending to give it to Mr. McManus but maybe, Mr. Martin, you can comment too.

We talked about the waiting list. So there is very much a preference for certain ones. Is there a preference for different programs?

Mr. MARTIN. Certainly, yes. As I mentioned in my prior testimony, there is certainly a lot more demand for skilled nursing and for the highest levels of care.

Mr. DUNN. Memory units?

Mr. MARTIN. Yes, in particular memory—

Mr. DUNN. How are you set up for memory units? Are you short?

Mr. MARTIN. I am sorry?

Mr. DUNN. Are you short?

Mr. MARTIN. Yeah. There is a lot of demand for memory care units, and it is actually a relatively new offering that we have only started in the last handful of years.

Mr. DUNN. I thought that Oxnard—I thought I saw where you are an outpatient memory unit. Can you explain to me how that works?

Ms. KRUL. We have special areas designated for those who have compromised memory. This area is secure and people who are there receive specialty care. They have higher level of nursing care. They have higher level of personal care. Those people require one-on-one feeding. Those people require maybe three-to-one toileting just because it is complicated and—

Mr. DUNN. So this would be for like 10 to 12 hours a day?

Ms. KRUL. It depends. If family needs them to be the whole day, it would be like as early as 7:00 a.m. and as late until 5:00 p.m. It could be possible that, yes.

Mr. DUNN. And then when the family picks them up, they are—

Ms. KRUL. We provide transportation.

Mr. DUNN [continued].—back on the family setting.

Ms. KRUL. That is correct.

The best part of this unit is that it is complete nursing care, whatever medications are to be administered, they are administered; if there is other nursing care or health care is needed, it is done.

People are in a controlled, safe environment, have special activities to stimulate them to get their memory maybe not turned but at least they are not anxious, they are not pacing, they have a controlled environment; and the families really appreciate that a lot because during the day they can take care of themselves, go to their own doctor appointments, go to work, and that is a huge relief because the burden of caregiving is the biggest burden for families.

Mr. DUNN. So let me turn to Dr. Hartronft again.

How much does your—you take care of the whole VISN or just the GLA?

Dr. HARTRONFT. Just the GLA.

Mr. DUNN. How much does GLA spend on long-term care, total, all of them?

Dr. HARTRONFT. Okay. For all of our NIC programs it was—the obligations in fiscal year '17 were approximately 40 million. The contract in the community nursing homes was approximately 29 million of that.

Mr. DUNN. Thank you. That is quantification. That is numbers that help us.

I want to go back one more to Dr. Boyd, I think. Veteran-directed care, a certain niche of care that has been funded where you budget the veteran and they sort of contract their own care.

What do you think about the program? I think it is popular. It doesn't seem to be widely available. Talk to me.

Dr. BOYD. Yes. On Veterans-directed care we have 62 VA programs in 18 VISNs. It is fairly popular in some locals. We do have programs in 18 of our VISNs, so all of our VISNs. There are 62 VA programs, 36 States, but only a little over 2,200 Veterans are utilizing the program.

Again, as Ms. Krul had mentioned, this is a program where they do need assistance in more than three ADLs, and there are some other eligibility requirements, but this is a unique partnership that VHA has with local aging and disability networks within communities. So we do rely on that. It may very well be that the VHA or VA medical center wants to have the program, but they really need to work with that local agency, and sometimes there are some administrative technical things that we do try to work out.

And the program is not for every veteran. Someone within the veteran's family or the veteran him or herself needs to be able to manage a budget and this is not always something that we see. So it is not for everyone.

Mr. DUNN. Do you think we can grow it?

Dr. BOYD. I do believe that there are pockets where we could grow it. And I have had some personal experience coming from the field. It does go to that local relationship with the area on agency—agency on aging, and that partnership, and we just need to figure out what the barriers are in some of these areas and try to promote it from within. So I do believe that we could.

Mr. DUNN. Representative Brownley and I are going to call a 5-minute recess but over that recess I want you to be thinking about that program and the potential for fraud. So 5-minute recess.

Mr. DUNN. I rule it back in order, and we yield 15 minutes to Representative Julia Brownley.

Ms. BROWNLEY. We are making history here. I have never been yielded to anybody. So thank all of my constituents who are here today, and I guess convincing the Chairman to give me 15 minutes. So I will absolutely take it.

So along the line of questioning that we have been on here, I wanted to ask about memory care. I think probably it is a fair statement to say that the VA is probably behind and needs some catching up in terms of providing the appropriate memory care needs. I know that there is some dementia care in some of our facilities across the country, VA run facilities like the Community Living Centers. I think we offer dementia services there.

In terms of just locally, do we provide dementia services in L.A. or Sepulveda?

Dr. HARTONFT. At both those sites it depends on what severity level you are in. In the early phases we had things such a wander guards, but we do not have a dedicated, like, secure unit. And that has been some of the challenges, that they are also sparse in the community as well. So that is one area that we are looking at.

Ms. BROWNLEY. And one area that you are looking at and looking at more opportunities for community partnership?

Dr. HARTRONFT. Yes, ma'am.

Ms. BROWNLEY. Thank you. And we are not talking a lot about the caregiver program today here in this hearing but as I mentioned we have spoken a lot about the caregiver program back in Washington, D.C., and to me I think and I think for all the Members on really both sides of the aisle, it is a matter of equity to have the post-9/11 men and women receive the caregiver services if that is something that they want and so we expanded that caregiver service.

Now, I understand that the caregiver services wasn't under the umbrella of long-term care because if you are doing pre-9/11 that is going to be younger men and women generally who are receiving that care. It is probably because they are quite physically disabled and need the help and assistance.

But as we open this up to post-9/11 Veterans it is going to be an older clientele which we are going to serve. So I am just wondering if there is any conversation about once this program gets instituted and fully up to speed, are you thinking about potentially merging the caregiver program under the auspices of all of these long-term care programs?

Dr. HARTRONFT. At the local level it would make sense for us to make it under noninstitutional care essentially, especially as the people allow, because the nice thing with the caregiver program is they go in and make sure the home is safe, they give training to the caregiver and make sure the caregiver is able to, and as you do that, as you imagine with aging spouses and other challenges, that is something that would be important so that you can make sure of the safety of the home and other issues. So that will be an extra plus for many of our Veterans.

Ms. BROWNLEY. And what is the VA doing with regards to memory care in trying to assess that and looking at a well-articulated plan to move forward? Dr. Boyd?

Dr. BOYD. So you hit on something that has really been very much in the forefront since my very short time in my new role as well.

We have a lot of catchup to do there. We do have dementia care. We had our prior with geriatrics evaluation and management clinics and primarily that really dealt with our dementia and our more elderly patients, our more frail patients. What we have learned from our MHIC partners, and that is an acronym, but our Mental Health Innovation Centers as well as our Geriatric Centers of Innovation is that we can definitely buff up and improve early on; and again, I am talking about moving it back to the left when we first see signs let's be more sensitive to that and we see those flags before we get down the road where now we have to have institutional care. So we are looking at that.

I don't have it in front of me but there is significant research as well in this area, and one thing that I do want to mention is that—and this really goes to our community partners as well—with regards to dementia and the behavior issues that we many times see, unfortunately that keeps a lot of our Veterans, many of our Vet-

erans from being able to go to the community in a less restrictive or institutionalized setting than they would like.

And what we have learned—we have five VISNs now where we have had this innovation program of behavioral recovery outreach teams that are actually going to interface with the community. If we have a veteran in one of our CLCs, our Community Living Centers, that they really could with the proper attention and continuation of goals of care and their treatment could actually function at a less restrictive area and that is where they want to be, then what we would do, we actually send VA folks to that setting, that non-VA setting to work with them, actually have those folks come in and see the veteran in their then surroundings.

So we work with them on the behavior and some of the memory issues, so they don't rebound or need hospitalization as well. So again, it is about veteran preference. So that is an innovative idea and we are very, very—but we need more like that.

Ms. BROWNLEY. Thank you.

Dr. Hartronft, I have listed out all of these programs, noninstitutional/institutional. Can you give me an assessment, are all of these programs available here in Ventura County?

Dr. HARTRONFT. Currently, no. At this point we do not offer veteran-directed care services.

Specifically what we do instead is use a combination of the other noninstitutional care programs to provide the care that the Veterans need.

Another opportunity is the one that Dr. Boyd just mentioned. It is not a specific NIC program, but it is the behavior outreach which I think will help us work with our community partners even better.

I guess in Ventura County we specifically have purchased skilled home care, which is one of our NICs as well as Homemaker Home Health, and we also have the contract adult day health care and community nursing homes and the State Veterans Homes, are the primary ones that we can provide right now as permanently here in Ventura County.

Ms. BROWNLEY. But some of the other programs that we have mentioned here today could be available to Veterans. I mean it is not there. My guess—I don't have the data, but my guess is there are other programs online there because we don't know about the programs.

Dr. HARTRONFT. Yes, I agree. I agree with Dr. Boyd's assessment earlier is working with our community VSOs, Veteran Service Organizations, and partners and letting them know what is available as to—and then we figure out what is the need for this area. It is very important.

As you can imagine every county has its own markets available so you can't really do a template for every county. So that is why working with our community partners is so important.

Ms. BROWNLEY. Very good.

In terms of the CalVet home here, which we all take a lot of pride in and I have been to that facility many, many times and see lots of happy Veterans there and their families, and it is also, Dr. Dunn, these Veterans can also have their spouses at this facility. So it is a really a wonderful place.

I am curious to know what California's Department of Veteran Affairs does to look at the data, establish needs throughout the State of California and sort of what the process is. Are you building any new homes in the State of California or is this something that was great in its day, but we are never going to expand upon it?

Mr. MARTIN. As you know, the Ventura Veterans Home was opened I believe in 2009. It was part of a wave of five new Veterans Homes that were built in 2009.

Ms. BROWNLEY. When is the next wave and where is it?

Mr. MARTIN. We are not prepared to answer that question yet.

So there was a needs assessment done about 15 years prior to determine the future programming needs, and that is where skilled nursing was identified, secured memory care units were identified, which is how we tripled our capacity in a handful of years.

And right now we are taking a step back, having opened all these new facilities, finished construction and ramp up, we are taking a step back and taking a look at the data and see where the numbers really lead us, keeping in mind industry changes and VA directional changes in terms of noninstitutionalized care but also identifying that there are plenty of Veterans who really need a nursing home or secure unit or something similar where other non-institutional programs don't quite work with them.

So we are going through this need's assessment process right now. We have actually had some great support from the VA in getting data and subject matter expertise and we are hoping for a study to be finished on time by the end of next year.

Ms. BROWNLEY. And so I just want to bifurcate here. Long-term plan, you are going to have it next year but just in terms of Veteran Homes is that incorporated into that plan so that in a year we would sort of know what the CalVet plan is for new homes throughout the State?

Mr. MARTIN. Correct, yes. So we—

Ms. BROWNLEY. Okay. That is good.

So, you know, just in terms of this long-term care and some collaboration with the VA and your collecting all of this data, the VA is collecting the data as is CalVet, and how are the two agencies collaborating? How are they using it?

I mean, obviously, you have just said there is going to be a report. Maybe I should ask the VA.

Are you going to have a report also where this collaboration can come from?

Dr. BOYD. As far as the State goes, that would be with the area VA Medical Center Directors with regards to any plans for the State Veterans Homes here within California.

Mr. MARTIN. Maybe I should speak too. We have received some support from—I know you have a data analysis unit in your headquarters in D.C., so we were receiving support from them for collecting this data for our support and our—

Ms. BROWNLEY. I just think that the CalVet raises an important issue, and I think the fact that you are drawing on the data to create a long-term plan is really important.

I also think that as we go through this in terms of the VA servicing Veterans we are going to find gaps in those services and so I think the way to fill those gaps is through community-based pro-

grams with CalVet and more collaboration, and I think that there is probably in some cases greater efficiency and better use of the taxpayer dollars in this collaboration and making sure that we don't have duplication.

And so I guess I am really kind of looking for are these words on a piece of paper or are we actually, you know, engaged in collaboration in terms of where we can—how we can best collectively serve our Veterans?

Mr. MARTIN. So our process, we are still in the infancy of our process right now. So we are going to be in a more robust stakeholder process and community engagement process as part of our project.

So again, it is very early. Right now we are trying to get raw numbers to get a sense of what data already exists so that we are not revisiting the wheel and then based out of that then it could be a matter of applied analysis, applied science.

Ms. BROWNLEY. Dr. Boyd, you know, before we close out this hearing I wanted to ask you directly about the USA Today reporting relative to the nursing home ratings, and their—I think Dr. Dunn cleared up some of this in his opening comments but in that particular article it said that Sepulveda had a three-star rating, the VA rating is a five-star rating, is my understanding, at least based on the VA data here that is what it is.

Dr. BOYD. So on the Sepulveda was actually five-star.

Ms. BROWNLEY. Yes.

Dr. BOYD. And the GLA was actually a four-star.

Ms. BROWNLEY. And in the article, the article states that it is an issue around transparency and getting this information out so when people are making decisions, they have the best information in front of them, and I think that there is some agreement in terms of the VA of making sure that we do put out this information.

It was also mentioned in several of the articles that there might be, that the VA had underlying data that might shed light on how VA develops its nursing home ratings and why some VA facilities seem to score lower when compared to the private counterparts and there was, I think, a commitment on a promise for a report to be out by July 1st.

Are you aware of this report that the VA committed to?

Dr. BOYD. Yes, ma'am, and this report is actually posted on a public-facing Web site at www—

Ms. BROWNLEY. So there was one report but then there was supposed to be another sort of backup report that would shed, I think, more light on the process and I think that second one was supposed to be released on July the 1st.

Dr. BOYD. So what you may be inferring is the redacted long-term care institute records that went into the specifics of the quality metrics. That takes some time to get those redacted because they have patient information in them. That is probably what you are talking about.

Ms. BROWNLEY. In terms of nursing home ratings that don't have very good scores, I think we are fortunate here that we have two that do, and it sounds like our community partner scores are generally pretty good. At least that is what Mr. McManus reported.

But what are we doing, what are we doing to kind of rectify this situation and improve upon those who have the lower scores?

Dr. BOYD. So a couple of things.

Ms. BROWNLEY. It sounds pretty urgent to me.

Dr. BOYD. Yes, and thank you for that question.

So about a year ago, as you know, VA did get on the journey to adopt CMS—that is the Centers for Medicare and Medicaid Services—a methodology with which to have a star rating, and it is basically divided up into three areas, and you are right, we did very well, we fared very well with the private sector in two of the three sections, that being on our annual surveys accreditation as well as our nurse staffing model.

We did have some opportunities in the quality measurement section. That is the third of the three areas that figure into the overall scoring. In fact, 11 of our sites scored only one star in the quality measurement area, and what we have done is this. We took a deep dive in that and what we found is that—and by the way, if you go onto the Medicare site as well, they actually have a disclaimer saying that it is not a when it is done, it is not the—that is not the one thing that the family should look at totally; it is a starting point. It is a snapshot in time for CMS of patient care at that time.

What we found was that we had not done a very good job of documenting because it is not something that we had really disciplined ourselves for. The other thing is that our case mix in our CLCs, our Community Living Centers, is quite different than in the private sector.

As many of you know, it is no surprise, we have spinal cord injury patients that we absolutely will care for in our CLCs, and we have our hospice care within our CLCs as well, and we will care for them, and also we have serious and mentally ill residents as well that do require some of the anti-psychotic medications.

Those three major categories increase the complexity of our case mix and they will skew some of the numbers. It is not a defense at all by any means. It is not an excuse. It is reality.

And so after we clarified documentation which we hope that will really reflect the quality of care that all of our residents are receiving, it is currently not being seen in the chart, and hopefully that will improve that. And we do look forward to having congressional visits to all our CLCs so that they can see the quality of care delivered there.

Ms. BROWNLEY. And I hear what you are saying and concur with what you are saying to some degree, and I think it is important in many respects for the VA to compare themselves to the private sector, I think that that is important, and I do believe that Veterans, our customers, our patients, typically the cases are more complicated and certainly are cases that you are not going to see as frequently in the private industry.

But then I would argue we need higher standards for our Veterans because their cases are complicated and they are dealing with an abundance of different issues, and so, therefore, we should be far above and certainly not behind comparatively.

And we have certainly spoken, had many, many, many hearings in Washington about the overuse of drugs and medication and opioid addiction, and this is Dr. Dunn's, it is one of his favorite

topics, and if we are showing that we are overmedicating and that we may need to overmedicate slightly more than in private industry, but that is a real concern as it was reported in USA Today and I want to make sure that we get down to the bottom of it.

And so I have exceeded my 15 minutes and so I yield back to the Chairman. Thank you very much. I won't tell any of my Members back in Washington that you made—

Mr. DUNN. You cannot reveal how long this went over in Washington. I will be pilloried. So I yield to myself 15 minutes.

Ms. Krul, I have a quick question for you. You noted that a lot of your Veterans are at risk for skilled nursing placement and that the services you provide delay their nursing home placement. Do you have a sense of how much you are able to delay that?

Ms. KRUL. Yes, I do. We, in some cases, completely avoid placement. So our care is in some cases absolutely, if not for us, the person would've [KK2]been placed. So our care with all the meals, with all the nursing care, with all the personal care allows the veteran to live at home and continue—

Mr. DUNN. I know it is difficult. Have you developed a way to average the delay? Is there any way to quantify that? I understand it is a difficult metric.

Ms. KRUL. Yes and no. And we have several Veterans who absolutely have been with us for several years and would have been in the nursing home if not here. So these several years of quality of [KK3]life and living at home is there.

Some people who have stuck with us sometimes decline so much that our level of care is not appropriate for them anymore and then we refer them to other—

Mr. DUNN. But there are substantial savings for all the time that they—

Ms. KRUL. Absolutely.

Mr. DUNN. Let me ask you another question. Do you work with any of the VA caregiver coordinators, the ones we were talking about earlier in terms of respite for them, the caregiver coordinator?

Ms. KRUL. We work. How we work—

Mr. DUNN. Obviously, what you are doing is you are taking that veteran and coordinating care for them?

Ms. KRUL. Yes. Absolutely.

Mr. DUNN. Are you giving respite to the care coordinators as well?

Ms. KRUL. We absolutely do, just because we have a social work department, and that social work department coordinates care with the Department of Veterans Affairs. So people who will provide that care at home or otherwise don't need to do this. So our social workers coordinate everything what the veteran needs. We call directly in to the Department of Veteran Affairs social workers. They have very strong clinical staff, and they help us a lot with the coordinating care of the veteran.

Mr. DUNN. Very good. So something we were talking about a little earlier, there was the memory care and it keyed me to one of the points—one of the things that the VA, has another mission which is research and we actually have a fairly large research program across the country and some of that research is focused on

dementia, Alzheimer's, TBI, PTSD, all the various mental problems that are so common in our Veterans. I know you do research in the GLA. Do you do research in those areas?

Dr. HARTRONFT. Yes, sir. Between our MIRECC, which is the mental illness type of research and also the geriatric research, some of our caregivers look at everything from traumatic brain injury to aging and also more of the social factors; many times things like having a caregiver and then this respite and adult day health care, because one of the factors of increasing the veteran's chance of being institutionalized is caregiver burnout. So there are so many variables.

Mr. DUNN. I get that. But you are doing clinical trials down there in L.A. What is the availability up here in Ventura to participate in those clinical trials for these Veterans up here?

Dr. HARTRONFT. That is a good question. I think that is another area we can improve.

Mr. DUNN. Are either CalVet or are you aware of any availability of clinical trials inside the Veterans Administration up here in Ventura? So Ventura patients?

Mr. MCMANUS. No.

Mr. MARTIN. I am not aware of it.

Mr. DUNN. So the GLA is fortuitously located in very close proximity to world class academic centers that are doing research in these very areas, UCLA, Cedars Sinai, USC, et cetera. Do you work with them?

Dr. HARTRONFT. With the community partners you mean, sir?

Mr. DUNN. No. In research.

Dr. HARTRONFT. Yes. UCLA and many of our partners we overlap in many of the areas with aging and also traumatic brain injuries and other areas, yes, sir.

Mr. DUNN. And in my experience, we used to share a lot of faculty back and forth. Does that still happen?

Dr. HARTRONFT. Yes, sir.

Mr. DUNN. I was thinking about prostate cancer myself in my own niche of interest in medicine. You have some amazing prostate cancer research going on in L.A.

With researchers at the institutions I mentioned, are they working with your center?

Dr. HARTRONFT. Yes, sir. We have a lot of overlap with them, NIH funding, VA funding.

Mr. DUNN. So the VA funding is, of course, of immediate interest to us but also the NIH funding. Often, they collaborate on the same programs. And this stuff is deep, deep, deep in the Veterans, and it is actually also attached to the Agent Orange concerns as well as prostate cancer.

So that is an area that is of keen concern and if these Veterans up here in Ventura could participate in those clinical trials, I think that would be a very real—I think that would be a benefit for them. They are not going to find any better, deeper, more knowledgeable faculties than are available right here in this VISN; not the county but the VISN. So that is an important thing to put on the radar.

And I would like to come back actually. I have been out here a number of times on prostate cancer as a civilian. I guess I will have to go back as a Veterans Administration official.

Turning my thoughts one more time to a fond subject that I was reminded when a gentleman walked in here, the canine services. How much do they cost like on a per vet basis, would you say? This is typically for PTSD mental health.

Nobody has a feeling for that number? No granular numbers on that? That ought to be something to know. We all like it. I am a dog person and I like dogs, but I think we ought to have a feeling for what the cost is on that.

Do you have a feeling for what diagnoses the canine assistance program is applicable to other than PTSD? Nobody? Dr. Boyd?

Dr. BOYD. So in fact, it can be for any need, any clinical need or psychosocial need that the veteran has, actually.

Mr. DUNN. I mean like anxiety or—

Dr. BOYD. Or seizures. It could be for a lot of different things, yes, sir.

Dr. HARTONFT. Diabetes.

Mr. DUNN. So we are going to be visiting the GLA Med Center; if not the med center, the long-term care centers this afternoon. We certainly look forward to getting down there and talking with you.

Do you have any more pressing questions?

Ms. BROWNLEY. I just have one more question.

Mr. DUNN. I yield to Representative Brownley.

Ms. BROWNLEY. So Dr. Dunn and I were in a hearing, I think it was last week and what we were discussing was some rule changes around prosthetics and in some of the testimony—and Dr. Boyd, this question is really for you—and I don't know whether you are aware of some of the proposed rule changes with regards to prosthetics, but in testimony coming from many it was stated that in the rule change that issues like metal alert devices or personal emergency response systems or medical I.D. bracelets may no longer be provided to Veterans by the VA because of the way this rule has been changed.

And we, the Committee Members, argued very strongly against this, that this would be a very dangerous road to travel and how important that is, particularly as we are talking about today, and the reason I am bringing it up is about Veterans staying in home.

So I am just wondering if you could comment if indeed the VA goes through with this rule change, what are the impacts going to be on the institutionalized care or long-term care services.

Dr. BOYD. Thank you for the question. I am not familiar with the legislation and the technical—

Ms. BROWNLEY. It is not legislation. It is rule changes.

Mr. DUNN. It is promulgated inhouse at the VA.

Dr. BOYD. So I am not familiar with that. I definitely am interested. You have sparked my interest in that especially with the conversation here today. I would like to take that for the record and definitely get back to you. I wrote it down and that is one that really brings up a good point.

Ms. BROWNLEY. I mean, I think Dr. Dunn and I, we were definitely—

Mr. DUNN. We agree.

Ms. BROWNLEY [continued].—on the same wavelength and I think that based on this discussion my takeaway was that there is a big disconnect between the lawyers and the clinicians and that we need to get to the bottom of it but weighing in on issues that are under your jurisdiction would be very helpful in terms of ensuring that we get it right.

Dr. BOYD. I will definitely take that back. Thank you.

Mr. DUNN. Let me associate myself with those remarks because it doesn't make sense. And it really was—it appeared to be a very heavy-handed unilateral rules-making exercise that took no input from the VSS and no input from Congress.

So I think if you could go back and correct the direction of the ship on that, that would be greatly appreciated.

Let me tell you, we are going to adjourn this, but we will make ourselves available for some few minutes certainly, and our staffs here are available, and I hope you will take advantage of also the outstanding witness panel that we have to ask questions of them.

Thank you all very much for this productive and enlightening hearing. I can assure you that the future of VA long-term care and the quality of that care which you seem to enjoy an unusual high level out here in Ventura will continue to be a focus of this Subcommittee.

Thank you to the Ranking Member, Representative Julia Brownley. Thank you for requesting this hearing in the first place, and I have enjoyed us getting out of D.C. for a little while and seeing what the good folks of the West Coast are doing for fun.

If there are no further questions, we are now excused.

And I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material. And, without objection, that is so ordered.

This hearing is now adjourned.

[Whereupon, the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Katy Krul

Oxnard Family Circle Adult Day Healthcare is a medical model day program that provides care for Veterans in our community. The Veterans who receive care are at risk of skilled nursing placement if they do not receive services at the center. They are frail, elderly individuals who require intervention from registered nurses, rehabilitative services, and assistance with personal care needs including toileting, feeding, and bathing. We provide transportation for Veterans from their homes to the center, meals, stimulating daily activities, social work case management services and psychological counseling, massage services, and podiatry care. The center also has a specialized memory care unit that we developed in conjunction with the Alzheimer's Association.

Many of the spouses or other family members of our Veterans are overwhelmed with the day-to-day responsibility of caring for the Veteran. We find that the caregivers are at risk of experiencing a decline in their physical and mental health conditions. Our program is the resource for vital respite care for many families as it offers day-long extended services for 5 days per week.

Oxnard Family Circle provides care to Veterans who have served in World War II, Korea, Vietnam, and Iraq war periods. Essential benefits for veterans in our program are comradeship, the sense of social belonging, and connection to a group that is unique to their shared military experiences. We develop an individualized treatment plan for each Veteran that focuses on the specific medical, dietary and psychiatric needs of that person. Specialized programming that is provided includes an Equine Therapy program, outings that facilitate integration into the community, psychological groups, 1:1 counseling services, Music and Memory activities, Art therapy, support groups for family members, educational events in conjunction with the Disabled American Veterans, Alzheimer's Association, Public Health and Ventura County Area Agency on Aging.

Our setting allows the Veterans to function with a sense of dignity. In the home setting, they often feel diminished as their loved ones assist them with basic activities of daily living including toileting, bathing, having assistance with transfers and walking. Many of our Veterans are uncomfortable and resistant to family members providing this level of assistance. Veterans and their families benefit from the personal care assistance that is provided by Oxnard Family Circle's professional staff.

Oxnard Family Circle works closely with the Department of Veteran's Affairs to coordinate the care needs of Veterans. Referrals for Adult Day Healthcare services may be received from the local VA Outpatient Clinic. Many Veterans reside in our community who may not be connected with the VA Healthcare System. Our staff educates Veterans as to the types of benefits that they may receive and assists them with enrolling in the healthcare system.

We also refer Veterans and families to the Ventura County Veterans Services Office for assistance with financial benefits. We maintain close communication with the Veteran's physician and VA Social Workers during the time that the Veteran is enrolled in our program. When a Veteran's care needs increase so that Adult Day Healthcare Services are no longer appropriate, Veterans may be referred to the VA Community Nursing Home Program or VA Hospice services. Aid and Attendance may be applied for to pay for care in the Veteran's home setting or an assisted living facility.

All Veterans who are VA Healthcare Eligible may be appropriate for Adult Day Healthcare Services, as long as the Veteran has been determined to have the following clinical conditions:

- 1.Three or more Activities of Daily Living Dependencies (ADL), or
- 2.Significant Cognitive Impairment, or
- 3.Require CADHC services as adjunct care to community hospice services, or

4. Two Activities of Daily Living Dependencies and two or more of the following conditions:

- a) Has dependency in three or more Instrumental Activities of Daily Living (IADL);
- b) Has been recently discharged from a nursing facility, or upcoming nursing home discharge plan contingent of home & community-based care services;
- c) Is seventy-five years old, or older;
- d) Has had high use of medical services defined as three or more hospitalizations in the past year and/or utilization of outpatient clinics/emergency evaluation units twelve or more times in the past year;
- e) Has been diagnosed with clinical depression;
- f) Lives alone in the community.

We are particularly appreciative of the support and advocacy that has been provided to us by Congresswoman's Julia Brownley's office.

Thank you for allowing me this time to talk about the services that are provided by Oxnard Family Circle Adult Day Healthcare.

On behalf of Oxnard Family Circle ADHC:

Katy Krul,
Acting Executive Director

Maria Meza,
Program Director

Prepared Statement of Mike McManus

Ventura County Human Services Agency

Good morning, Chairman Dunn, Ranking Member Brownley, and Members of the Committee. Thank you for the opportunity to provide information to the Committee regarding long term care options to Southern California veterans through the Greater Los Angeles Department of Veterans Affairs (VA) Healthcare System.

My name is Mike McManus and I am the County of Ventura, Veteran Services Officer. My staff and I connect fellow veterans, their dependents, and survivors with federal and state veterans' benefits and local resources. One of our primary responsibilities is connecting veterans with VA disability compensation for such conditions as Post Traumatic Stress, Traumatic Brain Injury (TBI), and for conditions resulting from physical injury while in the military. We also assist veterans to enroll in VA health care and refer to local and regional care resources.

The Veteran Services Office has five accredited personnel who interview veterans, file the appropriate benefit claim, advocate on behalf of the veteran, and make needed referrals to other service providers. We also have support staff that enable us to meet client needs. The Veteran Services Office has conducted a variety of outreach activities to inform the veteran community about benefits, to include VA health care. The office currently operates out of the main office and 10 field offices to make it as convenient as possible for veterans to meet us. We partner with a variety of organizations helping connect veterans to earned benefits and services. One primary source of partnership is through the Veteran Collaborative of Ventura County, which is led by the Veteran Services Office. The VSO is reaching more veterans than ever before. In Fiscal Year 12/13 the office saw 3,572 people, however, by Fiscal Year 17/18 office staff assisted 6,764 people (source: VetPro). In FY 12/13 the Veteran Services Office connected county veterans with over 8.75 million dollars in federal benefit payments, but by FY 16/17 (latest year stats available), those benefit payments totaled over 11.5 million dollars (source: 2018 California Association of County Veteran Service Officer Annual Report).

I am a retired United States Air Force Senior Master Sergeant. I spent the last seven years of my 20 years in the military as a First Sergeant with one deployment for Operation Iraqi Freedom in 2003. As a First Sergeant I had overall supervision over all enlisted personnel with my units. I advised the unit commanders on all matters affecting their enlisted force to include issues involving mental & physical health and substance abuse, and those conditions that might impact service members, their families, their career, and the unit.

I've been the County's Veteran Services Officer since January 2010. My staff and I and partners such as the Ventura County Area Agency on Aging, assist Ventura

County veterans needing long term care. There are a variety of options available to veterans, provided they are enrolled in VA health care and are made aware of the various program options. Usually, the veteran would start by seeing their primary care provider and social worker at the Oxnard Community Based Outpatient Clinic.

Ventura County has over 40,000 veterans, thousands more National Guard, Air National Guard, and Reserve personnel who may over time be eligible for VA long term care. Approximately 22,000 Ventura County veterans served in World War II, Korea, and Vietnam and range in age from 65 up. In addition to the typical ailments of aging, over 4,100 of these veterans also have chronic injuries from military service.

In essence you have tens of thousands of veterans in Ventura County and many of these will need some form of long term care. I feel there is a large unmet need in the community due to misperceptions by veterans and lack of information from the VA. My staff and I have spoken with countless veterans who thought Medicare, Tricare, and/or the VA would provide for their long term care needs. They aren't aware that Medicare provides very little long term care, Tricare much less, and the VA only if the veteran is eligible, typically 70 percent service connected or higher. As outreach to the military/veteran community increases from organizations such as the Ventura County Veteran Services Office and the Veteran Collaborative of Ventura County the number of veterans seeking services increases and we can better educate them on realistic options.

In addition to veteran misperceptions, there is a lack of information provided to veterans regarding VA long term care options. There are a variety of options viable to veterans, including:

- VA nursing home care on the campus of the Greater LA Medical Center, care through one of the community nursing homes the VA contracts with such as Coastal View Health Care Center in Ventura and Shoreline Care Center in Oxnard, and care in one of the California Department of Veterans Affairs (CalVet) Veterans Homes that provides memory and/or skilled nursing care. The Homes are a wonderful experience for the veterans living there, however, most California veterans will not have the opportunity due to lack of beds.

Typically, a vet must be 70% service connected or higher to be eligible for VA nursing home care. Many veterans assume they're eligible once enrolled in VA health care, but that's not the case. Only four percent (4%) of Ventura County veterans have a service connected rating of 70% or higher.

- In some cases, the veteran turns to Medi-Cal to provide nursing home or health care aid. In this case, the Veteran Services Office will refer the veteran to a county Human Services Agency Community Service Center for information and enrollment. We will do what we can to connect a veteran with their VA benefit, but in some cases the veteran is ineligible for VA health care (e.g. Other Than Honorable Discharge), is not 70% service connected for injuries from service, or the veteran simply decides not use the VA for personal reasons.

- A veteran's VA primary care provider may also request a veteran's use of the Homemaker and Home Health Aide Care program, which use an organization that has a contract with the VA. A Homemaker or Home Health Aide can be used as a part of an alternative to nursing home care, and as a way to get respite care at home for veterans and their family caregiver. This program can help keep a veteran in their home.

- Ventura County is blessed to have Oxnard Family Circle providing adult day health care for veterans. They provide skilled services from nurses, therapists & social workers, case management and help with activities of daily living. This vital program provides much needed respite care for a family caregiver. This program can help keep a veteran in their home.

- There are several hospice providers in the county assisting veterans such as Livingston Memorial Visiting Nurse Association and Vitas. We've routinely heard positive comments about these two service providers as they assist veterans and their families at end of life. Hospice providers not only comfort the veteran, but refer to the Veteran Services Office so we can speak with the veteran or a family member about VA benefits. Many times, this is the first time such a discussion has occurred.

- The above programs come from the Veterans Healthcare Administration (VHA), but now I want to mention a benefit provided by the Veterans Benefits Administration (VBA), that can help veterans. Aid & Attendance (A&A) is a monthly amount paid in addition to either disability compensation or pension when the veteran requires the aid of another person in order to perform essential functions of daily liv-

ing, or they are bedridden, or are a patient in a nursing home, or who are limited to a corrected 5/200 visual acuity or less in both eyes. The A&A benefit can be used by the veteran to pay for a care giver to enter their home or to help pay the cost of living in an assisted living facility. This benefit is helpful, but by no means covers the cost of care.

The Veteran Services Office and our many partners will continue to assist our veterans. However, I feel the VA should counsel every veteran that is 70% service connected or higher on his or her long term care options. Ideally, this would be done via local town hall meetings so veterans can address specific circumstances with VHA representatives well versed in the many VA programs.

The VA should also educate veteran service organizations on VA long term care programs so they can assist in counseling veterans on their options.

I also feel the VA should expand their community partnerships with adult day health care providers to prolong veterans in their own homes and to provide respite for their care givers.

I'd like to thank Chairman Dunn and Ranking Member Brownley for this opportunity.

Points of contact from organizations reference above:

Ventura County Area Agency on Aging, Victoria Jump at 805 477-7300
 Coastal View Health Care Center, Jill at 805 642-0156
 Shoreline Care Center, Mike Frasier at 805 746-9681
 Oxnard Family Circle, Katy Krul at 805 385-4180
 Livingston Memorial Visiting Nurse Association, Diana Davis at 805 509-9280
 Vitas, David Mack at 805 437-2100

Prepared Statement of Thomas Martin

Members of the Subcommittee:

Thank you for the opportunity to provide written testimony regarding the future of veterans' long-term care. Understanding and projecting healthcare needs has become a top priority for the California Department of Veterans Affairs (CalVet) and we welcome any efforts to improve collaboration between the state, the federal government, and private providers. As I will discuss later in my testimony, the Subcommittee and CalVet are grappling with similar long-term care issues, parallel work which may offer opportunities for collaboration and innovative partnerships.

Background

CalVet operates eight Veterans Homes throughout the state, offering comprehensive services including medical care, dentistry, pharmacy, activities, , and various rehabilitation modalities programming. Ranging in size from 60 to 900 residents, the Veterans Homes are located in Barstow, Chula Vista, Fresno, Lancaster, Redding, Ventura, West Los Angeles, and Yountville.

To be eligible for admission, applicants must be former active duty servicemembers who were discharged under other-than-dishonorable conditions; in addition, they must be aged or disabled California residents who qualify for health care from the U.S. Department of Veterans Affairs (VA). Spouses of veterans may be eligible for joint admission. Priority admissions are available for recipients of the Medal of Honor, former prisoners of war, homeless veterans, and those with 70% or greater service-connected disability ratings. Today, the Veterans Homes care for up to 2,400 veterans and spouses.

Every state throughout the country operates at least one Veterans Home, each of which is closely connected to the VA. The VA annually surveys and certifies these facilities to ensure residents receive quality health care in a safe living environment. Once certified, the VA pays a per diem for all qualified veterans, ranging from approximately \$50 to more than \$500 per day, depending on the veteran's location, service history, and care needs. In addition, the VA funds up to 65% of construction costs for approved projects. Finally, many of our residents receive specialty and other services from the VA.

Demographic Changes

CalVet is at a turning point in its history. For nearly 130 years, the State of California operated no more than three Veterans Homes that emphasized dormitory-style independent living units with shared bedrooms and bathrooms. Beginning in 2009, five additional Veterans Homes opened in response to an increased demand for higher levels of care throughout the state and strong support for veterans' pro-

programming. As this construction and expansion period is ending and we are seeing the beginning of a massive demographic shift in the veteran population, CalVet is again exploring how veterans' care needs have changed in recent decades, how to coordinate with and take best advantage of proximity to VA support, how best to utilize the resources it has, and how the Department can best position itself for the future.

There are clear generational differences among veterans and these translate into differences in how they utilize long term care. Current residents served in World War II, in the Korean War, and - in increasing numbers - during the Vietnam Era. Different generations of veterans have very different physical, psychological, and emotional care needs, as well as different preferences for how they spend their time and the ways in which they interact with their peers.

Today, we see veterans are applying for admission later in life, caring for themselves for as long as possible and arriving at our Veterans Homes with greater care needs than prior applicants. A growing number of applicants were previously homeless and require substance abuse and mental health services. The demand for higher levels of care and specialty services has increased significantly.

Long-Term Care Needs Assessment

To meet the coming demographic changes, CalVet is undertaking an extensive statewide needs assessment. We have recruited several highly skilled individuals to lead this effort, using an array of surveys, studies, and datasets to develop projections. Based on all of these projections and the programming and resources of our facilities, CalVet will identify potential shortcomings in services while exploring the role of the Veterans Homes and other providers in bridging those gaps. The VA has graciously provided access to its data as well as support via subject-matter expertise, and we greatly appreciate its assistance with CalVet's project.

While our research is ongoing, we expect the assessment to confirm and reinforce some of the trends we already notice. For example, we anticipate continued demand for skilled nursing care as veterans live longer and have more complex healthcare issues. In particular, there will likely be a sustained need for secured memory care units for veterans with dementia-related illnesses.

CalVet also expects more demand for mental and behavioral health programming focusing on post-traumatic stress, substance abuse, and other conditions. Veterans with these conditions may not fit the classical model of a long-term care patient.

Finally, and perhaps most importantly, CalVet hopes to develop a better understanding of how the VA, Veterans Homes, non-profit organizations, and private long-term care facilities are or are not equipped to meet these challenges and what the VA's long-term plans are so all providers understand their respective roles in veterans' care.

No single entity can offer every service for every veteran. As healthcare providers, it is critical that we work together to identify our current and future roles in serving the aging veteran community. This hearing is an excellent opportunity to work toward that goal.

Conclusion

We are in the leading edge of a massive shift in the veteran population demographic. Veterans' healthcare needs and preferences are evolving, and their service providers must anticipate and adapt to those changes. CalVet will continue to collaborate with the VA and with industry leaders to ensure veterans receive the full spectrum of care that they earned in service of their country. Again, thank you again for the opportunity to address the Subcommittee and for convening this hearing on veterans' long-term care.

Prepared Statement of Teresa Boyd, D.O.

Good morning Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee. I appreciate the opportunity to discuss VA long-term care for Veterans and Veterans' choices for care as they age or face catastrophic injuries or illnesses. I am accompanied today by Dr. Scotte Hartronft, Chief of Staff, Greater Los Angeles Healthcare System.

Introduction

VA's Office of Geriatrics and Extended Care (GEC) is committed to optimizing the health and well-being of Veterans with multiple chronic conditions, life-limiting illness, frailty or disability associated with chronic disease, aging, or injury. GEC's

programs maximize each Veteran's functional independence and lessen the burden of disability on Veterans, their families, and caregivers. VA believes that these programs also honor Veterans' preferences for health and independence in the face of aging, catastrophic injuries, or illnesses by advancing expertise and partnership. The overarching goal of GEC is to provide optimal service to these Veterans while also empowering them with access, choice, and balance in their care. VA has recognized the importance of GEC programs and services by designating GEC, along with Primary Care and Mental Health, as a foundational service for the Department.

An Aging Population

Nearly 50 percent of the more than 9 million Veterans currently enrolled in the VA health care system are age 65 years or older. Between 2016 and 2026, the number of enrolled Veterans age 70 and older is projected to increase by 30 percent, from 3 million to an estimated 3.9 million. During the same time frame, the number of enrolled Veterans age 70 and younger is projected to decrease by 8 percent. The number of Veterans over the age of 85 enrolled in the system has increased almost 11-fold between 1999 and 2014 and is projected to surge more than 17-fold by 2034.

As Veterans age, approximately 80 percent will develop the need for long term services and supports (LTSS). Most of this support in the past has been provided by family members, with women providing most of the care. The number of potential family caregivers per older adult in America is currently seven, but the number of potential family caregivers will drop to four in 2030. The availability of these potential family caregivers can be jeopardized due to work responsibilities outside the home. Moreover, many Veterans are divorced, have no children, are estranged from their families, or live long distances from family members. This is especially true for the increasing numbers of women Veterans who are at higher risk for needing LTSS due to their longer life expectancies and greater risk of disability than men at any age.

The aging of the Veteran population has been more rapid and represented a greater proportion of the VA patient population than observed in other health care systems. Addressing the needs of these Veterans was recognized as a priority in the early 1980s. This led to development of 20 currently-existing centers of excellence called Geriatric Research, Education, and Clinical Centers and innovative models of care to meet this population's needs. The innovative patient care programs developed within VA have been shown to optimize Veterans' function, prevent unnecessary and costly nursing home admissions and hospitalizations, reduce unwanted and unnecessary tests and treatments, and thereby reduce health care costs.

GEC Programs In-depth

GEC's programs include a broad range of LTSS that focus on facilitating Veteran independence, enhancing quality of life, and supporting family members and Veteran caregivers. Many of the services provided via these programs are not available in any other health care system. The four categories of LTSS are Home and Community-Based LTSS, Facility-Based Care and Hospice Care, Ambulatory Care, and Inpatient Acute Care.

Home and Community-Based LTSS

Home and Community-Based services (HCBS) support independence by allowing the Veteran to remain in his or her own home as long as possible. More than one service can be received at a time. These programs include the following:

- **Adult Day Health Care:** A program Veterans can go to during the day for social activities, peer support, companionship, and recreation. The program is for Veterans who need skilled services, case management, and help with activities of daily living. Most Adult Day Health Care is purchased from community providers, but some VA medical centers (VAMC) also provide this service within their facilities.
- **Home Based Primary Care (HBPC):** Health care services provided to Veterans in their homes. A VA physician supervises the health care team that provides the services. This program is for Veterans who have complex health care needs for whom routine clinic-based care is not effective.
- **Homemaker/Home Health Aide:** A trained person comes to a Veteran's home and helps the Veteran take care of him or herself and his or her daily activities. These aides are not nurses, but they are supervised by a registered nurse who will help assess the Veteran's daily living needs.
- **Palliative and Hospice Care:** This program offers comfort measures that focus on relief of suffering and control of symptoms so that Veterans can carry out day-to-day activities. It can be combined with standard treatment and started

at any time through the course of an illness. VA established palliative care teams in every VAMC over a decade ago. Only 67 percent of non-VA hospitals with greater than 50 beds have palliative care teams.

- Respite Care: This service pays for a person to come to a Veteran's home or for a Veteran to go to a program while their family caregiver takes a break. Thus, the family caregiver is allowed time without the worry of leaving the Veteran alone.
- Skilled Health Home Care: Short-term health care services that can be provided to Veterans if they are homebound or live far away from a VAMC. The care is delivered by a community-based home health agency that has a contract or provider agreement with VA.
- Telehealth: This service allows the Veteran's physician or nurse to monitor the Veteran's medical condition remotely using monitoring equipment. Veterans can be referred to a care coordinator for enrollment in Home Telehealth services by any member of their care team. Enrollment is approved by a VA provider for Veterans who meet the clinical need for the service.
- Veteran-Directed Care: This program gives Veterans of all ages the opportunity to receive the Home and Community-Based Services they need in a consumer-directed way. Veterans in this program are given a flexible budget for services that can be managed by the Veteran or the family caregiver. As part of this program, Veterans and their caregiver have more access, choice, and control over their long-term care services.

It should be noted that Adult Day Health Care, Home Based Primary Care, Homemaker/Home Health Aide, Palliative and Hospice Care, Respite Care, and Skilled Home Health Care are all part of the Standard Medical Benefits package all enrolled Veterans with clinical needs receive.

While HCBS continues to improve care for Veterans, it has also helped reduce costs for the Department. VA financial obligations for nursing home care in fiscal year (FY) 2017 reached \$5.7 billion. The number of Veterans with service-connected disabilities rated 70 percent or more, for whom VA is required to pay for nursing home care, if it is needed, is projected double from 500,000 to 1,000,000 Veterans between 2014 and 2024. Therefore, if nursing home utilization continues at the current rate among Veteran enrollees, without consideration of inflation, the costs to VA for providing nursing home care for enrolled Veterans can conservatively be estimated to reach more than \$10 billion within the next decade.

Fortunately, appropriate targeting and use of the programs and services available through GEC, especially those services that are provided in home and community based settings, can reduce the risk of preventable hospitalizations and nursing home admissions and their associated costs substantially. Therefore, VA has increased access to HCBS over the last decade. There is an urgent need to accelerate the increase in the availability of these services since most Veterans prefer to receive care at home, and VA can improve quality at a lower cost by providing care in these settings.

States have found that through their Medicaid programs they have been able to reduce costly nursing home care by balancing their expenditures for long term services and supports between institutional and home and community based settings. Nationally, more than 50 percent of Medicaid expenditures for LTSS are for home and community based personal care services. Comparable personal care services (Home maker/Home Health Aide, Respite, and Adult Day Health Care) accounted for \$0.89 billion (11.1 percent) of VA's LTSS obligations in FY 2017. The total budget of all HCBS including personal care services accounted for 31 percent of the LTSS budget obligations in FY 2017. Current annual per Veteran costs for nursing home care are 8.6 times the annual costs for HCBS within VA.

Residential Settings are supervised living situations that provide meals and assistance with activities of daily living. These settings require the Veterans to pay their own rent, but HCBS can be provided if the Veteran has certified needs and is enrolled in the VA health care system. Medical Foster Homes (MFH) fall within this category. MFHs provide an alternative to nursing homes in a personal home at substantially lower costs. VA provides program oversight and care in the home by HBPC, while the Veteran pays on average \$2,400 per month for room, board, and daily personal assistance. MFHs currently operate in 45 States providing care for over 1,000 Veterans each day at a significant cost savings as compared to care provided in community nursing homes. Additionally, Veterans express much higher levels of satisfaction from care provided through the MFH program. Currently, non-VA MFH models are available in only two states.

Facility Based Care

Nursing homes are settings in which skilled nursing care, along with other supportive medical care services, is available 24 hours a day. All Veterans receiving nursing home care (NHC) through VA, whether provided in a VA-operated Community Living Center (CLC) or purchased by contract in a community nursing home (CNH), must have a clinical need for that level of care. VA strives to use NHC when a Veteran's health care needs cannot be safely met in the home. Certain Veterans have mandatory eligibility for nursing home care. These Veterans have service-connected disabilities rated at 70 percent or greater or who need nursing home care for service-connected conditions. Veterans with mandatory nursing home eligibility can be provided care in a VA CLC or a private nursing home under contract with VA. Consideration is given for Veterans' preferences based upon clinical indication and/or family/Veteran choice, when possible. Veterans without mandatory nursing home eligibility, a population that makes up the majority of Veterans, receive care on a resource available basis. If these Veterans are admitted to the CNH Program, placement at VA expense is limited to 180 days. More non-mandatory Veterans who need nursing home care usually receive that care in VA CLCs rather than in private nursing homes at VA expense.

VA also maintains strong, working relationships with the states in the oversight and payment of Veterans' care through State Veterans Home (SVH). Through this partnership, states provide care to eligible Veterans across a wide range of clinical care needs through services including nursing home care, domiciliary care, and adult day health care programs. VA provides construction grant funding during the initial construction of the state home, continuing operating funds for eligible Veterans through a grant and per diem program, and ongoing quality monitoring to ensure Veterans in SVHs receive high quality care in accordance with VA standards. Currently, there are 156 SVHs across all 50 states, including one here in Ventura, California.

Ambulatory Care and Inpatient Acute Care Programs

Finally, GEC offers Ambulatory Care programs including Geriatric Patient-Aligned Care Teams (GeriPACT), and Inpatient Acute Care Programs including Geriatric Evaluation and Management (GEM) and a variety of dementia and delirium programs. GeriPACT clinics provide longitudinal, interdisciplinary team-based outpatient care for high-risk, high-utilization, and predominantly (but not exclusively) elderly Veterans. The teams have enhanced expertise for managing Veterans whose health care needs are particularly challenging due to multiple chronic diseases, coexisting cognitive and functional decline, as well as psychosocial factors. GeriPACT integrates and coordinates traditional ambulatory and institution-based health care services with a variety of community-based services and strives to optimize independence and quality of life for these particularly vulnerable Veterans in the face of their multiple interacting cognitive, functional, psychosocial, and medical challenges. GeriPACT panel sizes are one-third smaller than regular PACT teams and have a social worker and a pharmacist as core members. By helping Veterans maintain function, preventing unnecessary hospitalizations, nursing home admissions, and unwanted tests and procedures, the total costs of care for targeted high-risk Veterans are about 15 percent lower when they are managed in GeriPACT than when managed by regular Primary Care PACT teams. Currently, only about half of VAMCs have GeriPACT, and VA is working to expand this program to larger Community-Based Outpatient Clinics.

Conclusion

VA's various long-term care programs provide a continuum of services for older Veterans designed to meet needs as they change over time. Together, they have significantly improved the care and well-being of our Veterans. These gains would not have been possible without consistent Congressional commitment in the form of both attention and financial resources. It is critical that we continue to move forward with the current momentum and preserve the gains made thus far. Your continued support is essential to providing high-quality care for our Veterans and their families. Mr. Chairman, this concludes my testimony. My colleague and I are prepared to answer any questions.

Statement For The Record

BERNARD SALICK, M.D.

Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee:

The purpose of this hearing is intriguing on a number of levels. Long-term care, a topic of interest to all people, comprises a growing sector of health care and is of special significance for the VA. Our nation, as a whole, is aging. This underscores the 21st Century health care system's success in extending our years today.

I commend the VA and this Committee for their wisdom in seeking alternative options to provide long-term health care to our Veteran population, given its particular range of needs, challenges and resources. Long-term health care services encompass a broad spectrum, including medical foster homes, adult day care, community living centers, caregiver programs and skilled nursing facilities. Each of these covers a specific set of health care needs. Each is required. Each is well-suited to a particular segment of the patient base. And each faces a key requirement - to maintain maximum health and capability for every Veteran for as long as possible.

Obviously, significant differences in health care needs of Veterans exist within these various long-term care options; and catastrophic disease and accidents intervene as we age. Thus, every long-term care option must be buttressed by access to specialized, comprehensive and coordinated acute and chronic care.

I am honored to offer my thoughts and experiences, garnered through 40-plus years in pioneering the creation of comprehensive outpatient diagnostic and treatment centers for catastrophic diseases. Our team has developed and refined a successful formula for delivering care to patients suffering from cancer, end-stage renal disease, HIV/AIDS, cardiovascular and many other diseases. Today we stand ready to meet the next challenge.

Several years ago, I began surveying our nation's health care landscape for areas requiring enhanced medical treatment. I concluded diabetes to be the significant catastrophic disease of epidemic proportion, standing at the forefront in desperate need of redesign, reinvigoration, and a medical approach that forms the basis of The Salick Formula to treat catastrophic disease.

Therefore, we have determined diabetes to be the necessary and logical next step for The Salick Team to target. It is an exponentially growing disease afflicting more than 30 million Americans, 24% of whom remain undiagnosed.

- The American Diabetes Association reports diabetes to be the "most costly chronic illness in the country, with expenses totaling \$327 billion in 2017."
- They document, "one of every seven health care dollars is spent directly treating diabetes and its complications." Any person suffering from diabetes can expect medical expenditures 2.3 times higher than other diseases.

Given these facts, it is obvious diabetes threatens the long-term health of our nation, and it is draining our economic strength. Following extensive scrutiny of where to most effectively target this disease, it became evident diabetes poses one of its greatest threats to America's Veteran population. The VA's patient enrollment of more than nine million is characterized by a high prevalence of patients with diabetes (twice the national average).

- One of every four enrolled patients in the VA Health Care System has diabetes.
- Moreover, 80% with diabetes also have microvascular complications, such as blindness and end-stage renal disease.
- And 70% suffer from obesity.
- Of those receiving service-connected disability compensation, more than 431,000 have diabetes. The number of diabetes diagnoses increases proportionately as our Veterans age.
- More than 35% of VA's patient population become stricken with one or more chronic conditions. A Stanford study shows that treating patients with one or more chronic conditions consumes 72% of the VA's Health Care budget.

The VA Health Care System and the Salick Comprehensive Diabetes Centers are able to fit well together to form a participating joint venture that will bring a new paradigm to the ever-increasing diabetes epidemic facing the globe. The Salick Formula lends itself well to complement the VA System. We have developed a model - beginning with two Centers - that could be replicated into a nationwide network of comprehensive, outpatient, 24/7 diabetes centers and satellites. The Center model would follow the Salick Formula:

a)First, by focusing on preventative care and educating the population on lifestyle changes that can prevent complications.

b)Second, by providing coordinated care through a team of practitioners that manage all of a patient's diabetes-related conditions and comorbidities (including complications of diabetes which make up over 93% of costs of the disease) and that work in an interdisciplinary fashion in a single location to develop an overall care plan, based on demonstrated best practices, that best suits the needs of each patient.

c)Third, by offering Veterans and military families the convenience of a “one stop shop” location that can provide virtually all diabetes-related treatments for patients and that offer the convenience of full staffing on a 24/7/365 basis.

d)Fourth, by locating satellite facilities in areas of greatest need to provide immediate access to care for our nation’s chronically underserved populations, in metropolitan and in less populated areas - which the CDC has identified as regions with the highest concentrations of diabetes and pre-diabetes.

In selecting appropriate venues to begin locating and jointly operating comprehensive diabetes centers in a coordinated assault against this disease, two areas of the nation stand out:

1)California:

a.Home to over 1.8 million Veterans; 325,000 in Los Angeles, 81,000 of whom have diabetes; nearly all of those have micro, or macrovascular complications.

b.The VA Greater Los Angeles outpatient clinics and inpatient wards are already at capacity in attempting to deal with this population, with estimated encounters of only 90,000/year at the West Los Angeles VA.

c.Veterans and their families who suffer from diabetes and its complications, and who presently do not receive coordinated care for all of their related complications or adequate care management, could benefit significantly from a 24/7 top quality comprehensive center. These Centers will improve outcomes and reduce acute episodes and hospitalizations, thereby improving care while controlling costs.

d.It appears that Veterans with diabetes are encountering significant hurdles in obtaining approvals for bariatric surgery, a growing treatment for this disease. A very low percentage of Veterans have been approved for this compared with the general public.

e.Additionally, the entire Southern California area is home to Veterans and active duty military from Los Angeles County extending to 29 Palms, Camp Pendleton, and the San Diego area; including the U.S. Naval Hospital.

2)Alabama:

a.Ground Zero for the Centers for Disease Control and Prevention’s “Diabetes Belt” (U.S. counties >12% prevalence of diabetes), Alabama ranks 2nd nationally (14.6%) according to 2016 Kaiser Family Foundation study; 500,000 Alabamians have diabetes; by 2030 that number is estimated to reach 661,000.

b.Neighboring states also high: Mississippi (13.6%); Arkansas (13.5%); Louisiana and Georgia (12.1%); Florida (11%). Alabama also ranks high in Adult Onset Hypertension (2nd at 40.4%); Obesity (3rd at 35.7%); and lack of exercise (31.5%).

c.Numerous military bases and an extensive VA Health Care System are located within Alabama and its neighboring states.

Diabetes patients in civilian, VA and DOD health care systems often face additional problems when their primary care physicians become disconnected from specialist interventions they receive when forced to seek late-night and weekend Emergency Room visits. These weekend and evening ER encounters can result in in-patient hospitalizations, often without the knowledge or participation of their local family doctors. Emergency care for diabetes patients in acute circumstances, when provided in a disconnected manner from a patient’s primary care physician, can significantly minimize benefits they could have received and result in extreme cost.

The Salick Team is interested in developing a unique agreement with the VA which might enable construction and joint operation, with the VA, of innovative 24/7 Comprehensive Diabetes Centers and satellite facilities. These Centers would benefit from our history of successfully managing treatment of chronic and catastrophic diseases which then would be focused on diabetes - and its related complications which account for over 93% of the costs of treating diabetes. These Centers would be available to Veterans, including those in all types of VA long-term care facilities and programs. Further, they would be designed to take advantage of state-of-the-art technologies, outcome measurements, and advanced scheduling procedures to avoid unnecessary emergency hospitalizations via 24/7 access to specialists and procedures putting the patient’s needs first - during any day or hour a patient needs medical care.

I salute the VA and this Committee for your continuing efforts, creativity and determination to improve health care for our nation’s Veterans. Our Team stands

ready to join the VA and this Committee in your valiant mission to “best serve our aging heroes.”

Thank you.

