

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

Mr. Chairman and Members of the Subcommittee:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment 1

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

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

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

Attachment 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Activity	Description	Timetable
Clarify eligibility standards and provide guidance	<ol style="list-style-type: none"> 1. Information Letter on mandated nature of eligibility for H&CBC 2. Handbooks & Directives for program operations 3. Wait List policy to be included in directives and handbook for home-based primary care (HBPC) 4. Standards for Establishing Programs for HBPC 5. VHA Handbook 1140.2, Respite Care 	<p>May 2003</p> <p>September 30, 2003</p> <p>September 30, 2003</p> <p>September 30, 2003</p> <p>Completed May 20, 2003</p>
LTC Needs Analysis	<ol style="list-style-type: none"> 1. Refining LTC model 2. Integrating new model into program planning 	<p>June 30, 2003</p> <p>September 30, 2003</p>
Education	<p>Conferences</p> <ol style="list-style-type: none"> 1. Health Services Research & Development 2. H&CBC: Leadership in Action 3. Pain Management Conference 4. Accelerated Clinical Training – Hospice and Palliative Care 5. Bridging Workforce Gap for our Aging Society 	<p>September 2003</p> <p>June 2003</p> <p>Completed Mar 6, 2003</p> <p>September 2003</p> <p>April/May 2003</p>
Care Coordination	<ol style="list-style-type: none"> 1. Function: A patient centric approach to integrating the care of patients across the continuum of care and provide appropriate level of care when and where the patient needs it. 2. New Program Office established. 3. VISN 8 Community Care Coordination Service created in October 1999. Use findings of VISN 8 pilot to inform H&CBC 	<p>May 2003</p> <p>September 30, 2003</p>
Monitor Performance	<ol style="list-style-type: none"> 1. Maintain current access to LTC services 2. Monthly Performance Report to Deputy Secretary 3. Discuss formal Performance Measure and set specific program targets of nationwide coverage 4. Discuss incentives to expand access with 10Q, 10N, (17) Finance Office 	<p>Ongoing</p> <p>Ongoing</p> <p>September 30, 2003</p> <p>July 30, 2003</p>
Evaluate New Approaches	<ol style="list-style-type: none"> 1. Pilot tests of effectiveness of comprehensive Long Term Care services at 3 sites, Columbia, SC, Denver CO., and Dayton, OH 2. Pilot test of effectiveness of assisted living substitute 	<p>FY 2005</p> <p>October 2004</p>