

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The timetable for the program is as follows:

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

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

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

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

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

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

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

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

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

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

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