STATEMENT OF
TERESA BOYD, D.O.
ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH
FOR CLINICAL OPERATIONS
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
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Good morning Madam Chairwoman, Ranking Member Dunn, and distinguished Members of the Subcommittee. I appreciate the opportunity to discuss VA long-term care and Veterans' choices for care as they age or face catastrophic injuries or illnesses. I am accompanied today by Dr. Beth Taylor, Chief Nursing Officer; Dr. Scotte Hartronft, Executive Director, Office of Geriatrics and Extended Care (GEC); and Dr. Elyse Kaplan, Deputy Director, Caregiver Support Program.

Introduction

VA 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. For the increasing numbers of Veterans, of any age, facing the challenges of serious chronic diseases and disabling conditions, VA GEC offers a comprehensive spectrum of geriatrics, palliative care, and long-term services and supports (LTSS) that surpasses all other US health care systems by providing services in the home, community, clinics, hospitals, and nursing facilities. The overarching goal of GEC is to meet these Veterans' long-term care needs in the least restrictive setting through access to options that honor their choice while promoting their optimal independence, health, and well-being. Our strong history of innovation continues, advancing models of care, practices, training, and partnerships that improve care not only for Veterans but for all Americans.

An Aging Population

Nearly 50 percent of the more than 9 million Veterans currently enrolled in VA's health care system are 65 years old or older. Between 2018 and 2028, the number of enrolled Veterans aged 75 and older is projected to increase by 46 percent, from 2 million to an estimated 2.9 million. During the same timeframe, the number of enrolled Veterans under age 75 is projected to decrease by 14 percent. The number of

Veterans aged 85 and older enrolled in the system has increased almost 300 percent between 2003 and 2018 and is projected to surge close to 500 percent by 2038.

As Veterans age, approximately 80 percent will develop the need for LTSS. Most of this support in the past has been provided by family members, with women providing most of the care. The average number of potential family caregivers per older adult in America is currently 7, but that number will likely decline to 4 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. In one of our programs we care for some of our most medically-complex and disabled Veterans, and although half are married, one-third of their spouses have chronic disabling conditions. This lack of a strong family caregiver 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 growing rapidly and represents 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 by 1975, which led to the development of 20 currently-existing Centers of Excellence called Geriatric Research, Education, and Clinical Centers (GRECC) within VA. Where available, these GRECCs have served as an incubator for research into health and health systems relevant to older Veterans and spawned innovative clinical programs that have been shown to optimize Veterans' function; prevent unnecessary and costly nursing home admissions and hospitalizations; and reduce unwanted and unnecessary tests and treatments, thereby reducing health care costs. Finally, GRECCs continue to address the geriatric workforce shortage, providing thousands of students training hours and exposure to care for older adults. The advances from GRECCs and other GEC innovations continue to benefit not only Veterans, but all Americans.

Geriatrics and Extended Care 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 4 categories of LTSS are: Home and Community-Based Services (HCBS); Facility-Based Care; geriatric services provided in outpatient clinics and hospitals; and Hospice and Palliative Care in all settings.

Home and Community-Based Services

HCBS supports 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, but are not limited to, the following:

- **Adult Day Health Care:** This is a day program provided to Veterans 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):** Through this program, Primary Care is provided to Veterans in their homes. A VA physician leads the interdisciplinary health care team that provides the comprehensive longitudinal health care. This evidenced-based program is for Veterans who have complex health care needs and 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 their daily activities. These aides are not nurses, but they are supervised by a registered nurse who helps assess the Veteran's daily living needs.
- **Palliative and Hospice Care:** This program offers comfort measures that focus on relief of suffering and optimizing quality of life.
- **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 away without the worry of leaving the Veteran alone.
- **Skilled Home Health Care:** These are mostly short-term health care services provided to Veterans if they are homebound or live far away from a VAMC. The care is delivered by Medicare or Medicaid-certified community-based home health agencies.
- **Telehealth:** This service allows the Veteran's physician or nurse to monitor their medical condition remotely using monitoring equipment. Veterans can be referred to a care coordinator for Home Telehealth services by any member of their care team. Home Telehealth 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 HCBS 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.

Adult Day Health Care, HBPC, 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) 2019 reached $6.3 billion. The number of Veterans with service-connected disabilities rated 70 percent or more, for whom VA is required to pay for needed nursing home care, is projected to increase from 1.9 million to 3.1 million Veterans between 2018 and 2028. 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 are expected to significantly increase.

Fortunately, evidence has shown appropriate targeting and use of the programs and services available through GEC, especially those services that are provided in HCBS, can reduce the risk of preventable hospitalizations and delay or prevent 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 rebalancing their expenditures for LTSS between institutional and home and community-based settings. As of 2016, national Medicaid expenditures for home and community-based services for the population most similar to VHA users, older adults and people with physical disabilities, represent 45 percent of total LTSS – up from 17 percent 20 years prior. Comparable personal care services (Home maker/Home Health Aide, Respite, and Adult Day Health Care) accounted for 10.6 percent ($930 million) of VA's LTSS obligations in FY 2019. The total budget of all HCBS, including personal care services, accounted for 31 percent of the LTSS budget obligations in FY 2019. 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 Veterans to pay their own rent, but HBCS can be provided if the Veteran has certified needs and is enrolled in VA's 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 through 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 high levels of satisfaction from care provided through MFH, but many are limited from MFH because of the costs to the Veteran.

In the Department's FY 2021 budget request, VA submitted a legislative proposal to require VA to include in the program of extended care services the addition of care in MFHs; this would apply to Veterans for whom VA is required to provide nursing home care.

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 one of the 135 VA-operated Community Living Centers (CLC), in a State Veterans Home (SVH), or purchased by contract or agreement in one of the over 2,000 available community nursing homes (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. Veterans who have service-connected disabilities rated at 70 percent or greater and need NHC for service-connected conditions or are being placed in a nursing home by VA staff for the delivery of inpatient hospice care have mandatory eligibility for NHC. Veterans with mandatory nursing home eligibility can be provided care in a VA CLC, an SVH, or in 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. Since 2012, each year more Veterans chose to die in VA CLC hospice beds than in all of VA Acute and Intensive Care Unit deaths combined. These CLC hospice beds provide specialized support for terminally ill Veterans in their final weeks and surveys of these Veterans' family members reveal high satisfaction with this care. 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 generally limited to 180 days. Extensions are available in certain circumstances. 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 maintains strong, working relationships with every state in the oversight and payment of Veterans' care at SVHs. Through this effort, states provide care to eligible Veterans across a wide range of clinical care needs through NHC, domiciliary care, and adult day health care programs. VA can provide: construction grant funding for construction and renovation 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. Currently, there are 157 SVHs across all 50 states.

Ambulatory Care and Inpatient Acute Care Programs

Finally, GEC offers Ambulatory Care programs (including Geriatric Patient-Aligned Care Teams (GeriPACT)); Inpatient Acute Care Programs (including Geriatric Evaluation and Management); 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 versus being managed by regular Primary Care Patient Aligned Care Teams. Currently, only about half of VAMCs have GeriPACT, and VA is working to expand this program to larger Community-Based Outpatient Clinics.

Caregiver Support Program

Caregivers are eligible for a host of VA services including those offered under the Program of General Caregiver Support Services (PGCSS). These general services are available to support all caregivers, when the Veteran is enrolled for VHA healthcare regardless of illness or injury. In addition to the general services offered under the PGCSS, caregivers in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) may also receive a monthly stipend, beneficiary travel, mental health counseling, enhanced respite services, and health insurance, if applicable. Under the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, we are working to give more family caregivers access to PCAFC and support them as they care for Veterans of all eras. Currently, PCAFC is only available to eligible Veterans injured in the line of duty on or after September 11, 2001. Prior to expanding eligibility for PCAFC, VA must upgrade its information technology (IT) system and implement other improvements to strengthen the program.

The Caregiver Support Program's shoulder-to-shoulder work with VA's Office of Information and Technology has realized the successful launch of a replacement IT solution, termed the Caregiver Record Management Application (CARMA). This solution supports the administrative needs of PCAFC; PGCSS; and the Caregiver Support Line. The initial phase CARMA was successfully released in October 2019, with a follow up release in December 2019 to transition the remaining functionality from the former system to CARMA. Further functionality enhancement to CARMA in FY 2020 will prepare the program for expansion - automating stipend payments, improving functionality that supports PCAFC processes, and solidifying integrations with key VA systems.

In support of achieving the goals of program stabilization and expansion required by the VA MISSION Act of 2018, a strategic and expedited staffing plan was initiated to ensure a strong foundational infrastructure on which to expand the PCAFC program. By August 2019, over 680 positions had been approved for hire. This hiring phase included establishing facility staff such as program coordinators in the field for both PCAFC and PGCSS, as well as establishing Veterans Integrated Service Network (VISN) Leads and VISN Clinical Eligibility and Appeals teams. By the end of January 2020, 51 percent of those positions had already been filled. Completion of full staffing is targeted to occur in time for program expansion in the Summer of 2020.

Conclusion

VA's various long-term care programs provide a continuum of services for older Veterans designed to meet their 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. Madam Chair, this concludes my testimony. My colleague and I are prepared to answer any questions.