United States General Accounting Office

GAO

Report to Congressional Requesters

May 2003

VA LONG-TERM CARE

Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care

GAO-03-487

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GAO Accountability • Integrity • Reliability
Highlights

Highlights of GAO-03-487, a report to Congressional Requesters

Why GAO Did This Study

With the aging of the veteran population, the Department of Veterans Affairs (VA) is likely to see a significant increase in demand for long-term care. In response to recent GAO findings that variation exists in availability of noninstitutional services across VA, GAO was asked to update and expand its previous work to determine (1) whether veterans' access to six noninstitutional services is limited by service availability and restrictions on use and (2) if access is limited, what factors contribute to limited access. GAO surveyed VA's 139 medical facilities, visited 4 of them and updated information collected from a fifth facility visited during earlier work, and interviewed headquarters and field officials.

What GAO Recommends

GAO is recommending that VA:

- ensure that facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services, and

- refine current performance measures to help ensure that all VA facilities provide veterans with access to required noninstitutional services.

VA concurred with the recommendations.

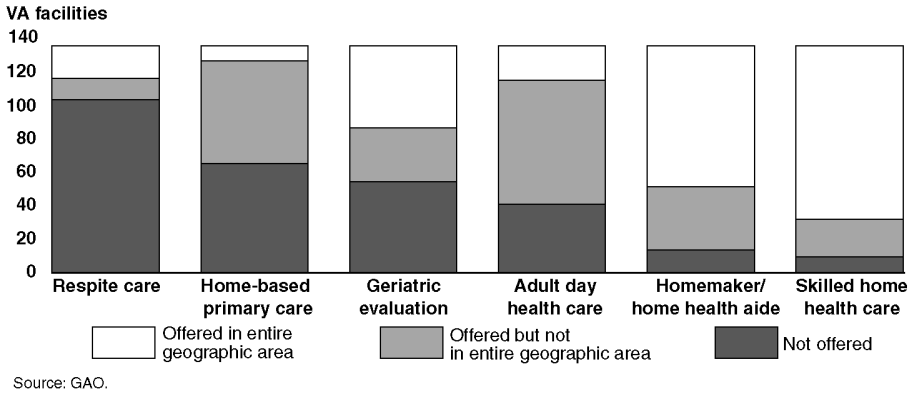
www.gao.gov/cgi-bin/getrpt?GAO-03-487.

To view the full report, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

What GAO Found

Veterans' access to the six noninstitutional services we reviewed is limited by service gaps and facility restrictions. Of VA's 139 facilities, 126 do not offer all six of these services—adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care. Veterans have the least access to respite care, which is not offered at 106 facilities. By contrast, skilled home health care is not offered at 7 facilities. Veterans' access is more limited than these numbers suggest, however, because even when facilities offer these services they often do so in only part of the geographic area they serve. In fact, for four of the six services the majority of facilities either do not offer the service or do not provide access to all veterans living in their geographic service area. Veterans' access may be further limited by restrictions that individual facilities set for use of services they offer. For example, at least 9 facilities limit veterans' eligibility to receive noninstitutional services based on their level of disability related to military service, which conflicts with VA's eligibility standards. Further, restrictions placed by many facilities on the number of veterans who can receive noninstitutional services have resulted in veterans at 57 of VA's 139 facilities being placed on waiting lists for noninstitutional services.

Noninstitutional Long-Term Care Services Not Available to All Veterans, Based on Geographic Areas, at VA's 139 Facilities as of Fall 2002



Source: GAO.

VA's lack of emphasis on increasing access to noninstitutional long-term care services has contributed to service gaps and individual facility restrictions that limit access to care. Without emphasis from VA headquarters on the provision of noninstitutional services, field officials faced with competing priorities have chosen to use available resources to address other priorities. While VA has implemented a performance measure for fiscal year 2003 that encourages networks to increase veterans' use of five of the six noninstitutional services, it does not require networks to ensure that all facilities provide veterans access to noninstitutional services.

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Abbreviations

HCS	health care system
VA	Department of Veterans Affairs

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United States General Accounting Office
Washington, DC 20548

May 9, 2003

The Honorable Bob Graham
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

The Honorable Lane Evans
Ranking Minority Member
Committee on Veterans' Affairs
House of Representatives

The Honorable John D. Rockefeller IV
United States Senate

The Department of Veterans Affairs (VA) spent about $23 billion on health care in fiscal year 2002, including about $3.3 billion on long-term care. Demand for VA long-term care is likely to increase significantly during the next decade. Because of the aging of the veteran population, VA estimates that the number of veterans age 85 and older—those most in need of long-term care—will more than double, from about 640,000 currently to about 1.3 million in 2012. Due to changes in VA's eligibility standards more older veterans will be eligible to receive VA health care, including long-term care services.

In recent years, VA has increased the proportion of its long-term care spending on care in noninstitutional settings, such as veterans' own homes. This is consistent with the preference of many veterans and others to receive care in their homes or in other settings, such as adult day health care centers, that are less restrictive than institutions. For example, some veterans receive assistance in their homes with bathing and dressing provided by home health aides. However, VA has traditionally provided the bulk of veterans' long-term care in institutional settings, such as nursing homes, which is reflected in VA's spending for long-term care services. In fiscal year 2001, more than 90 percent of VA's long-term care spending was for institutional long-term care.

In November 1999, the Congress passed the Veterans Millennium Health Care and Benefits Act (Millennium Act),[1] which required that VA provide

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

veterans access to three services—adult day health care, geriatric evaluation, and respite care. VA chose to meet the Millennium Act requirements by issuing a directive in October 2001 requiring that facilities provide adult day health care, noninstitutional geriatric evaluation, and noninstitutional respite care to veterans in need of such services.[2]

In April 2002, at the request of the Senate Committee on Veterans' Affairs, we testified on variation in the availability of VA's noninstitutional long-term care services.[3] Your offices expressed concern that this variation could mean that some veterans did not have access to noninstitutional services because of gaps in service availability and because of the restrictions that some facilities might place on veterans' use of these services, such as limiting the amount of service a veteran may receive. To address these concerns, you asked us to update and expand our previous work[4] to determine (1) whether veterans' access to six noninstitutional services is limited by service availability and restrictions on use and (2) if access is limited, what factors contribute to limited access. The six noninstitutional services you asked us to examine are the three that VA requires as a result of the Millennium Act— adult day health care, geriatric evaluation, and respite care—and three additional noninstitutional services—home-based primary care, skilled home health care, and homemaker/home health aide. See appendix I for information on these six noninstitutional long-term care services.

To do our work, we surveyed each of VA's 139 medical facilities to obtain data on the types of services offered and the number of veterans receiving the six noninstitutional long-term care services,[5] and where access to services was limited, we identified the reasons why services were limited. We compared these survey data to the data we obtained in our fall 2001 survey of VA long-term care services to determine the extent to which

[2]The act requires that VA provide noninstitutional extended care services to enrolled veterans until December 31, 2003.

[3]U.S. General Accounting Office, *VA Long-Term Care: The Availability of Noninstitutional Services Is Uneven*, GAO-02-652T (Washington, D.C.: Apr. 25, 2002).

[4]U.S. General Accounting Office, *VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven,* GAO-02-510R (Washington, D.C.: Mar. 29, 2002).

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

availability had changed since that survey. To gain an understanding of facilities' noninstitutional long-term care operations we also interviewed VA officials in headquarters and in each of VA's 21 network offices,[6] visited 4 VA medical facilities—located in Memphis, Tennessee; Richmond, Virginia; Tucson, Arizona; and Walla Walla, Washington—and updated information collected from a fifth facility in Albany, New York, which we visited for our previous report on noninstitutional services. These five facilities were chosen based on variation in both the number and type of noninstitutional services they offered. In addition, we evaluated directives and regulations and other guidance related to these six noninstitutional services issued by VA headquarters, networks, and individual facilities. For a complete description of our scope and methodology, see appendix II. Our work was conducted from June 2002 through April 2003 in accordance with generally accepted government auditing standards.

Results in Brief

Veterans' access to the six noninstitutional long-term care services in our study is limited by the lack of service availability and restrictions on their use. Of VA's 139 facilities, 126 do not offer all six of the services. Veterans have the least access to noninstitutional respite care, which is not offered by 106 VA facilities. By contrast, skilled home health care is not offered at 7 facilities. Furthermore, veterans' access to care is more limited than these numbers suggest, because even when facilities offer these services they often do so in only parts of the geographic area they serve. In fact, for four of the six services—noninstitutional respite care, home-based primary care, adult day health care, and noninstitutional geriatric evaluation—the majority of facilities either do not offer the service or do not offer the service in the entire geographic area they serve. Veterans' access may be further limited by restrictions that individual facilities set for use of services they offer. For example, 9 facilities, in conflict with VA's eligibility standards, limited veterans' access to noninstitutional services based on their level of disability related to military service. Further, restrictions placed by many facilities on the number of veterans who can receive noninstitutional services have resulted in veterans at 57 of VA's 139 facilities being placed on waiting lists for noninstitutional services.

[6]VA originally created 22 networks, but in January 2002 VA merged 2 networks into a single network, leaving the agency with 21 networks.

VA's lack of emphasis on increasing access to noninstitutional long-term care services and a lack of guidance on the provision of these services have contributed to service gaps and individual facility restrictions. VA headquarters has not emphasized increasing access to these services by establishing measurable performance goals as it has for other priorities such as maintaining workloads in VA nursing homes. Without such performance measures, field officials faced with competing priorities have chosen to use available resources to address other priorities. VA has implemented a performance measure for fiscal year 2003 that encourages networks to increase veterans' use of five of the six noninstitutional services, but it does not require networks to ensure that all network facilities provide veterans access to noninstitutional services. Moreover, VA has not provided facilities with adequate guidance on the provision of noninstitutional respite care, even though most have had little experience in providing the service. Some networks and facilities are confused about how to provide the service and as a result some are not providing the service. VA has also not provided adequate guidance on which noninstitutional services are required. In particular, VA has not specified whether the home health services requirement includes one, all, or some combination of home-based primary care, homemaker/home health aide, and skilled home health care. In the absence of VA headquarters guidance on what home health services are required, VA facilities vary in their interpretations of what services they must provide.

To help ensure that veterans have access to noninstitutional long-term care services and that such services are offered uniformly throughout VA, we are recommending that VA take actions to increase emphasis on provision of these services, provide adequate guidance on their provision, and ensure that VA's eligibility standards are used to determine eligibility. VA concurred with our recommendations, discussed preliminary actions it plans to take, and stated that it will provide a detailed action plan to implement our recommendations after this report is issued.

Background

Changes in VA's eligibility standards have resulted in an increase in the number of veterans who are eligible to receive VA health care, including noninstitutional long-term care services. The Veterans' Health Care Eligibility Reform Act of 1996[7] authorized VA to provide health care services not previously available to veterans without service-connected

[7]Pub. L. No. 104-262 §§ 101, 104, 110 Stat. 3178-79, 3182-83 (1996).

disabilities or low incomes.[8] As required by the act and due to an anticipated increase in demand for VA health care from these changes in eligibility, VA established an enrollment system to manage veterans' access to care. This system includes eight priority categories for enrollment, with higher priority given to veterans with service-connected disabilities, lower incomes, or other recognized statuses such as former prisoners of war. If sufficient resources are not available to provide care that is timely and acceptable in quality for all priority groups, the act requires VA to limit enrollment nationally, consistent with the eight priority groups. If needed, enrollment restrictions would begin with the lowest priority category. On January 17, 2003, VA announced that it would no longer enroll priority 8 veterans, those in the lowest priority category, for the duration of the year.[9]

VA long-term care includes a continuum of services for the delivery of care to veterans needing assistance due to chronic illness or physical or mental disability. Assistance with veterans' needs takes many forms and is provided in varied settings, including institutional care in nursing homes or in noninstitutional settings preferred by many veterans, including in-home care services and community-based services such as adult day health care centers. Long-term care also includes respite care services that temporarily relieve a veteran's caregiver from the burden of caring for a chronically ill and disabled veteran in the home. VA offers long-term care services directly or through other providers with which VA contracts.

VA provides most of its long-term care to veterans in institutional settings, such as VA nursing homes or state-owned veterans' homes rather than in noninstitutional settings. In fiscal year 2002, VA served about 36 percent of its long-term care workload, or average daily census, in noninstitutional settings (see table 1). That same year noninstitutional care accounted for 9 percent of VA's long-term care expenditures. In contrast, noninstitutional

[8]A service-connected disability is an injury or disease that was incurred or aggravated while on active military duty. VA classifies veterans with service-connected disabilities according to the extent of their disability. These classifications are expressed in terms of percentages—for example, the most severely disabled such veteran would be classified as having a service-connected disability of 100 percent. Percentages are assigned in increments of 10 percent.

[9]Priority 8 veterans are primarily veterans with no service-connected disabilities who have incomes above established limits for geographic regions set by the U.S. Department of Housing and Urban Development to reflect regional costs of living. Priority 8 veterans enrolled prior to January 17, 2003, remain enrolled to receive VA health care benefits.

care accounted for about 29 percent of Medicaid's long-term care expenditures in fiscal year 2001, the most recent year for which data are available.[10]

Table 1: VA Long-Term Care Workload and Expenditures, by Care Setting, Fiscal Year 2002

Long-term care setting	Average daily census[a]	Total expenditures
Institutional	43,363	$2,979,156,000
Noninstitutional	24,126	283,098,000
Total	67,489	$3,262,254,000

Source: VA.

[a]The average daily census represents the total number of days of inpatient care for institutional care and the total number of outpatient encounters for noninstitutional care, each divided by the number of days in the year. Thus, the figures represent VA's workload during the year and not an unduplicated count of veterans in these settings because some veterans receive more than one service.

VA has delegated decision making regarding financing and service delivery for long-term care and other health care services to its 21 health care networks. VA allocates resources for health care to each of the 21 networks primarily through the Veterans Equitable Resource Allocation system, in which networks are funded through a formula reflecting the number and types of veterans receiving care in the network, including those receiving long-term care.[11] In turn, VA's networks have budget and management responsibilities that include allocating resources received from headquarters to facilities within their networks—including resources used to provide long-term care services.

[10]Medicaid, the joint federal-state health-financing program for low-income individuals, is the nation's largest funding source for long-term care. In fiscal year 2001, Medicaid expenditures on long-term care totaled $75.3 billion.

[11]For more information on VA's resource allocation system see U.S. General Accounting Office, *VA Health Care: Allocation Changes Would Better Align Resources with Workload*, GAO-02-338 (Washington, D.C.: Feb. 28, 2002).

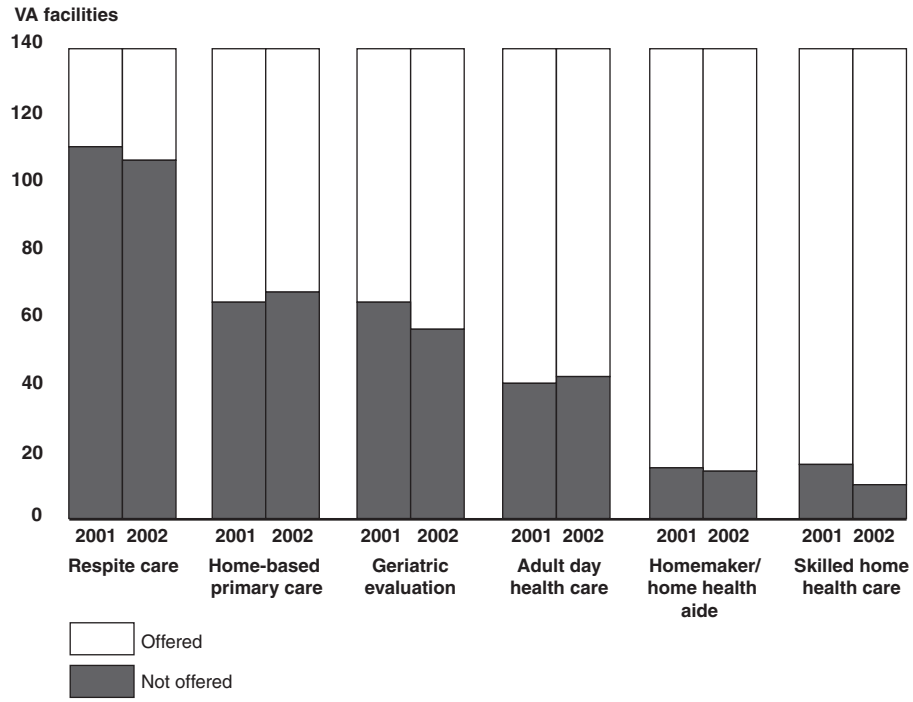
Veterans' Access Is Limited by Gaps in Service Availability and Facility Restrictions on Service Use

Veterans' access to the six noninstitutional services in our review—adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care—is limited due to gaps in availability and facility restrictions on use of the services. Of VA's 139 facilities, 126 do not offer all six noninstitutional services. Facilities that do offer a service do not always offer the service to veterans in the entire geographic area the facility serves. Further, veterans' access to the six noninstitutional services may be limited by restrictions that individual VA facilities place on service use. Some of these facility restrictions conflict with VA eligibility standards which state that most services are to be available to all enrolled veterans regardless of priority group. The restrictions include providing services only to certain veterans or limiting the number of veterans who can use services at any one time.

Access to Care Is Limited by Service Gaps Across VA

Access to care is limited because many VA facilities do not offer the six noninstitutional services in our review. Of VA's 139 facilities, 126 did not offer all of the six noninstitutional services in fall 2002, a pattern similar to that in fall 2001. (See fig. 1.) The least commonly available service of the six we reviewed in 2001 and 2002 was noninstitutional respite care. This service was not available at 110 of VA's 139 facilities in fall 2001, and as of fall 2002, noninstitutional respite care was not available at 106 of VA's 139 facilities. In contrast, the most widely available service we reviewed was skilled home health care, which was offered at all but 7 facilities. For a complete list of the services each VA facility reported offering, see appendix III.

Figure 1: Noninstitutional Long-Term Care Services at VA's 139 Medical Facilities

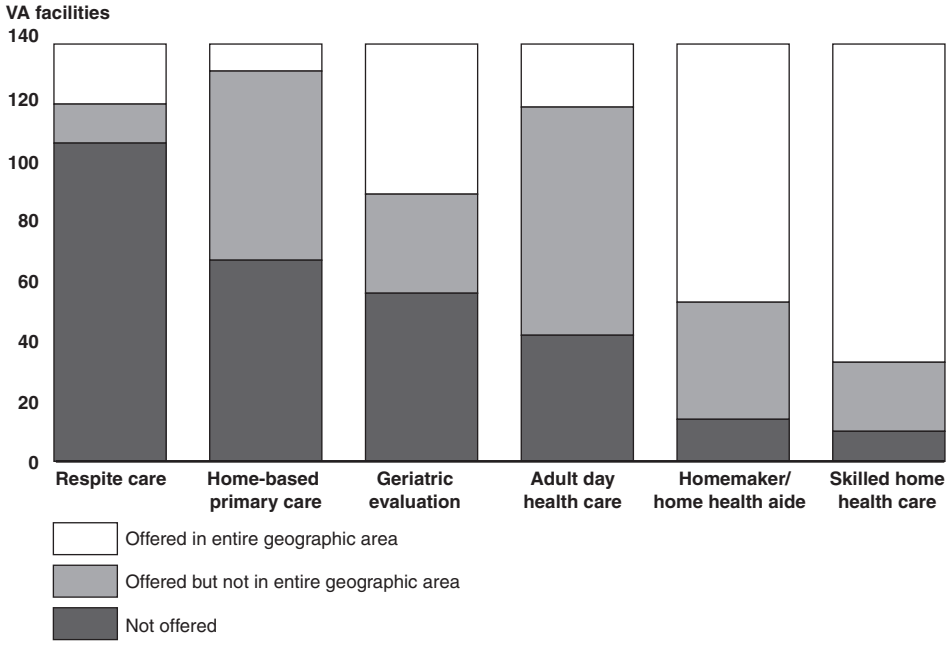


Source: GAO.

Note: Includes services provided directly by facilities or through contracts with other providers as of fall 2001 and fall 2002.

Veterans' access to these services is further limited because among facilities that offer services, many do so in only parts of the geographic area they serve. Our fall 2002 survey showed that for four of the six services— noninstitutional respite care, home-based primary care, adult day health care, and noninstitutional geriatric evaluation—the majority of the facilities either did not offer the service or did not offer the service in the entire geographic area they serve. As shown in figure 2, 42 facilities did not offer adult day health care and an additional 76 facilities did not offer it in their entire geographic service area. As a result, where veterans live in a facility's geographic service area sometimes determines whether they can access the services offered by the facility. The remaining 21 facilities reported that they offered adult day health care in all parts of their geographic service areas.

Figure 2: Noninstitutional Long-Term Care Services, Based on Geographic Areas, at VA's 139 Medical Facilities



Source: GAO.

Note: Includes services provided directly by facilities or through contracts with other providers as of fall 2002.

VA may also arrange for veterans to access three noninstitutional long-term care services from non-VA sources even though VA does not pay for these services. The Millennium Act and VA policy allow facilities to make available to veterans the services required as a result of the Millennium Act—adult day health care, noninstitutional respite care, and noninstitutional geriatric evaluation—through other providers or payers while still overseeing the care delivered using a case management approach.[12] However, VA headquarters has neither issued guidance on the use of case management to meet this requirement under the Millennium Act nor has it monitored the extent to which facilities use this option. Further, the use of case management by VA to make these three services

[12]Case management includes assessment of the veteran's care needs, care planning and implementation, referral coordination, monitoring, and periodic reassessment of the veteran's care needs.

available to veterans is limited by the eligibility of veterans for these other sources of care. That is, if veterans are not eligible for other sources of care, such as Medicaid and Medicare, and VA does not provide the service, then veterans will likely not have access to the three services.

Veterans' Access to Care Is Further Limited by Individual Facility Restrictions

Access to care is further limited by the restrictions that some facilities place on the six noninstitutional services in our review. These restrictions include (1) limiting services to veterans with certain levels of service-connected disability, (2) limiting the amount of service that veterans can receive, and (3) establishing a maximum number of veterans who can receive a service at any time.

Some Facilities Limit Access to Services Based on Veterans' Service-Connected Disability Levels

We found that nine VA facilities imposed their own eligibility restrictions on access to noninstitutional services based on veterans' service-connected disabilities. We identified five of these nine facilities through comments facilities made in our survey, although we did not systematically ask facilities this question in our survey. Because we did not systematically ask in our survey, it is possible that additional facilities may impose similar eligibility restrictions. Other VA facilities may have also instituted similar restrictions on access. These restrictions conflict with VA eligibility standards and result in inequitable access for veterans enrolled at these facilities. VA's eligibility standards state that most services are to be available to all enrolled veterans, regardless of priority group.[13]

In our survey of VA's 139 facilities, 5 facilities provided additional comments indicating that they limit certain services—including adult day health care, homemaker/home health aide, skilled home health, and respite care—to veterans with service-connected disabilities. Four of the 5 facilities limit services to veterans with service-connected disabilities of 70 percent or greater. In addition, one of the facilities we visited provides homemaker/home health aide services to veterans with service-connected disabilities of 70 percent or greater. Another facility we visited provides the service primarily to veterans with service-connected disabilities of 70 percent or greater or veterans with service-connected disabilities of at least 60 percent for a single condition; other veterans may receive the

[13]Although VA issued a regulation on September 17, 2002, granting priority for appointments to veterans with service-connected disabilities of at least 50 percent and veterans needing care for a service-connected disability, the regulation does not change other veterans' eligibility to receive services.

service, but only for 6 months. In addition, one network official told us that 2 facilities in his network limit homemaker/home health aide services to veterans with service-connected disabilities of 70 percent or greater because under the Millennium Act VA must pay for nursing home care when such veterans need it.[14] According to this official, because homemaker/home health aide services can keep veterans in their own homes rather than in nursing homes, providing the service to such veterans can delay the need for nursing home care and the resultant financial obligation for the facilities.

Access Is also Limited by Restrictions on the Amount of Services Provided

The amount of service veterans receive may depend on which facility provides their care. Facilities vary in the limits they set. Some facilities restrict the amount of a noninstitutional service a veteran can receive once the veteran has been authorized to receive care. For example, a network official told us that one network facility offers veterans up to 24 hours per week of homemaker/home health aide services while a facility official in another network told us their facility provides no more than 10 hours per week. A facility we visited in another network does not place any restrictions on the amount of homemaker/home health aide services provided.

Facility officials noted that they can serve more veterans if they limit the amount of service provided to each veteran. One facility we contacted provided veterans no more than 2 days per week of adult day health care. Because of this restriction, veterans whose medical needs require more adult day health care pay for the service themselves, find another payer such as Medicaid, or forego the additional service. At another facility we visited, veterans without service-connected disabilities were limited to 2 full days or 3 half days per week regardless of medical need. In 1998, this facility also reduced the number of homemaker/home health aide hours provided each week from 21 to 8 in order to increase the number of veterans who could be provided the service. At both facilities, officials emphasized that the purpose of limits on the amount of service provided was to increase the number of veterans who could receive at least some of the service.

[14]The Millennium Act requires that VA provide nursing home care to any veteran who needs such care and who has a service-connected disability of 70 percent or greater, or to any veteran needing such care specifically for a service-connected disability, even if the disability is less than 70 percent.

Access at Many Facilities Is Restricted by Limits on the Number of Veterans Served

In our survey of VA facilities, 57 of 139 facilities reported maintaining a list of veterans waiting for at least one of the services in our review. These facilities told us in effect that they are not meeting all their veterans' needs for noninstitutional services. Many facilities place limits on the total number of veterans they serve by establishing a budget cap—the maximum number of veterans who can receive a particular service at any time. For three of the six services in our study—home-based primary care, homemaker/home health aide, and noninstitutional geriatric evaluation—most facilities reported in our survey that despite offering the service, they were currently unable to provide services to additional veterans within their budget caps. Additional veterans needing services would have to wait until space or resources became available.

Lack of Emphasis, Inadequate Guidance, and Other Factors Contribute to Limited Access

A lack of VA emphasis on increasing access to noninstitutional long-term care services, inadequate VA guidance on providing these services, and other factors have contributed to limited access for veterans. VA had not provided measurable standards for the provision of these services until fiscal year 2003 or oversight to monitor their provision as it has for high-priority services. VA guidance on the provision of noninstitutional long-term care services has left unclear to some facilities how one service is to be defined and provided and whether some of the services in our review are a part of what VA requires be made available to veterans who need them. Other factors, such as availability of contractors to provide a service, also contribute to the lack of access for specific services.

VA Has Not Emphasized Increased Access to Noninstitutional Long-Term Care Services

VA network and facility officials told us that VA headquarters has not emphasized increased access to noninstitutional long-term care services but emphasized other priorities. As a result, these officials said they use their resources for the priorities VA headquarters emphasizes rather than noninstitutional services. For example, officials in 9 of VA's 21 networks told us that VA headquarters' emphasis on the performance measure that requires networks to maintain workload in VA nursing homes has led them to devote resources to nursing home care that they might otherwise have used to provide noninstitutional services. One network director told us that the "pressure" from VA headquarters to maintain nursing home utilization is much greater than that to offer noninstitutional services. In another network, an official at a VA facility not offering three of the services in our study told us that these services were "victims of competition for resources." In other words, the facility had not funded these three noninstitutional services because facility officials had chosen to devote resources to other services. Another network director told us

that, if forced to choose between funding different services, the network would allocate resources to services included in a performance measure.

One way VA emphasizes services is through performance measures, which VA establishes to monitor network officials' progress toward meeting certain VA strategic goals, such as increasing veteran access to services. VA has demonstrated that requiring network officials to meet measurable performance standards can promote change. For example, since their inception in fiscal year 1996 VA performance measures have included a measure for providing immunizations to prevent pneumonia to veterans age 65 and older and those at high risk of the disease. VA increased the percentage of veterans in this population who received the immunization from 26 percent in fiscal year 1996 to 81 percent in fiscal year 2002.

In October 2002, VA introduced a performance measure for noninstitutional long-term care which requires all networks to provide noninstitutional services to a portion of their enrolled veterans needing such services—14.4 percent in fiscal year 2003 and 16 percent in fiscal year 2006.[15] The fiscal year 2003 goal for this measure will require the majority of networks to increase utilization of their noninstitutional services. The performance measure includes five of the services in our review but does not include noninstitutional geriatric evaluation. However, the performance measure does not require networks to ensure that veterans can access noninstitutional long-term care services at all network facilities. Instead, network targets can be achieved in the current performance measure if networks increase utilization at facilities that already offer noninstitutional services.

VA Has Provided Inadequate Guidance on the Provision of Noninstitutional Respite Care

VA headquarters has provided inadequate guidance to networks and facilities on the provision of noninstitutional respite care to address confusion in the field about what this service is and how it should be provided. This confusion exists, in part, because VA has limited experience with noninstitutional respite care and VA traditionally provided respite care in institutions such as nursing homes. Noninstitutional respite care, by contrast, is provided only in noninstitutional settings, such as a veteran's own home.

[15]According to VA, when it plans for noninstitutional services it assumes that the vast majority of veterans will choose to use their Medicare benefits for home health care.

Although noninstitutional respite care has been required by VA for over a year, VA has not issued adequate guidance on the provision of noninstitutional respite care and VA staff told us they were unsure how to develop a noninstitutional respite care service. VA issued a directive in October 2001 that requires all facilities to provide noninstitutional respite care to veterans in need of the service yet it inadequately defines noninstitutional respite care and does not provide facilities with information regarding how to provide the service. For example, the directive states that noninstitutional respite care may be provided in a home or other noninstitutional settings. However, it does not specify which noninstitutional settings may be used for the purpose of respite care. In fact, officials in 6 of the 21 networks we contacted indicated that there was confusion in their networks about how to establish noninstitutional respite care programs and 1 of these networks reported this was the reason facilities in the network were not providing the service. Further, in our survey, six facilities reported that they offer noninstitutional respite care in community nursing homes, which are institutional settings, thus not meeting the requirement for noninstitutional respite care. VA headquarters officials said they are developing a handbook that will define and provide guidance on the provision of noninstitutional respite care.

VA Guidance Does Not Specify Which Home Health Services Are Required

VA requires that facilities offer a home health service benefit as part of VA's medical benefits package.[16] VA headquarters officials told us that the home services benefit includes home-based primary care, homemaker/home health aide, and skilled home health care. However, VA policy does not specify whether one, some combination, or all three home health services are required under the home health services benefit. Currently 138 out of VA's 139 facilities offer at least one of these three home health services, 59 facilities offer two of the three services, and 66 facilities offer all three. Without clear guidance to facilities on what services they must make available in order to fulfill the home health services benefit, facilities vary in their interpretation of what is included in the benefit and headquarters cannot ensure that veterans have access to the services to which they are entitled.

Because facilities and networks vary in their interpretation of what is included in the home health services benefit, facilities do not uniformly

[16]The medical benefits package is the set of services to be available to all enrolled veterans.

offer the same home health services. For example, at one facility we visited, an official told us that the facility interpreted the home health services benefit to mean that veterans must have access to skilled home health care—which the facility made available to all veterans. The facility restricted veterans' access to its homemaker/home health aide and home-based primary care services because facility officials did not believe these services were required under the home health benefit. Similarly, in another network an official told us that the network interpreted the home health services benefit to include all three home care services—home-based primary care, homemaker/home health aide, and skilled home health care. As a result, access to these three services varies according to facility interpretation of what is required. Without clear guidance to facilities on what services they must make available in order to fulfill the home health care services requirement, headquarters cannot ensure that veterans have access to the home health services to which they are entitled and veterans are likely to experience variation in the benefits package.

Other Factors Limit the Availability of Noninstitutional Services

Other factors limiting access to services include lack of contractors, difficulty hiring needed staff, and limitations imposed due to distances VA staff can travel. The lack of contractors is particularly important in adult day health care, where 62 facilities that either did not provide adult day health care at all or only did so in parts of their geographic service areas reported that they experienced difficulty in finding local contractors to provide the service. In addition, 63 facilities cited insufficient facility staff as the reason for not offering geriatric evaluation or only offering it to a portion of their geographic service area. Officials in VA headquarters told us that many facilities have been unable to recruit clinically trained geriatric staff, such as geriatricians and geriatric nurse practitioners, needed to operate this service.

For home-based primary care, 94 facilities that did not offer the service at all or did not do so in all parts of their geographic service area reported that they did not do so because many veterans live outside of the facility's home-based primary care service area. VA guidance limits the service to veterans who live within a locally established radius of the facility because

home-based primary care staff travel from the facility to veterans' homes to deliver care.[17]

Conclusions

Veterans' access to the six noninstitutional long-term care services we reviewed is limited and highly variable across the country. Extensive gaps in services exist at many facilities either because they do not offer the services or do not offer it in all parts of their service areas. Moreover, individual facility restrictions on veterans' use of services means that access may be further restricted. These include facility restrictions based on veterans' levels of service-connected disability that are inconsistent with VA eligibility standards. Facility restrictions have resulted in waiting lists for services at many facilities. The end result is that veterans' access to these services is often limited or nonexistent based on where they live.

Shortfalls and unevenness in veterans' access to noninstitutional long-term care services have resulted because VA headquarters has not provided adequate guidance and emphasis on making these services available. VA has not provided sufficient guidance to clear up confusion at facilities as to how noninstitutional respite care services are provided or to make clear which home health services facilities must provide. As a result, facilities vary in their interpretation of which services to provide, creating unevenness in their availability. Furthermore, VA has not sufficiently emphasized the importance of providing these services to encourage networks and facilities to make them a priority in their overall service continuum. In particular, VA has not developed a performance measure that would help ensure the provision of these services consistently across VA facilities.

Recommendations for Executive Action

To increase access to noninstitutional long-term care services and make access more even across networks and facilities, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to:

- ensure that facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services;
- define and provide guidance on noninstitutional respite care;

[17]At two facilities we visited where home-based primary care is offered, officials told us that veterans would likely be provided home health care through a contract service if they lived outside of each facility's home-based primary care service area.

- specify in VA policy whether home-based primary care, homemaker/home health aide, and skilled home health care are to be available to all enrolled veterans; and
- refine current performance measures to help ensure that all VA facilities provide veterans with access to required noninstitutional services.

Agency Comments

In commenting on a draft of our report, VA agreed with our findings and conclusions and concurred with our recommendations. VA stated that it will add eligibility sections in each new directive and handbook it issues concerning noninstitutional long-term care programs and develop performance measures to underscore the importance VA places on its noninstitutional long-term care programs. VA, however, did not provide details on how it plans to address our recommendations, but instead stated that it will provide a detailed action plan to implement our recommendations in response to the issuance of this report. VA's written comments are in appendix IV.

As agreed with your office, unless you publicly announce its contents earlier, we will plan no further distribution of this report until 30 days after its date. At that time, we will send copies to interested congressional committees and other parties. We also will make copies available to others upon request. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov. If you or your staffs have any questions about this report, please call me at (202) 512-7101. Another contact and key contributors are listed in appendix V.

Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues

Appendix I: VA Noninstitutional Long-Term Care Services in Our Review

- Adult day health care: health maintenance and rehabilitative services provided to frail elderly veterans in an outpatient setting during part of the day.

- Geriatric evaluation: evaluation of veterans with particular geriatric needs, generally provided by VA through one of two services: (1) geriatric evaluation and management, in which interdisciplinary health care teams of geriatric specialists evaluate and manage frail elderly veterans, and (2) geriatric primary care, in which outpatient primary care, including medical and nursing services, preventive health care services, health education, and specialty referral, is provided to geriatric veterans.

- Home-based primary care: primary health care, delivered by a VA physician-directed interdisciplinary team of VA staff including nurses and other healthcare professionals to homebound (often bedbound) veterans for whom return to an outpatient clinic is not practical.

- Homemaker/home health aide: personal care, such as grooming, housekeeping, and meal preparation services, provided in the home to veterans who would otherwise need nursing home care. It does not include skilled professional services.

- Respite care: services provided to temporarily relieve the veteran's caregiver from the burden of caring for a chronically ill and severely disabled veteran in the home. Noninstitutional settings for respite care include veterans' own homes.

- Skilled home health care: medical services provided to veterans at home by non-VA health care providers.

Appendix II: Scope and Methodology

We reviewed the Department of Veterans Affairs' (VA) provision of six noninstitutional long-term care services in order to update and expand our previous work to determine (1) whether veterans' access to six noninstitutional services is limited by service availability and restrictions on use and (2) if access is limited, what factors contribute to limited access. The six services we reviewed include the three services VA chose to require all facilities to provide to meet the Millennium Act requirements—adult day health care, noninstitutional geriatric evaluation, and noninstitutional respite care—and three additional noninstitutional services—home-based primary care, skilled home health care, and homemaker/home health aide.

To determine if veterans' access to the six noninstitutional long-term care services is limited and if it is limited, to what extent, we sent an electronic mail survey to VA's 139 medical facilities in September 2002. We asked facilities to indicate which of the six services they offered and, for each service they offered, asked them to provide the number of veterans currently receiving or authorized to receive the service and the number of veterans who received the service during July 2002.[1] The month of July 2002 was chosen because workload data were likely to be available at the time the survey was completed by VA staff. We also asked facilities to indicate whether each offered service was available to veterans living in all parts of their geographic service areas. We compared these survey data to the data we obtained in our fall 2001 survey of VA long-term care services to determine the extent to which availability had changed since that survey. We also compared our current survey results to information provided by VA headquarters, and where we noted differences we contacted facility officials to clarify their survey responses.

To determine the factors that contribute to limited access to the six noninstitutional long-term care services we asked survey respondents to indicate the reasons why their facilities do not offer certain services and what factors influence the number of veterans using the services they do offer. We also conducted telephone interviews of officials in each of VA's 21 network offices to assess the role each network plays in deciding what noninstitutional services network facilities will offer and what criteria facilities will use in allocating services.

[1]The utilization data provided by VA facilities does not represent an unduplicated count of veterans in these settings because some veterans may receive more than one noninstitutional service.

To augment information collected through our survey and telephone interviews, we visited four VA medical facilities to interview VA officials and clinicians on veteran demand for noninstitutional services and reasons for variation in access to the six noninstitutional services. We also updated information we collected from a site we visited during our earlier work on VA's noninstitutional services.[2] As shown in table 2, the five facilities included in this report—Albany, New York; Memphis, Tennessee; Richmond, Virginia; Tucson, Arizona; and Walla Walla, Washington—reflect differences in the number and type of noninstitutional long-term care services offered.

Table 2: Noninstitutional Services in Our Review Offered by the Five VA Facilities We Visited

VA facility	Number of services in our review offered at the time of our visit	Home-based primary care	Homemaker/ home health aide	Skilled home health care	Adult day health care	Geriatric evaluation	Respite care
Albany, New York	5	X	X	X	X	X	
Memphis, Tennessee	4	X	X	X		X	
Richmond, Virginia	2			X		X	
Tucson, Arizona	6	X	X	X	X	X	X
Walla Walla, Washington	2		X	X			

Source: GAO.

We selected the Memphis and Tucson VA facilities to visit because each offered at least four of the six services and had similar numbers of veterans enrolled. However, the number of veterans using their services differed substantially, which allowed us to explore the reasons for observed differences in service utilization. The Albany facility offered five of the six services and is located in a network that has extensive noninstitutional service offerings. In contrast, the Richmond and Walla Walla facilities were selected because they each offered two services; further, we selected the Walla Walla facility because it is located in a sparsely populated area.

We met with officials in VA's Geriatrics and Extended Care Strategic Healthcare Group and obtained documents on VA's noninstitutional long-term care services, including service descriptions, policies, guidance, and

[2]GAO-02-652T.

other information. In addition, we interviewed the Deputy Under Secretary for Health for Operations and Management to determine the level of oversight that this office provides regarding the noninstitutional long-term care services offered by VA facilities, including the implementation and tracking of network performance measures related to noninstitutional care.

Appendix III: Availability and Utilization of Six Noninstitutional Long-Term Care Services by VA Medical Facility or Health Care System

Table 3 provides information on the availability and utilization of the six noninstitutional long-term care services reported by VA's 139 medical facilities and health care systems for the month of July 2002.[1]

Table 3: Availability and Utilization of Six Noninstitutional Long-Term Care Services at VA Medical Facilities (July 2002)

	Number of veterans receiving service[a]					
VA medical facility or health care system (HCS)	**Home-based primary care**	**Homemaker/ home health aide**	**Skilled home health care**	**Adult day health care**	**Geriatric evaluation**	**Respite care**
Network 1 (Boston)						
Bedford	13	35	—	27	22	
Boston HCS		107	65	96	20	
Connecticut HCS	132	53	77	22	115	
Manchester	44	19	26	7		
Northampton		101	48	26		
Providence	55	14	52	8		
Togus		86	500	1	6	
White River Junction[b]		12	49	45	26	
Network 2 (Albany)						
Albany	159	62	22	107	613	
Bath	177	115		14		0
Canandaigua	132	186		33	15	
Syracuse	273	147	37	45	216	
Western New York HCS	263	285	68	120	26	
Network 3 (Bronx)						
Bronx	120	15	21		93	
Hudson Valley HCS	71	48	6	3		
New Jersey HCS	132	262	45	6		
Northport	47	64	32	12	49	
New York Harbor HCS	210	219	16	156	1,136	
Network 4 (Pittsburgh)						
Altoona[b]			12			
Butler	36	123		58		
Clarksburg		176	23	6		
Coatesville		80	0	24		
Erie		84	16	3		2
Lebanon		2	7		67	
Philadelphia		16	17		905	
Pittsburgh HCS	133	129	87	51	16	

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

VA medical facility or health care system (HCS)	Number of veterans receiving service[a]					
	Home-based primary care	Homemaker/ home health aide	Skilled home health care	Adult day health care	Geriatric evaluation	Respite care
Wilkes-Barre		30	99	1	76	
Wilmington		25	4		5	
Network 5 (Baltimore)						
Martinsburg		73		16		
Maryland HCS	220	273	52	287	12	3
Washington, DC	125	120	6	85	292	
Network 6 (Durham)						
Asheville	35	90	22	61	26	61
Beckley			10			
Durham	47	37	130		97	1
Fayetteville (NC)		19	18	11	17	
Hampton		27	29	13	0	
Richmond			101	0	1,800	
Salem		40	13	71		3
Salisbury		35	100	11		
Network 7 (Atlanta)						
Atlanta	90	51	52	7	550	7
Augusta	53	195	88	2	56	
Birmingham	94	4	62	0	27	4
Central Alabama HCS	135	57	48		257	
Charleston	96	57	92	6	169	10
Columbia (SC)	35	53	82	20		
Dublin		68	127			
Tuscaloosa		94	15			
Network 8 (Bay Pines)						
Bay Pines[b]	123	83	44	23	857	
Miami[b]	224	75	54	32	397	
N. Florida/S. Georgia HCS[b]	248	270	30	9	647	
San Juan	193	0	2		569	
Tampa[b]	163	39	155		300	
West Palm Beach		42	23	2		
Network 9 (Nashville)						
Huntington		60	49			
Lexington	23	32	53		52	1
Louisville		29	469		46	
Memphis[b]	112	73	227		560	
Mountain Home		158	42	14	15	
Tennessee Valley HCS		216	129	13	—	
Network 10 (Cincinnati)						
Chillicothe		186	102	3		
Cincinnati		22	60	71	26	
Cleveland	249	378	26	9	288	

VA medical facility or health care system (HCS)	Number of veterans receiving service[a]					
	Home-based primary care	Homemaker/ home health aide	Skilled home health care	Adult day health care	Geriatric evaluation	Respite care
Columbus		44	13	25		
Dayton	53	275	179	37	42	
Network 11 (Ann Arbor)						
Ann Arbor		88	13		54	0
Battle Creek	120	107	22	31		1
Danville	96	117	—	40		0
Detroit	100	29	100	1	5	
Indianapolis	111	109	49	20	48	0
Northern Indiana HCS	96	180	87	1		4
Saginaw		31	15	2	8	2
Network 12 (Chicago)						
Chicago HCS[b]	94	30	52	36	12	
Hines	183	64	90	45	133	
Iron Mountain		12	15	0		
Madison		21	—	5	18	
Milwaukee	146	30	23	60	60	
North Chicago	144		1	19		
Tomah		5	1			
Network 15 (Kansas City)						
Columbia (MO)	134	55	18	0		3
Eastern Kansas HCS		61	54	6	18	
Kansas City		64	16	3		
Marion		31	215			
Poplar Bluff		38	22			
St. Louis	75	78	30	10	—	
Wichita[b]		35	40	9		
Network 16 (Jackson)						
Alexandria		15	21	7		
Central Arkansas HCS[b]	187	145	31	73	719	
Fayetteville (AR)			3			
Gulf Coast HCS	75	51	134		195	
Houston	92	36	60	6	333	
Jackson		35	115	28		
Muskogee[b]			8	38		
New Orleans	82		12	35		
Oklahoma City	32	34	160	11	—	—
Shreveport	64	33	80			
Network 17 (Dallas)						
Central Texas HCS		97	23	2	18	0
North Texas HCS[b]	195	98	39	18	62	
South Texas HCS	189	128	57	44	418	

VA medical facility or health care system (HCS)	Number of veterans receiving service[a]					
	Home-based primary care	Homemaker/ home health aide	Skilled home health care	Adult day health care	Geriatric evaluation	Respite care
Network 18 (Phoenix)						
Albuquerque[b]	96	168	3		135	
Amarillo[b]			82			
Big Spring						
El Paso[b]			3		1	
Phoenix	75	57	250	—		
Prescott		6	72	38	—	
Tucson	163	128	156	39	25	8
Network 19 (Denver)						
Cheyenne		107	1			
Denver	76	134	66	61	122	14
Fort Lyon		85	165			0
Grand Junction[b]			6			
Montana HCS						
Salt Lake City[b]	127	115	98		83	
Sheridan		25	5	2		
Network 20 (Portland)						
Alaska HCS		15	87			
Boise		45	43		5	
Portland	119	26	68		94	
Puget Sound HCS	149	125	19	35	144	0
Roseburg		25	17			
Spokane		28	11	12		10
Walla Walla[b]		14	—			
White City Domiciliary		29	—	76	60	3
Network 21 (San Francisco)						
Central California HCS[b]	52	18	19		38	
Honolulu[b]	65	11	4	2	75	
Northern California HCS	185	78	69	6		
Palo Alto	115	29	48	15	90	10
Reno	83	83	83	9	35	0
San Francisco	99	69	40	8	80	
Network 22 (Long Beach)						
Greater Los Angeles HCS	245	95	12	57	123	
Loma Linda		90	210	25		
Long Beach	115				119	
Southern Nevada HCS			33		34	0
San Diego	77	40	15	50	80	
Network 23 (Minneapolis)[c]						
Black Hills HCS		105	101			1
Central Iowa HCS	49	17	66			
Fargo		69	240	2		

VA medical facility or health care system (HCS)	Number of veterans receiving service[a]					
	Home-based primary care	Homemaker/ home health aide	Skilled home health care	Adult day health care	Geriatric evaluation	Respite care
Iowa City		182	302	85	352	4
Minneapolis	116	200	130	200	44	0
Nebraska/Western Iowa HCS		94	82	7	36	1
Sioux Falls		51	50	2	16	
St. Cloud		76	105	87	12	1

Source: GAO.

Notes: Responses to our surveys were submitted September through November 2002.

Facility cells that are empty indicate that a facility did not report offering the service at the time of our survey. A dash indicates that a facility reported offering the service but did not report the service's July 2002 utilization.

[a]Services include those provided directly by VA staff or through contracts.

[b]Facility reported using only a volunteer service to provide noninstitutional respite care to veterans. We did not include volunteer respite care services in our number of facilities offering noninstitutional respite care.

[c]Network 23 was created when Networks 13 and 14 were merged into a single network in January 2002. VA currently has 21 networks.

Appendix IV: Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

April 7, 2003

Ms. Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues
Health Care Team
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed your draft report, ***VA LONG-TERM CARE: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care*** (GAO-03-487) and agrees with your findings and conclusions. VA concurs with your recommendations and offers these preliminary comments. The Veterans Health Administration will add eligibility sections in each new directive and handbook concerning Home and Community Based Care Programs. It will also develop performance measures to underscore the importance the Department places on its noninstitutional long-term care programs.

VA will provide its detailed action plan to implement GAO's recommendations when responding to your final report.

Thank you for the opportunity to comment on your draft report.

Sincerely yours,

Anthony J. Principi

Anthony J. Principi

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Musselwhite, (202) 512-7259

Acknowledgments

In addition to the contact named above Pamela Dooley, Steve Gaty, Marcia Mann, and Kristin Wilson made key contributions to this report.

Related GAO Products

Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably. GAO-02-1121. Washington, D.C.: September 26, 2002.

VA Long-Term Care: The Availability of Noninstitutional Services Is Uneven. GAO-02-652T. Washington, D.C.: April 25, 2002.

VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven. GAO-02-510R. Washington, D.C.: March 29, 2002.

Veterans' Affairs: Observations on Selected Features of the Proposed Veterans' Millennium Health Care Act. GAO/T-HEHS-99-125. Washington, D.C.: May 19, 1999.

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