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VA LONG-TERM CARE

Changes In Service Delivery Raise Important Questions

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GAO-04-425T

Highlights of GAO-04-425T, a testimony before the Committee on Veterans' Affairs, House of Representatives

VA LONG-TERM CARE

Changes In Service Delivery Raise Important Questions

Why GAO Did This Study

The Department of Veterans Affairs (VA) is likely to see a significant increase in long-term care need over the next decade. The number of veterans most in need of long-term care services—those 85 years old and older—is expected to increase from about 870,000 to 1.3 million over this period. Many of these veterans will rely on VA to provide or pay for nursing home care or noninstitutional services that may help them remain at home and, for some, delay or prevent the need for nursing home care. VA operates its own nursing home care units in 132 locations. VA also pays for nursing home care under contract in non-VA nursing homes—referred to as community nursing homes. In addition, VA pays part of the cost of care for veterans at state veterans' nursing homes and also pays a portion of the construction costs for some state veterans' nursing homes.

This Committee has expressed concerns about recent trends in VA long-term care service delivery and how VA plans to meet the nursing home care needs and related long-term care needs of veterans as the elderly population most in need of long-term care increases. GAO was asked to determine for fiscal years 1998 through 2003 (1) how VA nursing home workload has changed and (2) how VA noninstitutional long-term care workload has changed.

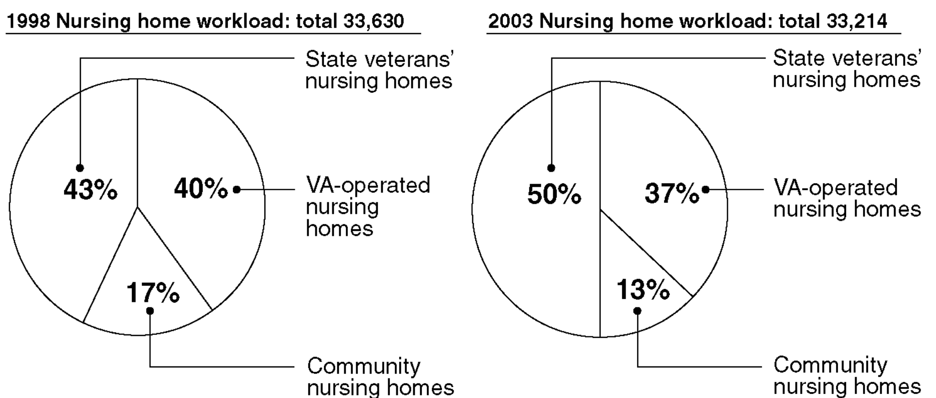
www.gao.gov/cgi-bin/getrpt?GAO-04-425T.

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

What GAO Found

Recent trends in VA nursing home care and noninstitutional service delivery raise important questions, particularly whether access to services is sufficient to meet the needs of a rapidly growing elderly veteran population. VA's overall nursing home workload—average daily census—was 33,214 in fiscal year 2003, 1 percent below its fiscal year 1998 workload. The workload was below the fiscal year 1998 level each year, decreasing by as much as 8 percent below the fiscal year 1998 level in fiscal year 2000. VA's use of nursing home care by setting also changed over the 6-year period. First, the percentage of workload in state veterans' nursing homes increased as the number of state veterans' nursing homes receiving VA payments increased. Second, the percentage of workload in VA's own nursing homes declined, in part, because VA decreased the number of long-stay patients and increased the number of short-stay patients it treats in the nursing homes it operates. This is consistent with VA's increased emphasis on post-acute care. Third, the percentage of workload in community nursing homes declined from 17 to 13 percent. VA officials told us that now shorter-term contracts are often used to transition veterans to nursing home care, which is paid for by other payers such as Medicaid.

Percentage of Nursing Home Workload By Setting, Fiscal Years 1998 and 2003



Source: GAO analysis of VA data.

Note: The workload measure is average daily census, which represents the total number of days of nursing home care provided in a year divided by the number of days in the year.

VA's noninstitutional long-term care workload—average daily census—increased by approximately 75 percent from fiscal years 1998 through 2003. Workload increased by 4,655 during this period to 10,892, reflecting a change in VA's approach to care which includes meeting more long-term care need through noninstitutional services. Most of the growth in noninstitutional workload came from VA's greater use of contract skilled home health care, which includes medical services provided to veterans at home, and homemaker/home health aide such as grooming and meal preparation.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss veterans' use of long-term care services, which include nursing home care and noninstitutional services provided or paid for by the Department of Veterans Affairs (VA). Concern with meeting veterans' long-term care needs is increasing as the number of veterans most in need of these services—those 85 years old and older—is expected to increase from about 870,000 this year to 1.3 million over the next decade. Many of these veterans will seek assistance from VA to provide or pay for nursing home care or a range of noninstitutional services that may help them remain at home and, for some, delay or prevent the need for nursing home care.

To provide assistance to veterans with chronic illness or physical or mental disability, VA provides a continuum of institutional and noninstitutional long-term care services. VA provides care that its own employees deliver and contracts with other health care providers to deliver care. VA operates its own nursing home care units in 132 locations and also pays for nursing home care under contract in non-VA nursing homes—referred to as community nursing homes. In addition, VA pays part of the cost of care for veterans at state veterans' nursing homes and also pays a portion of the construction costs for some state veterans' nursing homes. VA also provides noninstitutional services to veterans in their own homes or in community settings using both its own employees and through contracts with other providers.

This Committee has expressed concerns about recent trends in VA long-term care service delivery and how VA plans to meet the nursing home care needs and related long-term care needs of veterans as the elderly population most in need of long-term care increases. To assist the Committee in its oversight responsibilities in this area, you asked us to determine for fiscal years 1998 through 2003 (1) how VA nursing home workload has changed and (2) how VA noninstitutional long-term care workload has changed.

My testimony today is based on our ongoing review of long-term care workload for this Committee.[1] For this review, we measured nursing home

[1]We reported preliminary findings on nursing home workload in a testimony to this Committee on May 8, 2003. U.S. General Accounting Office, *Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs* GAO-03-756T (Washington, D.C.: May 8, 2003).

workload as defined by average daily census, which reflects the average number of veterans receiving nursing home care on any given day during the course of the year. We also measured noninstitutional workload using average daily census; however, the number of veterans receiving these services may be less than workload because a veteran may receive more than one service in a day. We analyzed data on nursing home workload that VA provided to determine how workload had changed from fiscal years 1998 through 2003. We also verified VA's nursing home workload numbers based on contacts with officials from VA's 21 health care networks and VA headquarters. To determine how noninstitutional long-term care workload has changed during this period, we analyzed data on visits for six noninstitutional services which VA either provides directly or pays for others to provide: home-based primary care, adult day health care, homemaker/home health aide, skilled home health care, home respite care, and home hospice care. We also interviewed VA officials at headquarters and obtained information from the networks to better understand the reasons for changes in nursing home workload during this period. In doing our work, we tested the reliability of the data and determined they were adequate for our purposes. We did our work in accordance with generally accepted government auditing standards from January 2003 through January 2004.

In summary, recent trends in VA nursing home and noninstitutional service delivery raise important questions, particularly whether access to services is sufficient to meet the needs of a rapidly growing elderly veteran population. VA's overall nursing home workload—-average daily census—- was 33,214 in fiscal year 2003, 1 percent below its fiscal year 1998 workload. The workload was below the fiscal year 1998 level each year, decreasing by as much as 8 percent below the fiscal year 1998 level in fiscal year 2000. Fourteen of 21 networks experienced declines in nursing home workload during this period. Moreover, VA's use of the three nursing home settings changed over this 6-year period. First, the percentage of workload met in state veterans' nursing homes increased from 43 to 50 percent as the number of state veterans' nursing homes receiving VA payment increased. The percentage of workload met in state veterans' nursing homes increased in 19 of VA's 21 health care networks. Second, the percentage of workload in VA's own nursing homes declined from 40 to 37 percent. Thirteen networks provided a smaller percentage of workload in VA-operated homes during this period. The percentage of workload provided in VA-operated homes declined, in part, because VA decreased the number of long-stay patients and increased the number of short-stay patients it treats in its own nursing homes. This is consistent with VA's policy to give priority to post-acute patients and certain other

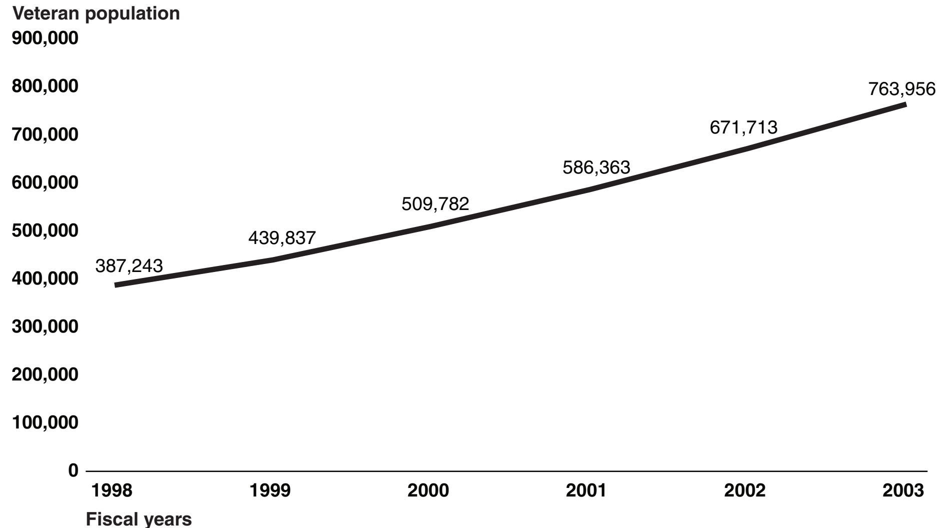
nursing home patients. VA generally provides long-term nursing home care as resources permit. Third, the percentage of workload in community nursing homes declined from 17 to 13 percent. Seventeen networks reduced the percentage of their nursing home workload provided in community nursing homes during this period.

VA's noninstitutional long-term care workload—average daily census—increased by approximately 75 percent from fiscal years 1998 through 2003. Workload increased by 4,655 during this period to 10,892, reflecting a change in VA's approach to care which includes meeting more long-term care need through noninstitutional services. Most of the growth in noninstitutional workload came from VA's greater use of contract skilled home health care, which includes medical services provided to veterans at home, and homemaker/home health aide services such as grooming and meal preparation. These services are most likely to help veterans prevent or delay the need for nursing home care.

Background

Meeting veterans' long-term care needs has become a more pressing issue as the veteran population ages. The elderly veteran population most in need of long-term care—those 85 years and older—grew dramatically from about 387,000 to about 764,000, an increase of about 100 percent from fiscal years 1998 to 2003. (See fig. 1.)

Figure 1: Growth in Veteran Population, 85 Years and Older, Fiscal Years 1998 Through 2003



Source: GAO analysis of VA data.

Over the past two decades the provision of long-term care has been shifting away from institutions and nursing homes towards more noninstitutional long-term care services in VA and in other programs. In recognition of this change in approach to how long-term care is provided, the Federal Advisory Committee on the Future of VA Long-Term Care recommended, in 1998, that VA update its long-term care policy by meeting the growing demand for long-term care through significant expansion of its capacity to provide home and community-based services—also known as noninstitutional long-term care services—while maintaining its nursing home capacity at the 1998 level.[2]

VA provides a continuum of noninstitutional long-term care services to provide care to veterans needing assistance. Long-term care provided in noninstitutional settings—-including services provided in veterans' homes and community-based services such as adult day health care centers—-is preferred by many veterans. Noninstitutional care also includes respite care services that temporarily relieve a veteran's caregiver from the

[2] *VA Long-Term Care At The Crossroads: Report of the Federal Advisory Committee on the Future of VA Long-Term Care* (Washington, D.C.: June 1998).

burden of caring for a chronically ill and disabled veteran in the home. VA offers noninstitutional long-term care services directly or through other providers with which VA contracts. (See table 1 for the noninstitutional long-term care services in our review.)

Table 1: Selected VA Noninstitutional Long-Term Care Services

VA noninstitutional long-term care service	Definition	Source of care
Home-based primary care	Primary health care, delivered by a physician-directed interdisciplinary team of staff including nurses to homebound (often bedbound) veterans for whom visits to an outpatient clinic are not practical.	VA providers
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.	Contracted providers
Adult day health care	Health maintenance and rehabilitative services provided to frail elderly veterans in an outpatient setting during part of the day.	VA and contracted providers
Skilled home health care	Medical services provided to veterans at home.	Contracted providers
Home respite care	Services provided at home to temporarily relieve the veteran's caregiver from the burden of caring for a chronically disabled veteran.	Contracted providers
Home hospice care	Services provided at home to veterans whose primary goal of treatment is comfort rather than cure for an advanced disease that is life-limiting.	Contracted providers

Source: VA.

Veterans can also receive nursing home care and noninstitutional services financed by sources other than VA, including Medicaid and Medicare, private health or long-term care insurance, or self-financed. States design and administer Medicaid programs that include coverage for nursing home care and home and community-based services. Medicare primarily covers acute care health costs and therefore limits its nursing home coverage to short-term stays following hospitalization. Medicare also pays for home health care. State Medicaid programs are the principal funders of nursing home and home health care services, besides patients self-financing their care. We have estimated that private insurance pays for about 11 percent of nursing home and home health care expenditures.[3]

[3]See U.S. General Accounting Office, *Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets* GAO-02-544T (Washington, D.C.: March 21, 2002).

Nursing Home Workload Declined Slightly And Use Of Nursing Home Care By Setting Changed

VA's overall nursing home workload—average daily census—was 33,214 in fiscal year 2003, slightly below its fiscal year 1998 workload. However, the workload was below the fiscal year 1998 level each year, reaching its lowest level in fiscal year 2000. Over the last 6 years, VA's use of nursing homes by setting changed. These changes in workload and use of different settings to provide nursing home care varied by network.

Nursing Home Workload Declined Slightly from Fiscal Year 1998 through Fiscal Year 2003

VA's nursing home workload was 33,214 in fiscal year 2003, 1 percent below its fiscal year 1998 workload. (See table 2.) Nursing home workload varied over this period but was consistently below the fiscal year 1998 level, decreasing by as much as 8 percent in fiscal year 2000 from its fiscal year 1998 level. The distribution of the nursing home workload among the three nursing home settings shifted during this period. From fiscal years 1998 through 2003, workload in the nursing homes VA operates declined by 1,014. In addition, workload in community nursing homes declined by 1,434. In contrast, workload in state veterans' homes increased by 2,032.

Table 2: Change in Nursing Home Workload Provided or Paid for by VA in Fiscal Years 1998-2003

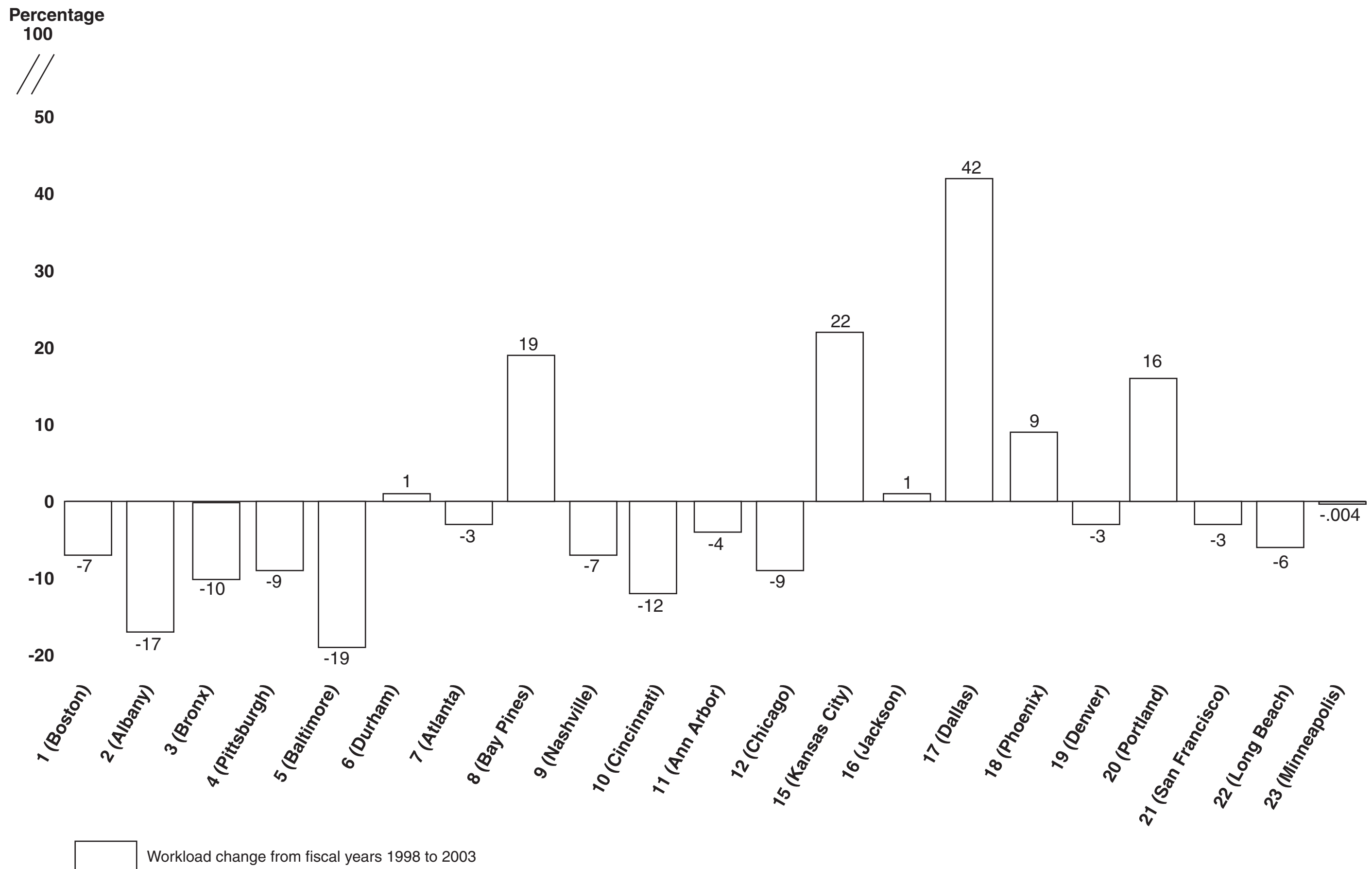
Type of nursing home	1998	1999	2000	2001	2002	2003	Change 1998-2003
VA-operated nursing homes	13,387	12,614	11,841	11,727	12,035	12,373	-1,014
Community nursing homes	5,636	4,575	3,799	4,163	4,080	4,202	-1,434
State veterans' nursing homes	14,607	15,046	15,259	15,533	15,985	16,639	2,032
Total	**33,630**	**32,235**	**30,899**	**31,423**	**32,100**	**33,214**	**-416**

Source: VA.

Note: The workload measure is average daily census, which represents the total number of days of nursing home care provided in a year divided by the number of days in the year.

Although VA nursing home workload did not change greatly from fiscal years 1998 through fiscal year 2003, some networks experienced significant increases or decreases. Fourteen of VA's 21 networks had lower nursing home workloads in fiscal year 2003 than in fiscal year 1998 for all three settings combined. (See fig. 2.) Network 5 (Baltimore) had the largest decline in workload—19 percent. Seven networks' nursing home workloads grew during this period. Network 17 (Dallas) had the largest increase in nursing home workload—42 percent.

Figure 2: Change in Nursing Home Workload by VA Network, Fiscal Years 1998-2003



Source: GAO analysis of VA data.

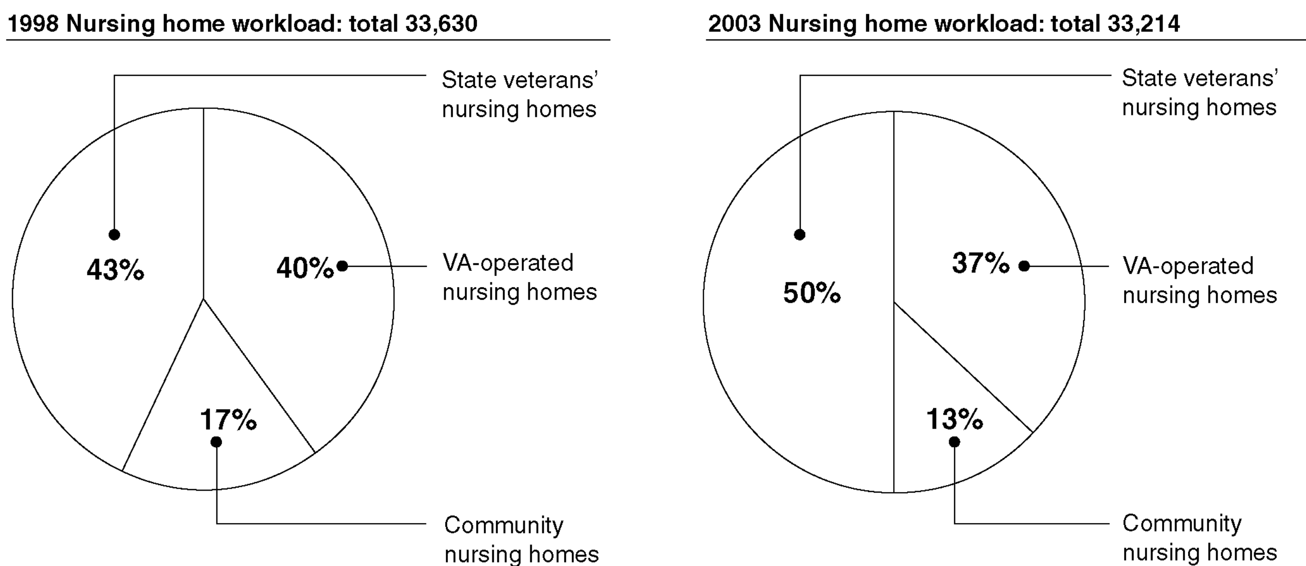
Note: Nursing home workload is measured using average daily census combined for VA-operated nursing homes, community nursing homes, and state veterans' nursing homes. Average daily census represents the total number of days of nursing home care provided in a year divided by the number of days in the year. VA merged networks 13 and 14 into network 23 in January 2002.

Use of Nursing Home Care Setting Changed from Fiscal Year 1998 through 2003

VA's use of nursing home care among the three settings changed from fiscal years 1998 through 2003. The percentage of workload met in state veterans' nursing homes increased from 43 to 50 percent. (See fig. 3.) This increase is attributable in large part to 18 more state veterans' nursing homes receiving payment from VA to provide such care. By fiscal year 2003, 109 state veterans' nursing homes received VA payment to provide this care. VA is authorized to pay for about two-thirds of the costs of

construction of state veterans' nursing homes and pays about a third of the costs per day to provide care to veterans in these homes.

Figure 3: Percentage of Nursing Home Workload By Setting, Fiscal Years 1998 and 2003



Source: GAO analysis of VA data.

Note: The workload measure is average daily census, which represents the total number of days of nursing home care provided in a year divided by the number of days in the year.

The percentage of workload provided in state veterans' nursing homes increased in 19 of VA's 21 health care networks. Network 17 (Dallas) had the largest increase in the percentage of workload provided by state veterans' nursing homes. The percentage of nursing home care provided by state veterans' nursing homes in this network increased from 0 to 30 percent during this period after the opening of four state veterans' nursing homes in Texas. By contrast, the percentage of workload provided by state veterans' nursing homes declined in 2 networks: Network 5 (Baltimore) by 3 percent and Network 21 (San Francisco) by 2 percent.

The percentage of nursing home workload provided in VA's own nursing homes declined from 40 to 37 percent during this period. Thirteen networks provided a smaller percentage of nursing home care in VA-operated nursing homes in fiscal year 2003 than in fiscal year 1998. Network 17 (Dallas) had the largest decrease in the percentage of

workload provided by VA-operated nursing homes, declining from 68 percent to 49 percent during this period. This resulted because the state veterans' nursing home workload increased substantially. By contrast, the percentage of care provided in VA-operated homes increased in 8 networks. Network 5 (Baltimore) had the largest increase, growing from 50 percent in fiscal year 1998 to 64 percent in fiscal year 2003. In Network 21 (San Francisco), the percentage of care in VA-operated nursing homes increased by 7 percent and in the remaining 6 networks the percentage of care in VA-operated nursing homes increased 3 percent or less.

Our analysis of length-of stay trends in VA-operated nursing homes shows that the decline in the number of veterans with long stays—90 days or more—largely explains the decline in nursing home workload during this period. The number of long-stay veterans declined from about 14,200 in fiscal year 1998 to about 12,700 in fiscal year 2002, the most recent year for which data are available.[4] At the same time the number of short-stay veterans—those with stays of less than 90 days—increased from about 26,700 to about 32,200. However, the increase in short-stay patients was not large enough to offset the decline in workload resulting from the decrease in long-stay patients. This results because multiple short-stay patients are required to generate the same workload as a single long-stay patient. For example, a single long-stay patient in a nursing home for 12 months creates a workload of an average daily census of 1 over a year. By contrast, 12 short-stay patients staying in a nursing home for one month each creates the same average daily census.

Among VA's networks, 16 had declines in the number of long-stay patients in VA-operated homes during this period. Five networks, however, had increases in the number of long-stay patients: Network 1 (Boston), Network 5 (Baltimore), Network 7 (Atlanta), Network 12 (Chicago) and Network 21 (San Francisco).

VA officials attribute some of the changes in nursing home workload in VA-operated facilities to an increased emphasis on short-term, post-acute rehabilitation care. VA's policy is to provide nursing home care in its own nursing homes as a priority to post-acute patients, patients who cannot be adequately cared for in community nursing homes or in noninstitutional

[4]This calculation requires complete data for the first 3 months of a fiscal year to determine if some patients in a prior fiscal year were in a VA-operated nursing home for 90 or more days. Data for the first 3 months of fiscal year 2004 were not available when we did our calculations. As a result, we provide our analysis for fiscal year 2002.

settings, and those patients who can be cared for more efficiently in VA's own nursing homes. In addition, VA may provide nursing home care, to the extent resources are available, to other patients who need long-term care for chronic disabilities. Consistent with VA's policy, the proportion of discharged veterans whose length of stays were less than 90 days in VA-operated nursing homes increased from 74 to 81 percent from fiscal years 1998 through 2003. This is similar to lengths of stay provided in facilities certified by Medicare—-but not Medicaid—-that provide post-acute skilled nursing home care.[5] About 81 percent of discharged patients in these certified Medicare facilities had length of stays of less than 90 days in fiscal year 1999.[6]

The percentage of workload in community nursing homes declined from 17 to 13 percent from fiscal year 1998 through fiscal year 2003. This decline occurred because VA reduced the number of patients served and the number of days paid for under contract in this setting. The number of patients in these settings declined from 28,893 to 14,032 during this period.[7] Some VA officials told us that in the past VA used community nursing homes for more patients and for longer-term contracts than currently. VA officials told us that now shorter-term contracts are often used to transition veterans to nursing home care, which is paid by other payers such as Medicaid. For example, some network officials told us that contracts for community nursing home care are often 30 days or less.

Of the 21 networks, 17 reduced the percentage of nursing home workload provided in community nursing homes during this period. Four networks reduced the percentage of nursing home care provided in community nursing homes by about 11 percent: Network 4 (Pittsburgh), Network 5 (Baltimore), Network 6 (Durham), and Network 17 (Dallas). By contrast, the percentage of workload provided in community nursing homes increased in 4 networks. The percentage of nursing home care provided in community nursing homes in Network 19 (Denver) increased by about 10 percent. The percentage of nursing home care provided in community nursing homes among the other 3 networks—- Network 23 (Minneapolis),

[5]Some nursing home facilities are certified only by Medicare to provide skilled nursing home care. Others are certified by both Medicare and Medicaid.

[6]See A. Jones, The National Nursing Home Survey: 1999 Summary. National Center for Health Statistics, Vital Health Stat 13(152), 2002.

[7]These patient numbers are based on discharges and are not unduplicated because a single patient may be admitted more than once in the same fiscal year.

Network 20 (Portland), and Network 18 (Phoenix)—increased 3 percent or less.

VA Noninstitutional Long-Term Care Workload Increased

VA's noninstitutional long-term care workload—average daily census—for the six services in our review increased by approximately 75 percent from fiscal years 1998 through 2003. Workload increased by 4,655 during this period to 10,892. (See table 3.) Much of this growth came from increases in skilled home health and homemaker/home health aide care—services that are most likely to help veterans prevent or delay the need for nursing home care. One of the services that grew most rapidly was skilled home health care which increased by 127 percent during this period. Although noninstitutional long-term care workload increased, all veterans may not have access to these services because there are limitations in the availability of these services. We previously reported a number of limitations in access to noninstitutional services that veterans experienced in the fall of 2002. At that time some facilities did not offer some of these noninstitutional services at all, or offered them only in certain parts of the geographic area they served.[8] For example, more than half of VA's 139 medical facilities did not provide home-based primary care or adult day health care in the fall of 2002.[9]

[8] U.S. General Accounting Office, *VA Long-Term Care: Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions* GAO-03-815T (Washington, D.C.: May 22, 2003), and U.S. General Accounting Office, *VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care* GAO-03-487 (Washington, D.C.: May 9, 2003).

[9] We reported on 139 medical facilities, even though VA had 172 medical centers, because in some instances 2 or more medical centers had 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 had 139 facilities.

Table 3: Change in Noninstitutional Long-Term Care Workload Provided or Paid for by VA in Fiscal Years 1998-2003

Type of noninstitutional service	1998	1999	2000	2001	2002	2003	Change 1998-2003
Home-based primary care	923	964	890	908	903	944	21
Adult day health care[a]	1,023	1,215	1,106	1,201	1,310	1,220	197
Homemaker/home health aide	2,385	3,141	3,080	3,824	4,180	4,317	1,932
Skilled home health care	1,906	2,148	2,555	3,273	3,851	4,332	2,426
Home respite care	[b]	[b]	[b]	[b]	[b]	2	2
Home hospice care	[b]	[b]	[b]	[b]	[b]	77	77
Total[c]	**6,237**	**7,468**	**7,631**	**9,206**	**10,244**	**10,892**	**4,655**

Source: VA and GAO analysis of VA data.

Note: Workload is measured by average daily census which represents the total number of visits of noninstitutional care provided in a year divided by the number of days in the year. The average daily census calculation for adult day health care uses 251 rather than 365 days because this service is not always provided 7 days a week.

[a] Numbers include contracted adult day health care and VA-provided adult day health care.

[b] Data not available.

[c] Total workload is not a measure of unique patients daily because the same patient may receive more than one service in the same day.

The noninstitutional workload numbers for home-based primary care in table 3 are different from those reported by VA in its appropriations submissions to Congress and in recent VA testimony.[10] In its reports on noninstitutional workload, VA has measured home-based primary care services using enrolled days—-the number of days a veteran is enrolled to receive a service—-rather than the number of home-based primary care visits a veteran receives. However, VA has measured use of the other noninstitutional services in visits. Therefore, to ensure comparability across services, we used visits as the workload measure for home-based primary care. As a result, our workload total for home-based primary care is smaller than the number VA reports because veterans do not typically receive a home-based primary care visit for each day in which they are enrolled in home-based primary care. Specifically, we report the 2002 home-based primary care workload as 903 while VA has reported it as

[10]House Subcommittee on Health, Committee on Veterans' Affairs, Statement of the Under Secretary for Health, Department of Veterans Affairs, *VA's Long-Term Care Programs*, 108th Congress, 1st session, May 22, 2003, Department of Veterans Affairs *FY 2004 Budget Submission: Medical Programs Volume 2 of 5 Final* (Washington, D.C.: March 2003), 2-148, and Department of Veterans Affairs *FY 2002 Budget Submission: Medical Programs Volume 2 of 6* (Washington, D.C.: April 2001), 2-101.

8,081. Our consistent measure of all services in visits results in a lower total noninstitutional workload than that reported by VA.

Concluding Observations

Over the last 6 years, the veteran population most in need of long-term care has grown dramatically. During this period, VA's use of nursing home care by setting has changed so that state veterans' nursing homes now provide one-half of all nursing home workload provided or paid for by VA. At the same time, VA decreased the workload it serves in its own nursing homes consistent with VA's policy to emphasize short-stay, post-acute care in its own nursing homes. VA also used community nursing home care less as it transitioned more veterans who needed such care to care paid for by other payers such as Medicaid. In addition, VA increased the long-term care workload provided in noninstitutional settings.

These trends over the last 6 years raise important questions for how VA is meeting current long-term care need and what it may need to do to meet future long-term care need.

- What does the significant variation in nursing home workload change among the networks over this 6-year period mean for meeting veterans' long-term care needs in different parts of the country?
- What are the implications for access, quality, and costs of VA's significant shift to using state veterans' nursing homes to provide one-half of its nursing home care?
- How has VA's increased emphasis on post-acute care in its own nursing homes affected its ability to continue providing long-term care in its nursing homes for veterans with chronic disabilities?
- To what extent does total VA long-term care workload—composed of a fairly constant nursing home workload and a rapidly expanding but smaller noninstitutional workload—meet the needs of a rapidly growing elderly veteran population?

The continuing rapid rise in the veteran population likely to be in greatest need of long-term care—those 85 years and older—poses a major challenge for VA health care. Answers to these four questions can help policymakers, VA, and its stakeholders better understand the best ways to meet VA's long-term care challenge. We look forward to continuing to work with you on these significant issues.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or other Members of the Committee may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact me at (202) 512-7101. Individuals making key contributions to this testimony include James C. Musselwhite, Thomas A. Walke, and Pamela A. Dooley.

Related GAO Products

VA Long-Term Care: Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions. GAO-03-815T. Washington, D.C.: May 22, 2003.

VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care. GAO-03-487. Washington, D.C.: May 9, 2003.

Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs. GAO-03-756T. Washington, D.C.: May 8, 2003.

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

Medicare: Utilization of Home Health Care by State. GAO-02-782R. Washington, D.C.: May 23, 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.

VA Long-Term Care: Oversight of Community Nursing Homes Needs Strengthening. GAO-01-768. Washington, D.C.: July 27, 2001.

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