Putting Veterans First: How to Increase Noninstitutional Care in the Greater Boston Area

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Introduction

The Veterans Health Administration (VHA) is a federal agency that was established to provide medical benefits to veterans. As the largest integrated health care system in the US, the types of services have evolved over the years to meet the ever-changing needs of veterans, but the mission remains the same—to fulfill Abraham Lincoln’s promise to “care for him who shall have borne the battle, and for his widow, and his spouse”. Long-term care services for veterans began as a few homes established to care for the poor and disabled men returning from the Civil War, but they have now expanded to a variety of traditional and innovative institutional and noninstitutional care programs all over the country. With continued advancements in modern medicine, people are living longer, so there are still many living veterans from the World War II and Korean War eras who are well into their 70’s and beyond. Additionally, another large wave of veterans from the Vietnam era are now reaching age 65 and may start needing long-term care services now or in the near future. As the aging veteran population continues to grow and preferences for care change, at the national level the VHA is trying to adapt its policies and services to position the organization to provide quality and patient-centered care through the creation of its strategic plan in 2009. As a part of this plan, the organization has been pushing to increase the number of veterans enrolled in non-institutional care programs. Consequently, each medical center has a target number to reach that is tracked as a performance measure, but certain factors can make achieving this goal within budgetary constraints challenging.

VA’s Requirement to Provide NIC

The origins of long-term care services for veterans date back to the 19th century. After the Civil War, there were many soldiers returning home with service-related injuries and little to
no money. As a result, State Veteran Homes were created to provide long-term care for this indigent and disabled population; these homes also provided care for, not only Civil War veterans, but also veterans of Indian Wars, Spanish-American War, the Mexican Border period, as well as regular discharged members of the Armed Forces (VA History, n.d., para. 3). The first of these homes was the Naval Home established in Philadelphia in 1812 which was followed by two more facilities in Washington DC—the Soldiers’ Home in 1853 and St. Elizabeth’s Hospital in 1855 (VA History in Brief, n.d., p.4). While they initially provided room and board and minor medical care, they had advanced this medical care to the level of hospital care in the 1920’s.

Some state homes remained in operation and continued to be managed by the states, but some became part of the federal system. By 1930, there were 54 hospitals within the VA health care system. The VA Healthcare System has experienced dramatic growth since the 1930’s in the number of facilities and the types of services it provides to veterans by growing from 54 hospitals in 1930 to now include 152 hospitals, 800 community based outpatient clinics, 126 nursing home care units, and 35 domiciliaries divided into 21 regions (VA History, n.d., para. 6). To keep up with this growth, the VA has had to create and update its policies for eligibility for services and services offered.

Long-term care within the VA healthcare system has predominately been affected by two pieces of policy—one is a law and the other is a VHA directive. The Millennium Health Act was signed into law in 1999, which sought to “amend title 38, United States Code, to enhance programs providing health care, education, memorial, and other benefits for veterans” (Veterans Millennium Health Care and Benefits Act, 1999). This piece of legislation was driven by a 1998 report entitled *VA Long Term Care at the Crossroads*, which found that the VA was very focused on inpatient and acute care, but their long-term care program lacked a range of options—
in addition to not being prepared to handle the number of elderly veterans projected to need care in upcoming years (Burris, 2008). There are several key sections of this document that have changed the delivery of and access to long-term care services for veterans. The first of these sections state that the VA is required to provide nursing home care to any veteran in need of such care for a service-connected disability or who has a service-connected disability rated 70% of more. The second of these sections impact, more specifically, non-institutional long-term care. It dictates that the Secretary of the VA must operate and maintain the following services to eligible veterans: geriatric evaluation, nursing home care (within VA facilities or community facilities), domiciliary services, adult day health care, noninstitutional alternatives to nursing home care, and respite care (Veterans Millennium Health Care and Benefits Act, 1999). After the Millennium Act was signed into law, the VHA had to come up with policies at the national level to assist with the implementation at all of its medical centers; one way to do this was through directives.

VA employees and VA facilities provide some of these newly mandated services, but others are provided through contracts with state or community partners; the contractual services are part of the purchased care program—also known as fee basis. The VHA Directive 1140.6 was created to establish processes and oversight for veterans receiving purchased care services. This directive, aligned with the Millennium Health Act, has two primary goals: “to ensure that clinically-appropriate services are available in the home as a component of the medical care necessary to support veterans in restoring or improving their health status, maintaining their independence, or providing them with comfort-oriented support services at the end of their lives” and “to ensure that approaches used by VA health care facilities to implement a broad array of home and community based care program alternatives are flexible and innovative with an
emphasize on assuring the best of VHA and community resources are available to veterans in need of such care” (Perlin, 2006).

**Inconsistency in Access to NIC**

While this directive seems like it would allow all eligible veterans to receive noninstitutional care, this is not necessarily true. As an exception to the 70% service-connected eligibility for nursing home care directive, all veterans eligible for VA care are eligible for noninstitutional care services as part of the standard benefit package as long as they demonstrate a clinical need for them (Geriatrics and Extended Care, n.d.). Even though medical centers are required to offer these non-institutional care programs, there is a clause in the directive that states that VHA permits the use of an electronic waiting list of veterans in need of and seeking home health services when budget resources are not sufficient to meet all identified home health care needs of veterans; the only exception to this wait-list policy is home hospice care. The Medical Center Director is responsible for ensuring their facility has a written policy outlining its clinical and administrative processes for managing these programs (Perlin, 2006). Because this clause about budget resources exists in this directive, it leads to some variation in how facilities choose to administer these noninstitutional care programs.

The Government Accountability Office and the Office of the Inspector General have conducted several audits after the law went into effect, which evaluated the VA’s compliance with the Millennium Health Act; these audits have found that access to non-institutional care services is inconsistent among medical centers. In response to an OIG report of non-institutional purchased home care services, six of eight medical centers evaluated refuted the findings by indicating that they needed to reduce or contain fee basis costs due to funding constraints, and
five of those six medical center directors indicated that they did not consider the provision of purchased home care services to be a high priority compared to other medical services paid through the fee program (OIG, 2013). Similarly, VA network and facility officials at various other facilities cited their reasons for limited access to noninstitutional care services at their facilities which included lack of contractors in their geographical area, difficulty hiring needed staff with a specialization in geriatrics, limitations due to the distance that VA employees can travel, and they felt that there was not enough emphasis placed on noninstitutional care at the national level to make it a priority due to an initial lack of measurable performance standards to meet (Bascetta, 2003). Medical centers tend to use these performance measures as a method to determine their priorities and allocate their funding accordingly.

The VHA is a federal agency and receives its funding through congressionally-approved appropriations, but the individual medical centers receive their allocations based on their patient-weighted workload. The Veterans Equitable Resource Allocation (VERA) model was created to standardize the formula to distribute funding to networks and is based on two key factors to determine the patient-weighted workload. The first of which is the number of veterans that have been treated, and the second of which is the complexity of these patients that have been treated. Based on their diagnosis, patients are placed into one of ten categories that are rated from lowest to highest complexity which each have a reimbursement rate associated with them; the assumption that a patient with a more complex condition is more resource-intensive. The model was designed so that, essentially, money follows the veteran; the least complex category is basic medical care and the highest category is long-stay institutional care. According to Frederick Malphurs and Joseph Striano (2001),
The VA’s primary care population and services to basic care patients are essentially underwritten through the services we offer to special care patients at the complex rate; In every case nationally where networks have experienced a decrease in the number of complex care patients or curtailed resources for long-term care services, these networks have suffered overall negative financial consequences. (p. M670)

Even though the medical center’s funding is generated by patient workload, it is ultimately up to the Medical Center Directors to determine their facility’s priorities based on national and local initiatives and performance measures and how to, therefore, allocate their budget in order to provide services and to generate enough revenue to sustain the organization. Other high profile veteran health issues, for example mental health issues like Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), depression, substance abuse, homelessness, and even institutional long-term care can become prioritized over services seen as discretionary like non-institutional care.

The Situation in Massachusetts

New England has a large population of older veterans, so there is a constant demand for its geriatric care programs—both institutional and noninstitutional. According to the VA’s Office of Public Relations, there are 425,000 veterans living in the state of Massachusetts alone, of which more than 50% of them are over age 65; all of the other states in New England exceed the national
average of 44% of its veteran population being older than 65 as well (VetPop Model, 2011). With only 731 nursing home care beds spread out across the 8 New England medical facilities, VHA will need to utilize noninstitutional care services to be able to care for its veteran population (VISN1, n.d., para. 7). This leads to two primary concerns: in accordance within the law and directive, how can services be most fairly allocated among veterans and how can access to NIC programs be increased? There are three key challenges that make the expansion of noninstitutional care difficult which are financial constraints, oversight of purchased care services, and conflicting performance measures.

One of the biggest financial constraints is the high cost of living in the Boston area, which translates to higher costs to provide healthcare to its patient population. Unlike the private sector, which relies primarily on insurance companies, Medicare, and Medicaid for its revenue, the VA derives a majority of its funding from appropriations from Congress. In theory, the VERA model was meant to align the projected costs of providing care to the amount of funding a medical center receives. In reality, an analysis conducted by an external organization, RAND, found that there were several other variables greatly impact the cost of care but are not calculated into the VERA model. These variables include patient age and sex, geographic area, infrastructure of medical center buildings, and reliance on Medicare (Wasserman et.al., 2001). New England, Massachusetts in particular, has a large population of older veterans and, being
some of the first VA facilities in the country, it also has an aging infrastructure. These factors can cause a disparity in the amount of funding received in respect to the actual costs required to provide care. In fact, in the same analysis done by RAND, they found that in any of their simulated VERA allocation models, the New England region should actually have a 2.6%-4.4% increase in their funding (Wasserman et. al., 2001). Since the VERA model and funding is controlled by Congress and is unable to be changed at a local level, medical centers have two options to try to close the budget gap—increase the number of patients that they serve or try to control costs.

Moreover, the salaries for care providers in the Greater Boston area are high. The medical center’s largest costs to provide inpatient long-term care are salaries for its employees, which can be greatly influenced by the geographic area that it is located in. Because the VA is a federal agency, the Office of Personnel Management sets the pay scales for all government employees, but these pay scales also include a locality pay adjustment to account for cost of living differences between different geographic areas; the locality adjustment for the Boston metro area is 24.80% compared to the base rate (Pay and Leave, n.d.). For example, a nursing assistant receiving the base rate would start at about $27,000-$30,000, whereas a nursing assistant in the Boston metro area would start at about $34,000-$38,000. A majority of employees fall under this General Schedule pay scale, but some occupations, such as Registered Nurses or physicians are eligible for special types of pays. Registered Nurses are compensated under a different Locality Pay System to ensure that they are paid a competitive rate within the local labor market, and these rates are reviewed periodically. Similarly, physicians are eligible for market pay which sets salary based on their specialty area and experience so that, their salaries too, remain competitive for the local physician labor market (VA Careers, n.d.).
Greater Boston area is home to several world-class medical facilities that attract talented health care providers to work at, which can drive salary costs up further in order for the VA to remain competitive in this local labor market and be able to recruit talented licensed providers. The facility should be prudent in right-sizing its staffing level and mix to control salary costs.

It is not feasible for VA employees to provide all services, so a majority of the noninstitutional care services, primarily the home health aide and adult day health care programs, are provided in the community using contracted providers. These programs are beneficial, but there are also some downsides to using these purchased care programs. First, the oversight of the direct care workers is done by the contracted agency and much of the feedback for the quality of care provided relies on veteran and family certification that the work was done to their satisfaction since the direct care worker’s supervisor or a VA employee would not be at the home to witness. This can also put the VA at risk for improper payments if billing does not accurately reflect services actually rendered. Also, if there is high turnover at the agency or variations in scheduling, veterans and caregivers may lose some continuity of care if there is a lack of familiarity between patient and provider. Second, according to a Genworth Financial Cost of Care Survey (2014), it found that hourly costs in the Greater Boston area, particularly adult day health care, are higher than most of the US and are continuing to grow; if hourly costs go up but the budget remains flat, it could lead to difficult decisions whether to focus on the number of hours per veteran or the number of veterans receiving services. Third, the VA has seemingly conflicting performance measures to increase the Average Daily Census (ADC) and reduce their non-VA costs. Non-VA costs include care that is unable to be provided by the VA in a timely manner which can include screenings like colonoscopies, emergency room care, hospitalizations
for institutional long-term care patients at the facility, and other critical services for veterans.

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The high cost to provide care, coupled with the potential for reduced VERA funding if the patient-weighted workload decreases, can cause a budget gap and puts the Greater Boston area at risk of not being able to keep up with the demand for long-term care services. Because most full-time employees are hired on a permanent basis, their salaries—the largest expense of a medical center, are prioritized in a facility’s budget; this amount that employees receive is the same regardless of how many patients that they see. On the other hand, many of the noninstitutional care services are paid through the purchased care (fee basis) program. These costs are more variable and are subject to increase based on the negotiated hourly rate for each contracted agency, the number of veterans served, and the number of hours authorized for each veteran. In the Greater Boston area, the rates for both Adult Day Health Care and Home Health Aide services have shown annual growth over the past five years. This also has to be considered in the context of national issues. The current political divide between Democrats and
Republicans—especially over the nation’s budget led to a government shutdown and almost led to sequestration that would have resulted in automatic budget cuts. It is unknown if the VA will be subject to budget cuts in the future, but it is not optimistic that their budget will increase based on the political climate. The VA needs to be positioned to have performance-driven, evidence-based, and cost effective long-term care programs to be able to meet the needs of the aging veterans in the Greater Boston area and close the budget gap.

**How to Solve the Problem**

To help the VA meet its goal of increasing noninstitutional care, my recommendations are centered on four main goals—increase outreach to bring more veterans into the VA system, particularly those with complex conditions; integrate a variety of functional assessment tools in order to ensure that services are prioritized and allocated to those who need them most; grow and expand programs that utilize existing VA staff and resources, and apply for grants to start new and innovative programs. All of these goals are designed to combat the barriers by increasing reimbursements from VERA, demonstrating the importance of noninstitutional care to increase facility budget allocations for the programs, and reducing non-VA costs. The median age as of September 2003 was 58 years old with the number of veterans over 85 years has more than quadrupled since 1990; this is compounded by
the fact that VA analysts show that veterans, on average, are sicker than other Americans of the same age (Sprague, 2004). As cohorts of veterans continue to age—especially the large amount from the Vietnam era, it is important to have a plan to address how to provide long-term care to older Massachusetts veterans.

**Increase Outreach**

The number of veterans age 65 and older continues to increase, but not all enrollees fully utilize their VA benefits. Many older veterans are dual eligible for both VA and Medicare and choose whether to utilize one or both of these benefits to meet all of their needs at the lowest out-of-pocket cost to them. While it seems like this would be beneficial to have more options at a lower cost, it has been found that “Cross-systems use, or use of VA and non-VA may enhance access, flexibility, and choice in health care for veterans, however, there are concerns that dual use may create discontinuity and duplication of care leading to wasteful use of health care with little to no benefit to patients” (Hynes et al., 2007). On the other hand, older veterans tend to be sicker and disabled with a variety of chronic conditions and the VA has recognized that “despite the vast array of long-term care services in the VHA continuum, as the VA tries to assist patients in managing their chronic illnesses, there will never be enough resources or programs. The all-encompassing 24-hours a day nature of chronic illness is too much for any one system, even one as large as the VHA” (Malphurs, 2007). In order for patients to receive the best possible outcomes, federal, state, and community organizations will need to work together to coordinate care.

As the largest integrated healthcare system in the US with over 1000 facilities, the VA is in a unique position because they are responsible for the full range of healthcare needs for
eligible veterans, potentially from early adulthood until death (VA History, n.d., para. 6). Even
though a majority of veterans are entitled to VA healthcare, not all veterans utilize this benefit,
which leads to concerns as to why veterans choose not to use VA healthcare. Some veterans
may have gone to the VA after they got out of the service and had bad experiences, or been
scared off by the negative reputation of the VA in the first place. The negative reputation of
veterans hospitals sunk so low in the 1990’s, that conservatives used it as an example to critique
socialized medicine with statements like “just visit any Veterans Administration hospital. You’ll
find filthy conditions, shortages of everything, and treatment bordering on Barbarianism”
(Longman, 2005). There was also a mentality that “You’ve seen one VA hospital—you’ve seen
them all” (Malphurs, 2007). Even after a lot of improvements were made, Bruce Kinosian
(2007) found that, “VA’s experience is that even when the cost to the veteran is near zero, only
60-65% of eligible will chose VHA-provided care” and the factors primarily affecting this are
geographical considerations, lack of knowledge, procedural barriers, or perceived quality
difference between VA and non-VA care (p. 356).

Presently, the VA has come a long way to improve the quality of VA care under the
guidance of Secretary Eric Shinseki which is echoed in the VA’s strategic plan to “be people-
centric, results driven, and forward thinking” and “improve the quality and accessibility of health
care, benefits, and memorial services while optimizing value” (FY2014-2020 Strategic Plan,
2014). Moreover, the VA has multiplied its access sites by expanding its Community-Based
Outpatient Clinics to make more care available on an outpatient basis and reduces the
inconvenience of having to travel long distances for care (Sprague, 2004). Targeted in-reach and
outreach can be done to educate veterans and their families about what benefits are available to
them and show how much the quality of VA has improved over the years.
Grow Programs that Utilize Existing Human Resources

The VA employs a variety of clinical staff that provides care to older veterans in both the outpatient and inpatient setting including physicians, geriatricians, nurses, physical therapists, and occupational therapists. As the veteran population changes, their care needs and preferences can change too so a facility needs to be able to have a well-trained and flexible workforce and service offerings that can adapt to meet these needs within their scope of practice. Because employees are typically hired on a permanent basis, they are a fixed cost to the facility regardless on the number of patients that they see or the mode of delivery of services that they provide; an advantage of this is that the oversight of their performance and the assignment of their duties is done by the facility. The VA has high standards for the quality of its care, which is demonstrated in its commitment to have a first-rate workforce through its professional development opportunities, training programs, and performance management system for staff.

The VA has also recognized that veterans have a high incidence of chronic diseases so the agency has established programs to manage these conditions. These are incurable and disabling diseases such as heart disease, diabetes, strokes, cancer, and dementia that are resource-intensive to control and can cause serious complications are they are not properly managed—especially when they are coexisting with normal aging. If the Bedford VA wants to increase its noninstitutional care, they should invest their existing human resources into growing several of its evidence-based programs and cost-effective programs that manage chronic conditions, slow the decline in functional status of elderly veterans, and allow them to remain in their own homes longer and reduce hospital or nursing home bed days of care. Two of these programs in particular are Home-Based Primary Care and Home Telehealth.
Home-Based Primary Care (HBPC) is a program that has been existence for a while, but has begun to grow due to the increase in veterans needing this service. The program was designed for one of the most vulnerable populations of veterans who have disabling chronic conditions and for whom periodic doctor visits are insufficient; according to Emily Egan (2012), a statistical profile of the Home-Based Primary Care patients are:

- An average age of 76.5
- 96% are male
- Nearly half of the population have functional limitations and cannot perform 2 or more ADL’s without assistance
- Have an average of 19.4 diagnoses and take 15 prescription medications regularly

The ultimate goal of the program is to reduce the number of preventable hospitalizations and maximize independence for patients to give them the highest quality of life possible through the use of an interdisciplinary care team, including both primary care and mental health providers, providing care in the home (Beales 2009). By making home visits, it allows providers to see patients in their home environment, reduces the chance of missed appointments, and reduces the need for frail veterans to have to make trips to the medical center. This program also supports the veteran’s caregiver because both the veteran and their caregiver are actively involved in making decisions about their healthcare.

Technology’s use in the health care field is constantly progressing, and telemedicine is another program that is growing dramatically within the VA and employs some of this new technology. The target population and benefits of telehealth are very similar to Home Based Primary Care since the two programs have very similar goals and are home-based, but they vary slightly in the mode of delivery. Likewise, it should be no surprise that many veterans receive
both services. While HBPC typically only involves a few home visits a month, an advantage of telehealth is that it can be used on a daily basis and is more real-time. There are several different types of telehealth technologies that are used, but the basic device only requires a phone line to be able to use in the home and can transmit valuable information to the patient’s health record. Telehealth devices record vital signs such as temperature, blood pressure, pulse, blood glucose, and ask a short questionnaire about how the veteran is feeling that day, and if any of the measurements are out of range, it will generate an alert to the VA nurse case manager who will contact the veteran to determine a course of action (Noel et. al., 2004). Primary care providers or social workers can make referrals to both of these programs.

Create and Implement a Comprehensive Standardized Assessment Tool

The goal of noninstitutional care is to ensure that clinically appropriate services are available in the home, but with an interdisciplinary team doing the screening, there may be differing opinions about what the needs of the patient are and what services are needed. The current model being used to assess patients is the Minnesota Model, but the limitation of this assessment tool is that it only measures Activities of Daily Living (ADL’s). While veterans who are 70% or more service-connected automatically qualify for home-based programs, all veterans who meet the following criteria based on VHA Directive 1140.6 (2006) qualify for services:

(a) Three or more ADL dependencies, or

(b) Significant cognitive impairment, or

(c) Require H/HHA services as adjunct care to community hospice services, or

(d) Two ADL dependencies, and two or more of the following conditions:

1. Has dependency in three or more IADLs;
2. Has been recently discharged from a nursing facility, or has an upcoming nursing home discharge plan contingent on receipt of home and community-based care services;

3. Is seventy-five years old, or older;

4. Has had high use of medical services defined as three or more hospitalizations in the past year or has utilized outpatient clinics or emergency evaluation units twelve or more times in the past year;

5. Has been diagnosed with clinical depression;


Since there is no one standardized assessment tool to assess all of these characteristics, it leads to variation and makes it more difficult to objectively prioritize care among other veterans. Even though eligibility for the programs only require meeting one of the criteria, it leaves room for subjectivity as to who has the greatest need for services. For example, a veteran with both severe cognitive impairment and has three ADL dependences would technically be equally as eligible as a veteran with just the three ADL dependencies. A standardized assessment rating all of these elements at once could allow a more equitable system of increasing access by pulling veterans who demonstrate the greatest need for services off of the Electronic Wait List for any veteran less than 70% Service-Connected who is not automatically admitted to the programs.

Apply for VA Grants to Pilot New Models of NIC

In order to make the VA a 21st century organization, the Office of Geriatrics and Extended Care has been requesting proposals to pilot new models of care. In fact, since 2009,
more than 150 projects have been funded across the country (Innovative Approaches to Home Based Care, n.d.). Since these programs are funded through special funds directly from VA’s central office, it allows researchers and clinical staff to pilot and expand new models of care in the VA system that have been done in the private sector without having to compete for the limited funding of facility’s operating budgets generated from VERA. Since both Bedford and Boston have large research departments and geriatric service lines, these highly knowledgeable employees should focus some of their research on new care models to see if they could apply for funding and pilot in MA. One program, Veterans Directed Home and Community Based Services, is a new program under the same premise as cash and counseling programs that gives money directly to veterans and allows them the flexibility to purchase services of their choice—including paying a family member or friend to be a caregiver, which is already being piloted; however it is too soon to tell if it is successful enough to expand yet though. Several other pilot programs have been piloted at other VA medical centers across the country that show promise are Program at Home and Geriatric Resources for Assessment and Care of Elders (GRACE).

As an expansion of the Home-Based Primary Care program that was designed to help veterans manage chronic conditions at home, these two programs--Program at Home and GRACE are also designed to target these veterans that are considered high risk for hospital or nursing home admissions or readmissions and keep them in their homes longer through the use of home-based specialized services for acute illness and personalized care plans overseen by interdisciplinary teams. Program at Home is a VA pilot program that is based on the Hospital at Home model of care and has been piloted in Buffalo, New York, Portland, Oregon, and Southeast Louisiana. The premise behind the program is that veterans would receive the same level of care that they would receive in a hospital, but in the comfort of their own home which
includes daily physician oversight of all evaluations including physician home visits, daily registered nurse visits to the home, 24 hour telephone access to a physician and registered nurse, and access to laboratory services, oxygen, IV medications, and electrocardiograms (HBPC’s Hospital at Home Program, n.d.). The goals of the program are to be more patient-centered, reduce complications of acute illness and the risk of hospital-acquired conditions, and make more hospital beds available for patients who cannot receive their care at home. In an evaluation of the pilot program done at the Portland VA, it found that this program received high marks for patient satisfaction and reduced hospital length of stays, but found that it would be easier for large-scale implementation as an early-discharge model rather than a hospital avoidance model (Mader et. al., 2004). Since the Bedford VA Medical Center does not have an emergency department or acute care inpatient unit, this type of program would most likely be more beneficial for the Boston VA Medical Center.

So far, GRACE has been piloted in both Indianapolis and San Francisco and has had positive results for veterans returning to their homes following a discharge from a hospital. Dr. Theresa Allison, the Medical Director for GRACE and Home-Based Primary Care at the San Francisco VA, explains that in the GRACE program, “the veteran continues to receive care from their primary provider, and also receives an in-home initial assessment by a nurse practitioner and social worker who look for environmental factors, caregiver support dynamics, and mobility and medication factors that are “invisible” in a 20-30 minute clinic appointment”; this nurse practitioner and social worker then continue to follow up with the veteran at regular intervals in between clinic appointments and make sure that everything is OK (GRACE Program Helps Older Veterans, n.d.). The GRACE Medical Director at the Indianapolis VA, Dr. Usha Subramanian, echoes the benefits of the program, which include the fact that team members meet
with the veteran’s primary care physician to create and continue to review, modify, and prioritize a customized care plan focusing on 12 care protocols including conditions such as chronic pain, urinary incontinence, malnutrition, and medication management just to name a few, which is implemented by the GRACE team of nurse practitioner and social worker who she calls her “Dream Team” (GRACE Care Management for Older Veterans, n.d.). These programs are so beneficial because, not only do they go beyond basic outpatient clinic primary care, they bring together an interdisciplinary team to implement customized care plans in the comfort of veterans’ own homes. Veterans in MA could greatly benefit from this program, and because the program does not require a large number of staff to operate, it would not require a significant financial investment for salaries; the medical centers could potentially even repurpose 1-2 existing social workers and nurse practitioners to more strategically utilize its human resources and prevent more costly hospital admissions.

**Conclusion**

In conclusion, Massachusetts has a higher than average percentage of veterans age 65 or older, with a large cohort of Vietnam veterans beginning to reach this age and need long-term care. The New England healthcare system needs to be prepared to have capacity in a variety of noninstitutional care programs to handle this potential surge, which can both honor veteran preferences if they would like age in place and reserve the limited number of nursing home care beds for those who need them most. In an era when federal budgets are tight, it is important to have evidence-based programs that are also cost-effective or have the opportunity to seek out additional funding for new programs. These recommendations will allow the greatest number of veterans to receive care.
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