

The Role of the Department of Veterans Affairs in Geriatric Care

American College of Physicians*

The Department of Veterans Affairs (VA) operates the largest single health care system in the United States—the Veterans Health Administration. In 1990, its 172 medical centers, 126 nursing homes, 32 domiciliary care units, and 46 independent or satellite clinics and outreach clinics provided directly for 983 000 hospital admissions and 22.6 million outpatient visits (1). In its affiliations with more than 1000 schools for the health care professions, the VA provides experience within its medical centers to about 100 000 students and trainees annually. In fiscal year 1990, VA medical institutions employed almost 220 000 people, including 12 241 staff physicians (excluding residents in training) and had a medical care, education, and research budget of \$11.8 billion.

Despite these resources, during the 1980s the VA experienced increasing difficulties in assuring timely, high-quality health care to its constituents. These difficulties have been attributed primarily to unrealistic budget development, leading to inadequate federal financing, and to ineffective resource allocation methods at the national and local levels (2-6). This situation will continue to worsen unless effective remedies are quickly and consistently applied. As the nation seeks long-term solutions to the overall crisis in access to health care (7), it must not lose sight of the immediate needs of its veterans, for whom Congressionally mandated support is a historical tradition (8).

The VA health care system faces a tremendous potential overload in demand for services in the final decade of this century. While the number and percentage of elderly persons in the general population are growing rapidly, the corresponding changes within the veteran population are even greater because of the aging of World War II and Korea veterans. In 1990, these two groups comprised about 65% of all civilian men who were 60 to 64 years of age (9, 10). Consequently, the number of older veterans using VA health care benefits will increase dramatically in the years just ahead.

As of September 1990, about 7.3 million veterans had reached 65 years of age; by the year 2000, their ranks will have swelled to 8.9 million. In the same 10 years, the number of veterans over 75 years of age will have increased from 1.5 to 3.8 million, and the number of veterans over 85 years of age, who require the most

intensive and extensive services, will have increased to about 475 000. Among men over 65 years of age, there are twice as many veterans as nonveterans; by the year 2000, there will be three times as many veterans as nonveterans in this age group.

These projections alone forecast a great increase in the demand for VA services. The other factor is likely to be the inadequacy of insurance coverage of U.S. citizens for prolonged illness. If trends continue, because of the greater copayments required of the consumer by Medicare and other insurers, the proportion of older veterans seeking care in VA hospitals is likely to increase from its present low figure. The VA requires no copayments or deductibles for veterans (including those over 65 years of age), with service-connected illness or injury, for those with nonservice-connected problems who meet eligibility criteria for low-income status, and for those who are recipients of VA pensions or support. For others, copayments are required for both inpatient and outpatient care, and the VA has just instituted a \$2.00 copayment for each prescription obtained from the VA pharmacy by nonservice-connected veterans and for prescriptions for a nonservice-connected complaint by veterans who are less than 50% service-connected. The aging veteran population will still find this fiscally advantageous.

To meet this demand, the VA will need the budgetary and political support of policymakers, Congress, health professionals, and the public. These groups will need to understand the magnitude of the aging veteran population and to appreciate that the VA has served, until recent years, as a leader (11) and model in both the provision of comprehensive, efficient health services to the elderly and in medical education and research. With accurate needs assessment, budget development, and fiscal allocation, as well as improved organization and management, it may be possible to restore the VA to its leadership position.

Geriatric and Long-term Care Programs

The VA has pioneered what is for Americans a unique continuum of treatment programs to meet the needs of the elderly and other veteran patients who require long-term care. In addition to traditional acute and ambulatory care services, it provides a broad range of institutional and non-institutional long-term programs for patients who are not able to live independently. These services, described in Table 1, include hospice, nursing home, and adult day health care; hospital-based home care; domiciliary and community residential care; and respite care.

The VA has been structured to encourage appropriate, cost-effective medicine by delivering care in settings that maximize independence and minimize reliance

* This paper, authored by David M. Borofsky, MD, David H. Law, MD, and Jack Ginsburg, was developed for the Health and Public Policy Committee by the Subcommittee on Aging: Thomas P. Almy, MD, *Chair*; Patricia P. Barry, MD; John C. Beck, MD; Christine Cassel, MD; William A. Godfrey Jr., MD; David H. Law, MD; Joanne Lynn, MD; and Mark E. Williams, MD. Members of the Health and Public Policy Committee for the 1989-90 term were: Paul F. Griner, MD, *Chair*; Thomas P. Almy, MD; F. Daniel Duffy, MD; John M. Eisenberg, MD; Richard G. Farmer, MD; Donald I. Feinstein, MD; Lockhart B. McGuire, MD; Steven A. Schroeder, MD; H. Denman Scott, MD; Lynn B. Tepley, MD; and Quentin D. Young, MD. This paper was approved by the Board of Regents on 17 February 1989.

Table 1. Veterans Affairs Long-term Care Services*

Hospice care (inpatient and home care) is provided by five VA medical centers
Nursing home care (approximately 30 000 patients on any given day) is provided by VA-operated nursing homes; community-contract nursing homes; State Home (state operated) nursing homes
Department-operated adult day health care (an alternative to nursing home care) is provided by 15 medical centers and 95 contract centers
Hospital-based home care was provided to 16 217 patients through 298 000 visits in 1990 (approximately 20% of these patients were terminally ill and might otherwise have been hospitalized)
Domiciliary (VA and State Home) and community residential care home programs provide medical care to over 30 000 veterans who no longer need hospital or nursing home care but are not able to live independently
The respite care program provides periodic relief for the care givers of disabled veterans. This program is operated at 128 medical centers (newest VA patient treatment program).

* Services are listed from the most to the least intensive. VA = Department of Veterans Affairs.

on high technology. However, although the array of programs described above is impressive, not all programs are available at all VA medical centers. Furthermore, many of these programs have been threatened by chronic underfunding. It has been reported that facilities are in disrepair and understaffed, that the planned conversion of certain facilities to nursing homes is behind schedule, and that outpatient appointments, hospital admissions, and provision of prosthetic devices are sometimes inordinately delayed (2-5, 12, 13).

Although many of the complaints about the quality of care within the system are anecdotal, the fiscal difficulties of the VA are a matter of record. Medical directors surveyed by Congress at each of the nation's 160 VA medical centers reported an average of more than \$1 million in unfunded operating expenses per center in fiscal year 1987, for a national total of more than \$220 million. In addition, up to 30% of official operating beds were found to be closed because of staff or funding shortages (2). In July 1988, the VA projected a fiscal year 1989 national shortfall of \$820 million (14), and budget increases since then have not even kept up with health care inflation.

In April 1990, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) reported that 116 VA hospitals surveyed in 1988 had a significantly lower average overall accreditation score than non-VA hospitals. Although the JCAHO acknowledged that the comparison was not matched to rate VA hospitals against hospitals of similar size, services, and affiliations (15), the study was highly publicized in the medical and lay press. However, in 1990, the mean score for those VA hospitals surveyed had met and exceeded the last reported JCAHO national average grid score (16).

Regarding outpatient care, the veterans services organizations, whose independent analyses have been used by Congressional investigative committees (12) and the U.S. General Accounting Office (17), assert that problems caused by complicated eligibility criteria are compounded by the way the criteria are being applied. For veterans with nonservice-connected illness or disability who have low incomes, outpatient care has been covered only if it would "obviate the need" for inpatient care. Ironically, because this judgment is not always made by a clinician involved in the case, it can result in denial of outpatient care to patients who are "not sick enough" but who then require more costly hospitalization when their conditions worsen (3-5, 12).

Continued effort should be made to ensure that acute and long-term care services are available to all eligible veterans. Although there are serious problems in the VA system, its areas of strength can serve as examples, particularly for communities seeking to develop alternatives to hospital care.

Research in Geriatrics and Gerontology

In addition to its patient care activities, the VA has emphasized research on age-related health care problems. Much of this research is conducted in 12 geriatric research, education and clinical centers (GRECCs) designed to foster clinical teaching and research and to translate geriatrics and gerontology advancements into patient care delivery. One of the program's major achievements has been the development of geriatric evaluation units that provide intensive interdisciplinary team assessments to improve the problem identification, treatment, and placement of older patients who have remediable impairments, multiple chronic diseases, and interacting psychosocial problems. These activities can be enhanced by establishing additional sites and satellite centers. Indeed, in 1982, Congress authorized expansion to 23 such centers, but funds were not made available until 1991 when 3 additional GRECCs were awarded. In addition, VA research funding has been subject to unpredictable yearly fluctuations that have made it difficult to assure investigators that proposed multi-year studies will be supported properly (5). A blue ribbon commission was appointed by the Secretary to evaluate the research program and its needs, but the current and proposed budgets have failed to meet the recommended funding levels suggested by this distinguished group (18).

Geriatric Training

The training of health care professionals in geriatrics and gerontology is an important VA function. Working with elderly patients is an integral part of the clinical experience of the approximately 100 000 health trainees, including 30 000 resident physicians and 42 000 nursing and associated health students, who are trained in VA medical centers each year. Geriatrics training now is required in all internal medicine residency programs (19), and VA training can provide a model for other institutions working to implement this requirement.

However, it is crucial that VA physician training

Table 2. Veterans Affairs Programs for Geriatric Training in Fiscal Year 1990*

Geriatric training†

An interdisciplinary team training program that provides physicians and other health professionals with a structured approach to the delivery of health services by emphasizing the knowledge and skills needed to work in an interactive, interdisciplinary group

A masters level clinical nurse specialty program and a gerontological nurse fellowship program

Geriatric training for other allied health care professionals at VA medical centers and at Geriatric Research, Education and Clinical Center sites

VA centers providing continuing education opportunities in geriatrics

Seven regional medical educational centers‡

Eight cooperative health manpower education programs

Two dental education centers

Two continuing education centers

Twelve geriatric research, education and clinical centers (3 additional centers were started this year)

* VA = Department of Veterans Affairs.

† In addition to medical residency.

‡ These centers provided specific geriatric education to more than 10 200 VA employees.

place increased emphasis on ambulatory care. Residency Review Committee requirements for internal medicine now specify that at least 25% of the residents' time must be spent in ambulatory care settings (19). Funding and facilities for training in outpatient care have been relatively deficient in VA programs, because the system traditionally has been hospital-based and relatively bed-bound, with a congressionally mandated requirement to maintain a fixed (approximately 90 000) bed component. The VA's ability to provide ambulatory care experience to its trainees is also hampered by the current structure and interpretation of eligibility criteria for such care, as discussed above. In 1989, ambulatory care fellowships were initiated to begin development of academic primary care physicians with primary care and research experience in VA clinics.

The VA supports major fellowship or specialty training in geriatric medicine for physicians. This includes a 2- to 3-year program designed to develop a cadre of physicians committed to clinical excellence and to becoming leaders of local and national geriatric academic programs. As of June 1990, 234 fellows had completed the program. About 90% of the graduates continue to practice geriatric medicine, and about 40% remain in the VA system. With the establishment in 1990 of examinations for the certification of added qualifications in geriatrics, these special fellowship slots were converted to residency training positions in geriatrics, making the geriatrics program similar to other specialty training programs in the system. A similar program was developed in geriatric dentistry. Thirty fellows have completed this program as of June 1990. Other specific geriatrics training is summarized in Table 2. Strong geriatrics residency and fellowship programs provide resources that improve the environment for geriatrics education and clinical care throughout an institution.

The Wider Impact of Veterans Affairs Training and Research on Overall Clinical Excellence

The VA plays a major role in other U.S. health care education programs in addition to geriatrics training. In particular, 22 000 medical students received all or part of their supervised clinical experience in VA medical centers during 1990. These students represent nearly one third of the nation's total undergraduate medical school enrollment and are double the number of stu-

dents who participated a decade before. In addition, 30 000 resident physicians (more than a third of the nation's total) participated in approximately 8350 VA-supported medical residency positions at 135 VA medical facilities affiliated with 103 medical schools.

The ability of the VA to deliver high-quality care depends greatly on its affiliation agreements with medical schools. A loss of affiliation agreements, which might well result from precipitous policy changes or from degeneration within the system, would jeopardize not only the VA's educational and research programs but would also deprive the VA of its major guarantee of high-quality care and seriously impair opportunities to recruit and retain the best professional personnel. It is essential that the VA maintain a balance of services, including alternatives to hospital care (as discussed above), to provide these training opportunities.

The VA also conducts extensive research in areas other than geriatrics and gerontology. Approximately \$210 million was obligated for VA medical and prosthetic research in fiscal year 1989, and \$214 million was obligated for fiscal year 1990. High-priority areas of VA medical research include the acquired immunodeficiency syndrome (AIDS), schizophrenia, alcoholism and other substance abuse, aging, spinal cord injury, delayed stress, and the long-term health impairments of former prisoners of war. Research is also directed toward health problems prevalent among veterans, including cancer, diabetes, chronic heart disease, and chronic pulmonary disease. The VA also encourages studies that emphasize practical applications for medical care such as prosthetics and sensory aids to help the disabled. Research supported by the VA has yielded large gains in the cost effectiveness of medical care, both within and outside the VA system. The VA has also been a leader in the development of cooperative clinical trials, an activity that is basic to the development of rational guidelines for patient care. This activity should receive continued support.

The diverse spectrum of research activities is a strong incentive in the recruitment and retention of health care personnel in the VA system. The extent and high value of VA programs in medical education and research have made the VA an integral part of the nation's medical educational system. Major changes in the VA system would undoubtedly produce significant repercussions

for academic medical centers. By the same token, changes in the medical education system (for example, reduction of medical school class size or the closure of some schools) would affect the VA. Therefore, proposals for significant change in VA health care should be evaluated *before* implementation to determine possible effects on the national medical education enterprise and vice versa. Academic medical centers and training programs must be given adequate notice so that they can develop plans to lessen the adverse impact of any such change.

Cooperation and Sharing among the Department of Veterans Affairs and Other Health Care Providers

When necessary, federal law authorizes the VA to share, provide, or purchase specialized medical resources with federal (for example, Department of Defense) and state health care institutions, as well as with local community hospitals. The program has grown steadily each year in the scope of services both provided and obtained. Although success in this area (5) has only slightly countered the impact of the VA's overall fiscal and quality-of-care problems, the broadened range of sharing opportunities has served to improve the cost effectiveness and quality of medical care provided to veterans and nonveterans. As medical care continues to become more complex and more costly, the interdependence between the Veterans Health Administration and the rest of the health care system will intensify.

The Veterans Health Administration's former Medical District Initiated Program Planning (MEDIPP) program required each VA medical center to explore its potential role as a sharing partner in its community. Between fiscal years 1985 and 1990, the VA in this capacity has provided more than \$66 million in medical services and technologies to the nonfederal sector while purchasing more than \$229 million in health care resources from non-VA entities.

The VA is thus a major user of services from the community, where such services are authorized, are not available in a VA facility, or are justified by a veteran's circumstances or by considerations of cost effectiveness. The VA paid for 74 106 patients to be treated in non-VA facilities in fiscal year 1990 and for 1.2 million fee-basis visits to non-VA physicians. The VA purchases nursing home care for many more patients in community nursing homes than it treats in its own nursing homes. Long-term survey data from the National Center for Health Statistics have indicated that about 86% of all veterans customarily receive their health care from community sources, whereas about 14% of veterans receive care under VA auspices (20).

Before the initiation of the MEDIPP program, the VA had been criticized as being hierarchical, centrally controlled, and not responsive to rapidly changing local needs. Under MEDIPP, there was still much room for improvement; indeed, the program had its own set of problems (4, 5). Even more flexibility for local management is eagerly sought within the VA and, in some respects, this is a commendable goal. However, the veterans service organizations have noted that flexibility

attained under MEDIPP was not strongly linked to accountability. In some cases, innovative strategies or activities were devised or activated without sufficient concern for funding availability or duplication of services (5).

These problems may be remedied by a new resource planning and management (RPM) system that is being initiated to address a national health care program for veterans. This system will have centralized policy setting and planning but decentralized implementation. It is hoped that the strengths and weaknesses of each individual VA facility will be assessed in the light of the health care needs of veterans in a specified area, the availability and complementarity of services at other VA medical centers, and the feasibility of using Department of Defense or community resources where VA facilities or services are unavailable. The management, planning, and resource allocation processes within the Veterans Health Administration should be structured to allow the most efficient and flexible local approaches to health care delivery within available resources.

Conclusion

The VA programs in patient care, research, and education in geriatrics present an impressive and comprehensive array of geriatric services that are unmatched by other health care systems in the nation. As such, they can and should serve as a model for several important aspects of national health planning. Fiscal and quality-of-care problems now interfere significantly with the VA's ability to fill this role.

With the elevation of the head of the VA to a cabinet-level position, Congressional investigative committees have noted improved federal advocacy for the VA, which has been reflected in both the President's 1991 and 1992 budget proposals (12, 13, 21). Also, substantial supplemental funding has been obtained several times in recent years to help address severe deficits. However, increased funding for fiscal year 1990 was not even sufficient to return the VA to the level of health care services it provided in 1988 (5). Clearly, continued improvement is needed.

Changes in national policies affecting health care or the VA, or both, must not be made in isolation. Development of new policies must include recognition of interrelationships among health care systems and the impacts that policies in one system will have on the provision of medical care provided throughout the nation.

The American College of Physicians supports efforts aimed at streamlining and improving the delivery of VA medical services and stands ready to work with Congress, the VA, veterans' organizations, and others dedicated to the provision of optimal health care for U.S. veterans.

In summary, the American College of Physicians believes the following:

1. The VA must have adequate budgetary support to re-assert and maintain its leadership in the provision of comprehensive services to veterans; geriatrics research; and the education and training of health care profession-

als in geriatrics. This support must increase to meet the growing needs of elderly veterans in this decade.

2. Continuing national pressures to restrain health care costs mandate the most economical use of existing health care resources. This means that eligibility criteria for VA care should be structured and administered to assure adequate input regarding both their clinical and their financial impact. In addition, cooperation and sharing among VA and other health care providers should be promoted to improve the efficiency and effectiveness of health care delivery by the VA as well as by its partners.

3. Changes in public health policy will affect VA programs. Any change should be evaluated for its impact on the VA's ability to achieve its goals.

Requests for Reprints: Linda Johnson White, Director, Department of Scientific Policy, American College of Physicians, Independence Mall West, Sixth Street at Race, Philadelphia, PA 19106-1572.

References

1. Department of Veterans Affairs. Annual Report of the Secretary of Veterans Affairs, Fiscal Year 1990. Washington, DC: U.S. Government Printing Office; 1990.
2. U.S. Congress. House Committee on Veterans Affairs. Survey of Veterans' Administration Medical Centers. 100th Cong. 2nd session. 1988. House Committee Print No. 10.
3. Meeting the Challenge: To Keep the Promise: An Independent Budget by Veterans for Veterans' Programs, Fiscal Year 1989. A Joint Project of AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States.
4. The Need is Now: An Independent Budget by Veterans for Veterans' Programs, Fiscal Year 1990. A Joint Project of AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States.
5. The Price of Peace—The Nation's Obligation: Correcting Budget Priorities For Veterans—Fiscal Year 1991 Independent Budget for Veterans Affairs. A Joint Project of AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States.
6. A Nation's Commitment: A Matter of Honor to Those Who Serve. Independent Budget for Veterans Affairs, Fiscal Year 1992. A Joint Project of AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States.
7. American College of Physicians. Access to health care. *Ann Intern Med.* 1990;112:641-61.
8. The Role of the Veterans Administration in an Evolving Health Care System. Position Statement of the American College of Physicians Board of Regents. Available from: American College of Physicians, Philadelphia, PA 19106-1572.
9. Office of Planning and Management Analysis, Management Sciences Service, Demographics Division. Veteran Population: March, 1990. Washington, DC: Department of Veterans Affairs.
10. Survey of Aging Veterans. Washington, DC: Veterans Administration, Office of Reports and Statistics; 1984.
11. American Geriatrics Society Position Statement: The Role of the Veterans Administration in the Care of the Elderly. New York: The American Geriatrics Society; 1987.
12. Congressional Record. 136th Congress, H-1555. Daily edition, 18 April 1990. Washington, DC; 1990.
13. Congressional Record. 136th Congress, S-549. Daily edition, 30 January 1990.
14. Fiscal Year 1989 Budget Problem Definition—Options (draft). Washington, DC: Veterans Administration, Department of Medicine and Surgery; 1988.
15. Jesse WF, Vice President for Accreditation Surveys, JCAHO. [Letter to Arthur Lewis, MD, Acting Chief Medical Director, Veterans Administration Central Office, Washington, DC]. Source: Department of Veterans Affairs, Washington, DC.
16. Department of Veterans Affairs, Office of Quality Management. Letter IL 15-9-001. Washington, DC; 2 Jan 1991.
17. Management of VA: Implementing Strategic Management Process Would Improve Service to Veterans. U.S. General Accounting Office Report to the Congress. Washington DC: U.S. Government Printing Office; 1990. GAO/HRD-90-109.
18. Department of Veterans Affairs Advisory Committee for Health Research Policy. Final Report. Washington, DC; 1991.
19. Accreditation Council for Graduate Medical Education, Residency Review Committee, Internal Medicine. Special requirements for residency training programs in internal medicine. Approved 9 September 1988, Implementation 1 October 1989.
20. Health Characteristics of Veterans and Nonveterans. Health Interview Surveys, 1971-1981. Washington, DC; Veterans Administration, Office of Information Management and Statistics; 1984:8-9.
21. The Budget of the U.S. Government, 1992. Washington, DC: U.S. Government Printing; 1991.