

Vietnam Veterans of America White Paper on Aging Veterans

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**RECONFIGURING
VETERANS' HEALTH
ADMINISTRATION
TO ADDRESS
AGING VETERANS'
HEALTHCARE NEEDS**





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Reconfiguring Veterans Health Administration to Address Aging Veterans Healthcare Needs

How should the traditional Veterans Health Administration (VHA) bedside-care teams be reconfigured to meet the imminent needs of aging veterans? This need emanates from a more culturally and socioeconomically diverse aging veteran population experiencing chronic, multiple conditions requiring more healthcare services. Driving this need for marked transformation is the reality that, as of 2022, more than [5 million additional veterans](#)¹ may be eligible to enter the VHA healthcare system as a result of the *Promise to Address Comprehensive Toxins (PACT) Act*.²

Within this cohort of 5 million is an aging Vietnam veteran population that may put intense stress on VHA's healthcare system, including its funding sources. A lack of personal savings for long term-care (LTC) and a sometimes-fragmented VHA delivery system will pose significant risks to the health and quality of life of these aging veterans. VHA's healthcare workforce will also need to be retooled to manage the multiple chronic conditions prevalent in this vulnerable population. Addressing the needs of the elderly should be a top priority of policymakers at every level.



- 1 The White House. "President Biden Signs the PACT Act and Delivers on His Promise to American's Veterans." *Fact Sheet*. August 10, 2022. <https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/10/fact-sheet-president-biden-signs-the-pact-act-and-delivers-on-his-promise-to-americas-veterans/>.
- 2 Congress.gov. "H.R.3967 - 117th Congress (2021-2022): Honoring our PACT Act of 2022." June 16, 2022. <https://www.congress.gov/bill/117th-congress/house-bill/3967>.

A Profile of Older U.S. Veterans

The U.S. population is rapidly aging. According to the Census Bureau, the U.S. population ≥ 65 will increase almost 70 percent by 2060.³ An analysis of data from the Health and Retirement Study (HRS) of the National Center for veterans Analysis & Statistics (NCVAS) finds that in 2020 almost 9 million veterans were 65 or older.⁴ Over 2 million are Vietnam veterans.⁵

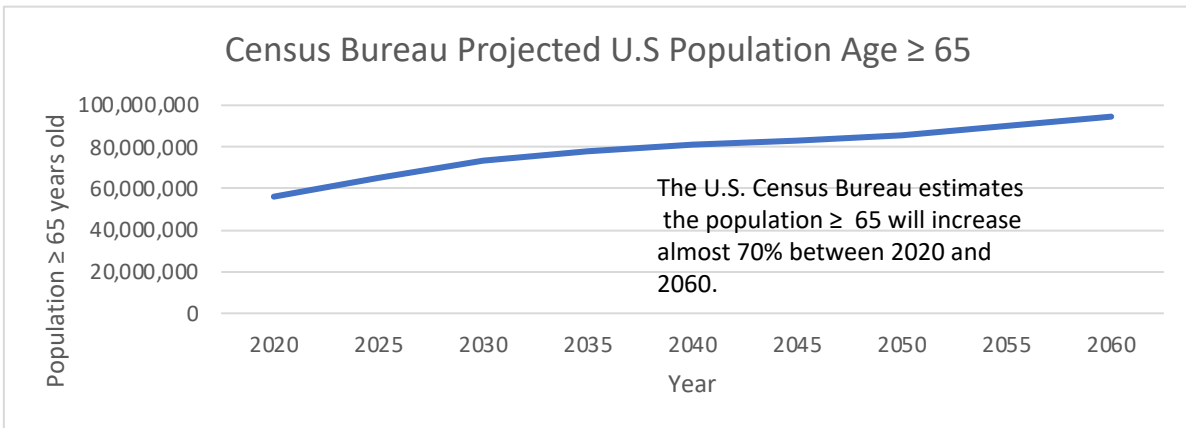


Figure 1. U.S. Census Bureau’s Projected U.S Population Greater Than or Equal To 65 Years Old.

A National Council on Aging analysis to understand the health and economic characteristics of older veterans found two key findings compared to non-veterans in the same age group:

- Older veterans have higher incomes, but they have less of a financial safety net in terms of savings and home equity.
- Older veterans are in worse health.⁶

Meeting the health needs of an aging population is not new to the VA. The VHA has been providing quality care for older veterans for decades. This is a complex group with significant healthcare needs, including care for chronic health conditions linked to military service. The unique needs and considerable growth of this specific population behooved the Department of Veterans Affairs (VA) to tailor its patient-centered medical home model (PCMH) for older adults.

A long-standing VHA geriatric PCMH model is GeriPACT, which stands for [Geriatric Patient Aligned Care Team](#). Its roots go back to 1984. In 2010 the ambulatory-care Geriatric Primary Care programs were rebranded as GeriPACT. The goal is to provide veterans with as much independence and quality of life (QOL) as possible. GeriPACT combines VA healthcare with non-VA resources and services offered in the veteran’s community.

Over the first four years (2011 – 2016) of implementing this program at the VA Tennessee Valley Healthcare System, the GeriPact team reduced yearly hospitalizations for its elderly, high-risk, high-need veteran population with multiple comorbidities from 21% to 13%. The mean number of medications per patient fell

3 U.S. Census Bureau. 2017 “National Population Projection Table 1, Projected population size and births, deaths, and migration.” Access December 7, 2022. <https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html>.

4 National Center for Veterans Analysis & Statistics. Population National Tables updated Sep. 7, 2022.

5 U.S. Census Bureau. 2020. “Table 13. Persons (aged 15 and over) who received Veteran’s Benefits during year.” Veterans Data Tables, SIPP Detailed Program Receipt Tables: 2020. <https://www.census.gov/data/tables/2020/demo/public-assistance/sipp-receipts.html>.

6 Lauren Popham, Jane Tavares, and Marc Cohen. “A Profile of Older U.S. Veterans,” Veteran Issue Brief, NCOA, November 6, 2019. <https://www.ncoa.org/article/a-profile-of-older-us-veterans>.

from 11 to 9, and the 30-day all-cause readmission averaged only 10%.⁷ For comparison, this [NCQA table](#) shows Medicare HMO and PPO readmission rates for patients ≥65 during the same period.

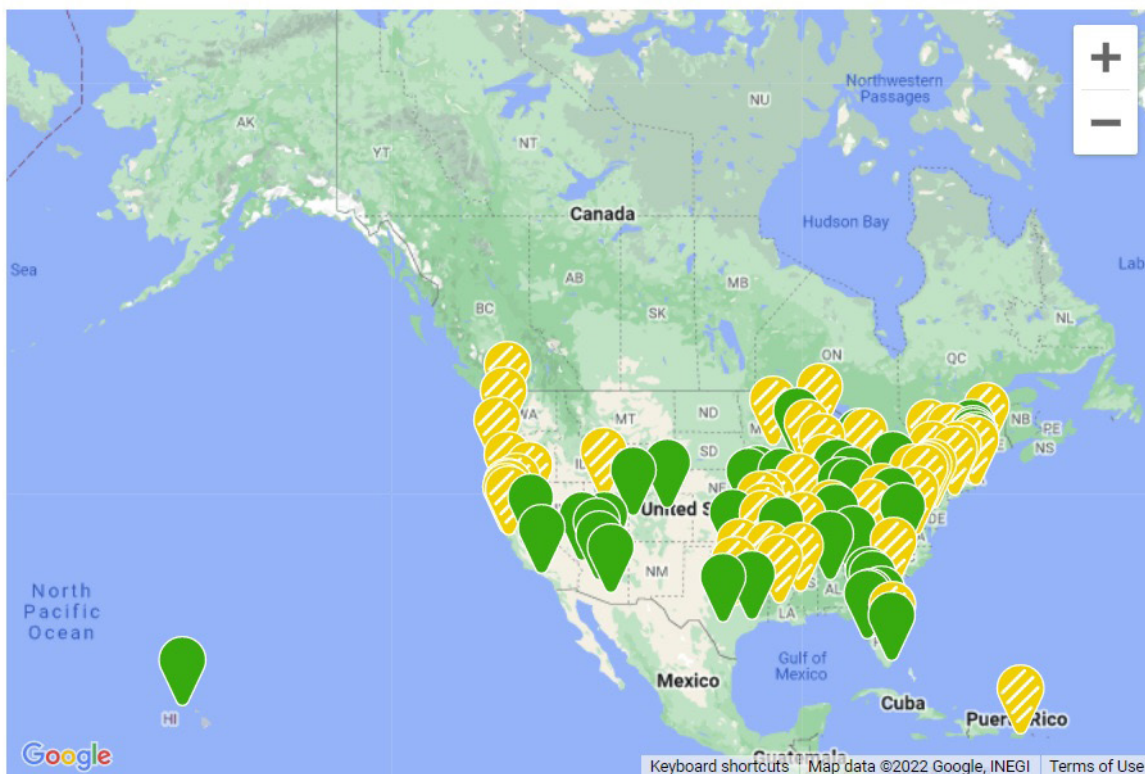
In FY20 the VHA Office of Geriatrics and Extended Care (GEC) identified [Age-Friendly Health Systems](#) as a strategy. VA’s [Diffusion Marketplace](#) tracks the dissemination of this innovative PCMH. Currently the Diffusion Map⁸ below shows there are 39 successful VHA Age-Friendly Health Systems and 47 adoptions in progress.

Readmission Rate ≥65		
Year	Medicare HMO	Medicare PPO
2016	12.9	12.6
2015	15.2	15.7
2014	17.5	17.9
2013	12.7	12.8
2012	13.7	13.7
2011	14.1	13.5

Figure 2. NCQA Table

Diffusion tracker

Does not include Clinical Resource Hubs (CRH)



- Successful adoptions
- In-progress adoptions
- Unsuccessful adoptions

Figure 3. VA’s Age-Friendly Health Systems Diffusion Tracker.

7 Powers JS, Xie C, Moseley M, Abraham L, Buckner J, Azubike N. “Implementation of a Geriatric Patient-Centered Medical Home: the Geriatric Patient – Aligned Care Team (GeriPACT),” *OBM Geriatrics* 2, no. 3 (2018): doi: 10.21926/obm.geriatr.180308.

8 U.S. Department of Veterans Affairs. “Age-Friendly Health Systems Diffusion Tracker,” *VA Diffusion Marketplace*, <https://marketplace.va.gov/innovations/age-friendly-health-systems>.

In the words of Teresa Boyd, D.O., Assistant Deputy Under Secretary for Health, before the House Committee of Veterans Affairs Subcommittee on Health:

By helping veterans maintain function, preventing unnecessary hospitalizations, nursing home admissions, and unwanted tests and procedures, the total costs of care for targeted high-risk Veterans are about 15 percent lower when they are managed in GeriPACT versus being managed by regular Primary Care Patient Aligned Care Teams. Currently, only about half of VAMCs have GeriPACT, and VA is working to expand this program to larger Community-Based Outpatient Clinics.⁹

Redefining Elder Care in America Project (RECAP) is a pilot underway at two VA health centers.¹⁰ It uses predictive analytics to help identify veterans at higher risk for nursing home placement. A care coordinator works proactively with the veteran and the primary care provider to consider the aging in place benefit, using home- and community-based services.

These programs deliver focused care to older veterans, with multiple, chronic diseases, as well as coexisting cognitive, functional, and psychosocial decline. Additionally, this PCMH model, designed to meet older adult needs, may increase patient and provider satisfaction while reducing cost and healthcare utilization.

There is also a growing demand for VA's long-term care (LTC). According to a [2020 Government Accountability Office \(GAO\) report](#), from FY 2014 – FY 2018 the number of veterans receiving LTC increased 14% (from 464,071 to 530,327). Spending increased 33% (from \$6.8 to \$9.1 billion). Demand for LTC will continue to increase. Expenditures are projected to double by 2037. The report goes on to say, “VA plans to expand veteran’s access to noninstitutional programs, when appropriate, to prevent or delay nursing home care and to reduce costs.”¹¹

As veterans continue to age, they may find that home healthcare is their best option. Veterans may elect to use the Program of Comprehensive Assistance for Family Caregivers (PCAFC) (aka. Caregivers Program). On October 1, 2022, eligibility for this program expanded to veterans of all service eras. Veterans must have a service-connected disability rating of 70% or more and need assistance to perform activities of daily living (ADL) or require supervision, protection, or instruction.¹²

[Vet Centers](#) are community-based counseling centers providing a wide range of social and psychological services. As more veterans become eligible for this care, coupled with the national shortage of behavior-health and mental-health providers, it is becoming more difficult to maintain the desired PCMH model in the Vet Centers. Vet Center leaders are pressuring counselors to see more veterans than the recommendation of the VA's own Clinical Capacity Group.^{13,14}



- 9 Teresa Boyd, Quote from: U.S. Congress. Hearing of the House Committee on Veterans Affairs Subcommittee on Health. “Statement of Teresa Boyd, D.O., Assistant Deputy Under Secretary for Health, for Clinical Operations, Veterans Health Administration (VHA), Department of Veterans Affairs (VA).” (Date March 3, 2020.) <https://www.congress.gov/116/meeting/house/110596/witnesses/HHRG-116-VR03-Wstate-BoydT-20200303.pdf>.
- 10 U.S. Department of Veterans Affairs. “Aging in Place and Its Unique Challenges for Veterans.” June 21, 2022. <https://www.futureofpersonalhealth.com/senior-health/aging-in-place-and-its-unique-challenges-for-veterans/>
- 11 U.S. Government Accountability Office. “VA Health Care: Veteran’s Use of Long-Term Care, and VA Faces Challenges in Meeting the Demand.” February 19, 2020. <https://www.gao.gov/products/gao-20-284>.
- 12 U.S. Department of Veterans Affairs. “Veterans Affairs Program of Comprehensive Assistance for Family Caregivers Eligibility.” *Fact Sheet*. https://www.caregiver.va.gov/pdfs/FactSheets/CSP_Eligibility_Criteria_Factsheet.pdf (Last visited November 7, 2022).
- 13 Tom Hall, PhD. “Vet Centers Must Remain Patient-Focused.” *The VVA Veteran* 42(6), November/December 2022.
- 14 Courtney Kube and Rich Gardella. “Former Therapist: VA is Hurting Mental Health Care for Combat Veterans at its Vet Centers.” *Health Care*, NBC News, November 3, 2019, <https://www.nbcnews.com/health/health-care/former-therapist-va-hurting-mental-health-care-combat-veterans-its-n1075781>

A [March 1, 2019, memorandum](#) to all Vet Center managers specified that productivity standards for counselors would increase from 20 sessions per week to 30. Given the VA's Clinical Capacity Group's recommendation was 18 sessions per week, Tom Hall, PhD, Vietnam Veterans of America's PTSD/SA Committee Chair, called this increased goal, "a recipe for therapist burnout amid a national shortage of Clinicians."¹⁵

Staffing concerns are not new to VA. A 2015 GAO report¹⁶ cites the same challenges we see today, hiring competent staff to meet the demand:

- Pay disparities with the private sector.
- Lengthy hiring processes.
- A nationwide shortage of mental-health professionals



Maintaining the level of PCMH model healthcare to veterans ≥65 requires implementing policies that attract providers, key healthcare professionals, and competent staff. On May 3, 2022, Gina Grosso, VA's Assistant Secretary for Human Resource Administration Operations, Security, and Preparedness, told the Senate VA Committee that VA hired 59,000 new employees since the start of the fiscal year. VA was able to hire thousands of new staff, thanks in part to the authorities response to COVID-19 and funding included in the CARES Act and the American Rescue Plan.

The [Specialty Education Loan Repayment Program \(SELRP\)](#) offering student-loan repayment, the [RAISE Act](#) which sets higher pay caps for advanced practice registered nurses (RNs) and physician assistants (PAs), and the recently passed [PACT Act](#), have helped VA see job applications surge.¹⁷

While the VA is focusing on improving recruitment and retention of medical personnel generally, it has not announced a specific plan to address the existing shortage of geriatric specialists necessary to ensure care for aging veterans is properly coordinated and specialized to their needs and desires. As of 2022, there are only 7,300 geriatric specialists in the United States. This equates to 1.07 specialists per 10,000 geriatric patients.¹⁸ There are multiple contributing factors to this shortage, including: physician burnout, anticipated retirement, and less pay for this specialty.

According to Jessica Bonjorni, Chief of Human Capital Management at VHA, as of May 3, 2022, there were about 31,000 candidates in VHA's pipeline. Currently VHA's biggest concerns are focused at both the low and high ends of the pay scale continuum. In addition to physician shortages, VHA has immediate needs for entry-level nurses, housekeeping, aids, health technicians, and food service workers.¹⁹

15 Tom Hall, PhD. "Vet Centers Must Remain Patient-Focused." *The VVA Veteran* 42(6), Vietnam Veterans of America, November/December 2022, p. 29.

16 GAO (Government Accountability Office). "VA mental health: Clearer guidance on access policies and wait-time data needed." Washington, DC: *Government Accountability Office*. 2015.

17 Jory Heckman. "VA Sees Job Applications Surge as It Stands Up New Pay, Bonus Authority Under PACT Act." *Federal News Network*, October 25, 2022, <https://federalnewsnetwork.com/hiring-retention/2022/10/va-sees-job-applicants-surge-as-it-stands-up-new-pay-bonus-authority-under-pact-act/>.

18 ChenMed. (2022, March 18). *The Physician Shortage in Geriatrics*. <https://www.chenmed.com/blog/physician-shortage-geriatrics#:~:text=Presently%2C%20the%20U.S.%20only%20has,care%20for%20about%20700%20patients>.

19 Jory Heckman. "VA Hired 59,000 Employees This Fiscal Year, But Still Struggles with Workforce Shortages," *Federal News Network, Veterans Affairs*. May 4, 2022. <https://federalnewsnetwork.com/veterans-affairs/2022/05/va-hired-59000-employees-this-year-but-still-struggles-with-workforce-shortages/>.

During the current hiring surge, VA should understand how to best leverage non-clinical workers like community health workers, patient navigators, and health coaches. Evidence suggest that integrating these workers into the multidisciplinary care teams:

- Increase overall access to healthcare
- Improve healthcare screening
- Is a promising practice addressing social determinants of health (SDOH)
- Increase care coordination and link patients to healthcare and social services.^{20,21,22}

Hiring competent staff to meet the demand remains difficult. The *Vet Center Improvement Act of 2021* (S.1944 and H.R. 3575) requires VA to re-evaluate productivity expectations for readjustment counselors. On a parallel tract, the VA's Clinic Practice Management Optimization Spotlight Initiative is an enterprise-wide standards for bookable hours and appointment lengths focused on being truly veteran-centric. These standards are expected to have been fully implemented by January 31, 2022.²³ Coupled with the *Vet Center Improvement Act*, they will help improve Vet Center staffing and hiring practices. This will go a long way toward improving the veteran-to-counselor ratio, ultimately providing better and timely care for those using Vet Center services.

Access Barriers to Healthcare Access for Rural Aging Veterans Persist

According to the VA, 4.7 million veterans live in rural communities. The [Office of Rural Health](#) supports 2.7 million rural veterans enrolled in the VA healthcare system. Fifty-five percent of these rural veterans are over the age of 65.

Conditions that are more manageable in suburban and urban areas (e.g., poverty, homelessness, substance addiction, etc.) are more complicated in rural areas, primarily due to a lack of resources due to funding or distance. These two issues, in addition to a lack of internet access – 27% of enrolled rural veterans do not have internet at home – create complications, especially for older veterans.²⁴

VA health facilities have worked to foster partnerships with local community health centers, Rural Health Clinics (RHCs), and hospitals. They have focused on expanding access to telemedicine, using mobile VA clinics, and on creating Community Based Outpatient Clinics (CBOCs).²⁵ The VA also collaborates with Veterans Service Organizations (VSOs) to increase healthcare and human services



20 Rural Health Information Hub. “Interdisciplinary Care Teams, Patient Navigators, and Community Health Workers.” *RHIhub*, March 6, 2020 <https://www.ruralhealthinfo.org/toolkits/sdoh/2/healthcare-settings/care-teams>.

21 Katherine B. Roland, Erin L. Milliken, Elizabeth A. Rohan, Amy DeGroff, Susan White, Stephanie Melillo, William E. Rorie, Carmita-Anita C. Signes, and Paul A. Young. “Use of Community Health Workers and Patient Navigators to Improve Cancer Outcomes Among Patients Served by Federally Qualified Health Centers: A Systemic Literature Review.” *Health Equity*. May 1, 2017, 1(1), 61-76, doi: 10.1089/hecq.2017.0001. PMID: 28905047; PMCID: PMC5586005, <https://pubmed.ncbi.nlm.nih.gov/28905047/>

22 Patricia J. Peretz, Luz Adriania Matiz, Sally Findley, Maria Lizardo, and David Evans, and Mary McCord. “Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative.” *Am J Public Health*, August 2012, 102(8): 1443-1446. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3464827/#_ffn_sectitle.

23 Miquel H. LaPuz. “VHA Office of Integrated Veteran Care: Latest Updates.” Presentation, Assistant Under Secretary for Health (AUSH) for Integrated Veteran Care (IVC). December 15, 2022.

24 Office of Rural Health. (2022, March 31). “Rural Veterans,” *Dept. of Vets. Affairs*, <https://www.ruralhealth.va.gov/aboutus/ruralvets.asp>.

25 Rural Health Information Hub. “Rural Veterans and Access to Healthcare.” *RHIhub*, <https://ruralhealthinfo.org/topics/returning-soldier-and-veteran-health> (last visited December 14, 2022).

access and affords qualifying veterans with access to community-based healthcare providers via the [Veteran Community Care Program](#).

This year, VA began a [five-year expansion](#) of several home- and community-based care programs. These programs include establishing 70 Veteran-Directed Care (VDC) programs, 75 Home-based Primary Care (HBPC) programs, 58 Medical Foster Home programs.

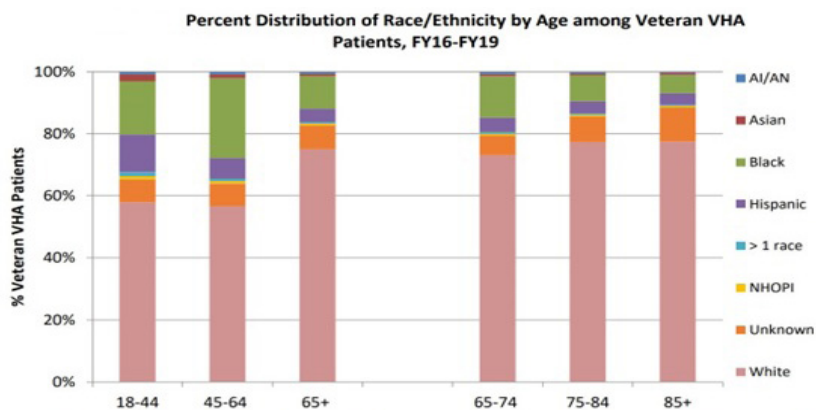
According to the Executive Director of VA Office of Geriatrics and Extended Care, Scotte Hartronft, M.D.:

These evidence-based programs allow veterans to age-in-place, avoid or delay nursing home placement, and choose the care environment that aligns most with their care needs, preferences, and goals. veterans using these programs have experienced fewer hospitalizations and emergency department visits, reduced hospital and nursing home days, and fewer nursing home readmissions and inpatient complications.²⁶

Community care can be beneficial for aging veterans. Conversely, there are concerns about the ability of community-care providers to meet veterans’ needs and to match or exceed the quality of care at the VHA facilities.²⁷ A concerted effort must be made to ensure that aging veterans have access to high-quality, prompt VA-external healthcare as needed.

Within the VA’s Aging Veteran Population Health Inequities Persist

Despite comparable access and quality of care, racial and ethnic disparities persist among older veterans.²⁸ The COVID-19 pandemic underscored the impact of these disparities among older veterans. The *National Veteran Health Equity Report 2021: Focus on Veterans Health Administration Patient Experience and Health Care Quality*²⁹ provides the data Figures 4, 5, and 6 below.



Race/Ethnicity	18-44	45-64	65+	65-74	75-84	85+
AI/AN	0.8%	0.8%	0.6%	0.7%	0.5%	0.3%
Asian	2.2%	1.2%	0.7%	0.7%	0.6%	0.7%
Black	17.2%	25.9%	10.6%	13.4%	8.4%	5.9%
Hispanic	12.1%	6.6%	4.3%	4.6%	3.9%	3.7%
More than one race	1.4%	0.8%	0.5%	0.6%	0.5%	0.4%
NHOPI	1.0%	0.8%	0.6%	0.6%	0.6%	0.5%
Unk	7.4%	7.3%	7.7%	6.3%	8.2%	11.0%
White	57.9%	56.7%	75.1%	73.2%	77.3%	77.5%

Note: AI/AN denotes American Indian or Alaskan Native; NHOPI denotes Native Hawaiian or other Pacific Islander; Unk denotes unknown, declined, or missing race/ethnicity

Figure 4. Percent distribution of race/ethnicity by age among Veteran VHA patients, FY 2016-2019.

The distribution of race or ethnicity varies among the various age groups. These data highlight the need for healthcare services designed to meet the needs of culturally diverse populations. As noted by the American

26 U.S. Department of Veterans Affairs. “VA Amplifies Access to Home, Community-Based, Services for Eligible Veterans.” *Office of Public and Intergovernmental Affairs*. January 24, 2022. <https://va.gov/opa/pressrel/pressrelease.cmf?id=5757>.

27 Peter Rasmussen and Carrie M. Farmer. (2022). “The Promise and Challenges of VA Community Care: Veterans’ Issues in Focus.” Santa Monica, CA: RAND Corporation. <https://www.rand.org/pubs/perspectives/PEA1363-5.html>

28 Rachel E. Ward, Xuan-Mai T. Nguyen, Yanping Li, Emily M. Lord, Vanessa Lecky, Rebecca J. Song, Juan P. Casas, Kelly Cho, John Michael Gaziano, Kelly M. Harrington, and Stacey B. Whitbourne. “Racial and Ethnic Disparities in U.S. Veteran Health Characteristics,” *Int J Environ Res Public Health*. March 2, 2021, <https://ncbi.nlm.nih.gov/pmc/articles/PMC7967786>.

29 Donna L. Washington (ed). *National Veteran Health Equity Report 2021: Focus on Veterans Health Administration Patient Experience and Health Care Quality*. September 2021. https://va.gov/HEALTHYEQUITY/docs/NVHER_2021_Report_508_Conformant.pdf.

Psychological Association, “African American older adults experience significant health disparities, including lower life expectancies and increased risk of chronic health conditions such as hypertension, diabetes, dementia, stroke, and cancer.”³⁰ These disparities are significant. After the age of 64, strokes occur over twice the rate for black patients versus white patients.³¹ Additionally, black patients are more likely to face discrimination in pain management.³²

Blacks, American Indian, or Alaska Native veteran groups have the greatest disparities compared with non-Hispanic White veterans.

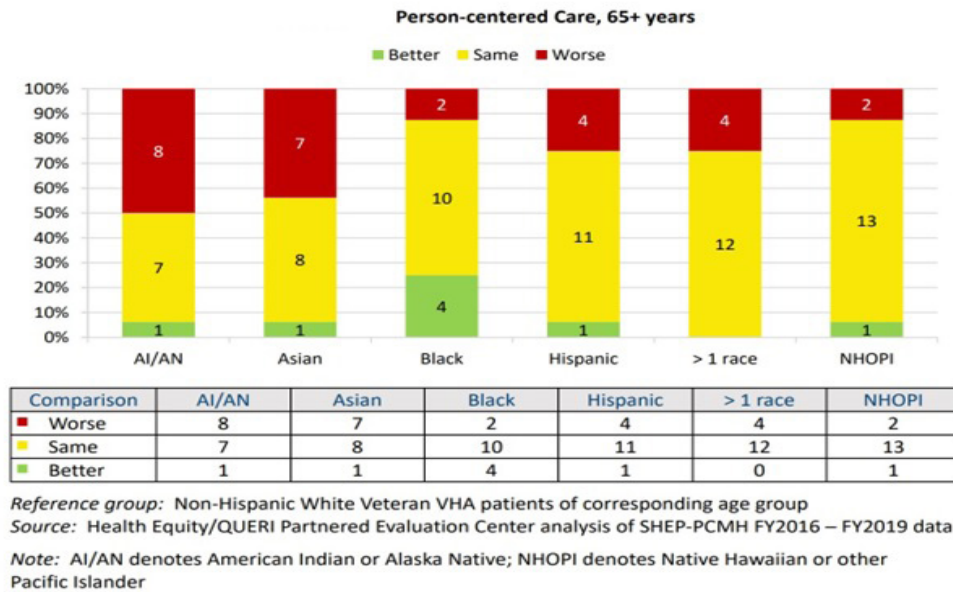


Figure 5. How different race/ethnic groups of veterans ≥65 years old rated person-centered care by race.

Figure 5 shows the number and percentage of 16 different measures for which racial/ethnic minority VHA veteran patients ≥65 experienced better, same, or worse person-centered care compared with White veterans. The graph shows that for American Indian/Alaska Native veterans eight measures were scored as worse, seven were the same, and one scored better than White veterans ≥65.

To address the needs of American Indian and Alaska Native veterans, VA has signed a memorandum of understanding with the Indian Health Service (IHS). In this memorandum, both organizations laid out four mutual goals:

- Increase access and quality of healthcare;
- Facilitate enrollment and navigation of VA and IHS healthcare systems;
- Facilitate the integration of healthcare records for American Indian and Alaska Native patients;
- Improve patient access through resource sharing.³³

30 Frances Adomako. “African American Older Adults and Race-Related Stress: How Aging and Health-Care Providers Can Help.” *Am Psych Assn*, <https://apa.org/pi/aging/resources/african-american-stress.pdf> (last visited Nov. 4, 2022).

31 Brian Trimble and Lewis B. Moregenstern. “Stroke in Minorities.” *Neurol Clin* 26(4), November 2008: 1177-1190.

32 Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver. “Racial Bias In Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites.” *Proc Natl Acad Sci USA* 113(16), April 19, 2016: 1117-1190 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843438>.

33 Memorandum of Understanding Between the United States Department of Veterans Health Administration and United States Department of Health and Human Services Indian Health Service. October 1, 2021. <https://www.va.gov/TRIBALGOVERNMENT/docs/VA-IHS-MOU-Fully-Signed-10-1-21.pdf>.

While interagency partnerships may be beneficial, there are serious concerns regarding IHS-run hospitals. The IHS is chronically underfunded, and IHS-run hospitals experience significant rates of patient harm (e.g., in 2017, 13% of patients suffered patient harm, mostly due to inadequate care.) The highest rates of harm occurred among elderly patients (30%). More problematic is the fact, due to inadequate records and data handling, the actual rates of harm may be substantially higher.³⁴ Another concern is the distribution of funds - according to the U.S. Commission on Civil Rights (USCCR), “[a]pproximately 70 percent of Native Americans live in urban areas today.”³⁵ Despite this fact, the average annual distribution of the IHS budget for urban Indian healthcare has remained at about one percent.³⁶

More work is needed to understand and address residual disparities within VHA, particularly in all-cause mortality among American Indians and Alaskan Natives. Improving quality of care and appropriate utilization within VHA along with examining the social determinants of health and health equity may explain the persistent disparities in mortality and morbidity.³⁷

Women Veterans ≥50 Are Least Likely to Use Earned Benefits

Gender composition differs dramatically across veteran age groups.

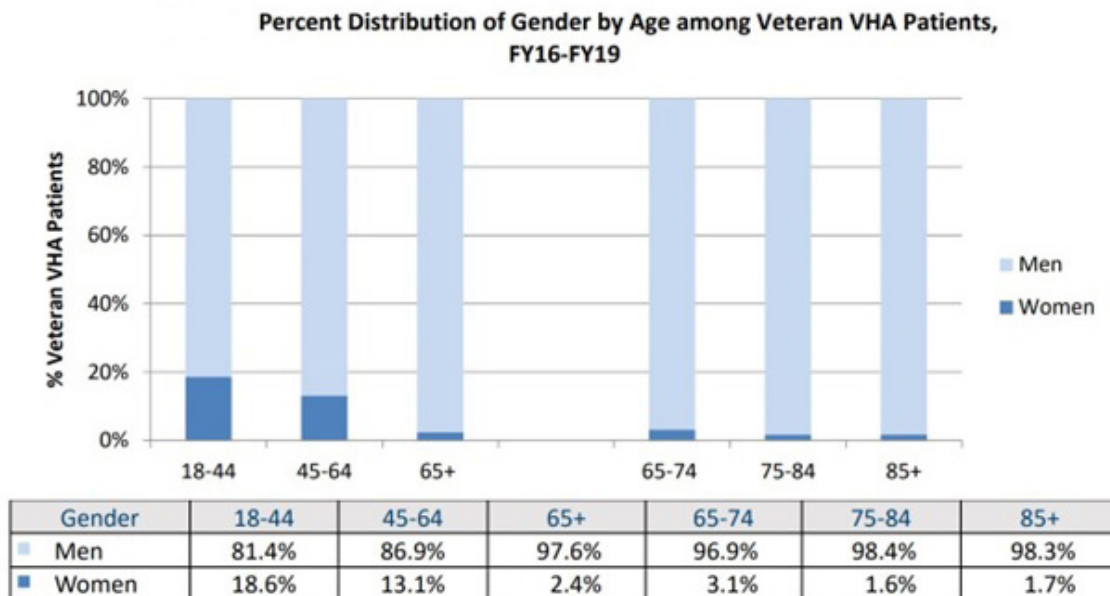


Figure 6. Percent of women Veterans ≥50 years old likely to use earned benefits.

34 Jordan K. Lofthouse. “Improving Accountability and Performance in the Indian Health Service.” *Policy Brief*, Mercatus Center. January 31, 2022. (Last visited November 2, 2022).

35 U.S. Commission on Civil Rights. *Broken Promises: Continuing Federal Funding Shortfall for Native Americans*, p. 73, December 2018. <https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf>.

36 Id.

37 Wong MS, Hoggatt KJ, Steers WN, Frayne SM, Huynh AK, Yano EM, Saechao FS, Ziaieian B, Washington DL. (2019) “Racial/Ethnic Disparities in Mortality Across the Veterans Health Administration.” *Health Equity* 3:1, 99–108. DOI: 10.1089/heq.2018.0086



Women are only 2.4% of the patients ≥ 65 . Women constitute 3.1% of the 65-74 years group; 1.6% of the 75-84 years group; and 1.7% of the 85+ years group. Although the overall numbers of women veterans are small, the burden of chronic illness is high. Almost 70% of women veterans ≥ 65 report three or more comorbid chronic conditions, including arthritis, hypertension, depression, chronic lung disease, osteoporosis, cancer, and Post-traumatic Stress Disorder.³⁸

Of the nearly 2 million women veterans, approximately 800,000 are enrolled with the VHA. Within this group, 51% are in the 45-75-years age group. Most of these women have *not* accessed their disability benefits. Only 28% have used their mortgage benefits.³⁹ As the population of women veterans age, VA care will need to adapt to address their needs. VA must continue expanding the availability and range of services to address the unique needs of older veteran women.

Among women veterans ≥ 65 , the prevalence of chronic illness increases. These veterans require intensified management. Almost one-third screen positive for needing mental health care, highlighting the need for elder care that focuses on mental health in addition to chronic disease management.⁴⁰

Women veterans differ from non-veterans, being more likely to have experienced interpersonal violence, including sexual trauma, and having a higher prevalence of selected physical and mental-health disorders. Caring for older women veterans in the future will be influenced by their growing numbers and their likelihood of exposure to combat and its associated long-term physical and mental-health challenges. Examining social determinants of longevity, such as social support, may be a key step to understand and reduce these disparities.

Reconfiguring VHA to Meet the Imminent Needs of the Aging Veteran

VA has many proven, innovative programs that are addressing the needs and preferences of older veterans. Many of these programs are working piecemeal, improving care and the quality of life for older veterans by:

- Creating an adequately prepared workforce;
- Remediating healthcare disparities and inequities;
- Strengthening partnerships and value-based care coordination with community settings and local public health;
- Implementing proven approaches to veteran-centered care and delivery;
- Redesigning the structure of financing LTC services and support; and
- Allocating resources to achieve veteran-centered care and outcomes to include palliative and hospice care.

38 Steven S. Coughlin and Kimberly Sullivan. "Study Protocol: Southern Women Veterans' Health Study." *Ann Epidemiol Public Health*, 1(1), January 18, 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6195358>.

39 Daphne A. Lofquist. "Characteristics of Female Veterans—An Analytic View Across Age-Cohorts: 2015." *U.S. Census Bureau*. August 30, 2017. <https://www.census.gov/library/publications/2017/acs/acsbr15-03.html>.

40 Kate L. Sheahan, Karen M. Goldstein, Claire T. Than, Bevanne Bean-Mayberry, Catherine C. Chanfreau, Megan R. Gerber, Danielle E. Rose, Julian Brunner, Ismelde A. Canelo, Jill E. Darling, Sally Haskell, Alison B. Hamilton, and Elizabeth M. Yano. "Women Veterans' Healthcare Needs, Utilization, and Preferences in Veterans Affairs Primary Care Settings." *J Gen Intern Med* 37(Suppl 3), 791-798 (2022). <https://doi.org/10.1007/s11606-02-07585-3>.

With so many improvement initiatives under way, it is crucial that VHA's performance-improvement projects receive senior leadership's support to ensure effective change management and the adoption of best practices throughout VHA. LTC is complex with persistent and unexpected challenges. For example, COVID-19 priorities delayed implementing certain GEC programs. VHA should demonstrate its commitment to oversight and accountability by ensuring it has clear goals and objectives identifying what needs to be done and how it will accomplish strategic plans, despite unexpected setbacks. VVA encourages VHA to remain vigilant in its efforts to improve care and quality of life for older veterans.

After six years of being on the GAO's High-risk List, VA "still lacks a clear and comprehensive roadmap to address VA healthcare concerns and has not demonstrated meaningful progress."⁴¹ Three persistent and complex LTC challenges meeting the growing demand for LTC are:

- Workforce shortages and competencies;
- Geographic alignment of care, particularly for rural older veterans; and
- Older veterans specialty-care needs.

It is essential that VA leaders with sufficient authority drive the deployment and implementation strategies addressing these key challenges. VVA recommends that VHA leverage the valuable lessons learned during the performance-improvement projects' tests of change.

Fostering stronger collaboration and partnerships between VHA's separate health-support services and programs may help fully deploy these innovative solutions and best practices.

Fully deployed improvements will create an aligned infrastructure that promotes better health through the delivery of equitable, goal-directed care that recognizes the preferences and needs of older veterans. Ultimately, these improvements will reduce the per-capita cost of care.



41 U.S. Government Accountability Office. "Managing Risks and Improving VA Health Care," Retrieved December 19, 2022, from <https://www.gao.gov/highrisk/managing-risks-and-improving-va-health-care>.