S. HRG. 118–230

THE STATE OF VETERANS' LONG-TERM CARE IN MAINE

FIELD HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

JANUARY 26, 2024

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

54–781 PDF WASHINGTON : 2024

SENATE COMMITTEE ON VETERANS' AFFAIRS

JON TESTER, Montana, *Chairman*

PATTY MURRAY, Washington	JERRY MORAN, Kansas, *Ranking Member*
BERNARD SANDERS, Vermont	JOHN BOOZMAN, Arkansas
SHERROD BROWN, Ohio	BILL CASSIDY, Louisiana
RICHARD BLUMENTHAL, Connecticut	MIKE ROUNDS, South Dakota
MAZIE K. HIRONO, Hawaii	THOM TILLIS, North Carolina
JOE MANCHIN III, West Virginia	DAN SULLIVAN, Alaska
KYRSTEN SINEMA, Arizona	MARSHA BLACKBURN, Tennessee
MARGARET WOOD HASSAN, New Hampshire	KEVIN CRAMER, North Dakota
ANGUS S. KING, JR., Maine	TOMMY TUBERVILLE, Alabama

TONY MCCLAIN, *Staff Director*
DAVID SHEARMAN, *Republican Staff Director*

C O N T E N T S

JANUARY 26, 2024

THE STATE OF VETERANS' LONG-TERM CARE IN MAINE

FRIDAY, JANUARY 26, 2024

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Augusta, Maine

This field hearing was held pursuant to Notice of Hearing on January 26, 2024, at the University of Maine at Augusta, Richard Randall Student Center, Fireside Lounge, 46 University Drive, Augusta, Maine beginning at 2:00 p.m., Hon. Angus S. King, Jr., presiding.

OPENING STATEMENT OF HON. ANGUS S. KING, JR., U.S. SENATOR FROM MAINE

Senator KING. This is a field hearing of the Senate Veterans' Affairs Committee. In other words, this is a real live hearing just like you see in Washington, only it's happening here in Augusta, Maine, and I want to publicly thank the chair and co-chair of the committee, Jon Tester of Montana and Jerry Moran of Kansas who facilitated our ability to do this and are supporting this—our ability to do some listening and talking, and I'll talk about what the topic is in a minute. But I want to thank Jon Tester and Jerry Moran as well as the staff. I want to thank my own staff, Teague Morris and Rowland Robinson and the staff of the committee here. Behind every senator is a very able staff rolling their eyes, just so you know. And I also see some friends. This is always dangerous when you start recognizing people in the audience because there's someone you forget. I used to always miss legislators, it was awful. But I have to recognize Tracye Davis and Ryan Lilly. Tracye is the head of VA Maine at Togus. Ryan is her predecessor who is now in VISN for New England. And then also Dave Richmond, the head of Veterans Affairs for the State of Maine. So we've got lots of people here with lots of knowledge. And here is the topic: Long-term care for veterans.

Why are we talking about that subject? I can answer that question with two numbers. Seven minus seven and 31.

Over the next 10 years, the veteran population in Maine is projected to decline by 7 percent. However, the population—the veteran population in Maine above age 85 is projected to increase by 31 percent. That really tells you why we're here, because we are facing a very serious surge of veteran—of veterans needing and being prepared for some type of long-term care. And what we're gonna try to talk about today is the multiplicity of programs,

what's available, how do veterans access those programs, how do they know what's available and are there ways that we can improve that access, particularly as we're dealing with a population that's aging, that may not be as technologically engaged so a website or an e-mail may not always be the answer. So that's the challenge that we have today, to be talking about how do we deal with the needs of these wonderful veterans who are going to need more and greater services as they age. So that's really the plan that we're talking about today.

We have two panels. The first panel is VA oriented. We have Scotte Hartronft.

Is that good enough, close enough?

Dr. HARTRONFT. Yes.

Senator KING. Scotte came up from Washington to be with us. He is the Executive Director of the Office of Geriatrics and Extended Care. So he's the big guy from Washington on this subject. With him is Annette Beyea who is his counterpart here in Maine. She's the Chief of Staff—Associate Chief of Staff, Geriatrics and Extended Care and Community Living Center at the Togus VA Medical Center so we're going to talk with them for a while.

And then we have a second panel that involves providers here in Maine and veterans, and veterans' families who can talk about the process and where the gaps are.

Why are we doing this? It's to help me and the committee know what we need to do to help. How do we make the system work better? And quite often, people in my business feel that the work is done when the bill passes. The truth is, the work just begins when the bill passes. And one of my favorite sayings is, implementation is as important as vision. You can have a good idea and a good bill. If it's not adequately implemented, it doesn't meet the intended purpose. So the whole idea today is to give me ideas which I can then take back and the staff take back to the committee to inform our ongoing work in this particular area.

So let's start.

You have opening statements.

I'm going to impose a rule that we have in Washington which is five minutes because we do have a number of witnesses and—by the way, in Washington, when you see these hearings, what you don't know is that we have a little digital clock in front of us and we have five minutes. And I once asked Senator Tester when should I stop when the clock says five minutes? He suggested in the middle of the word "if". So we want to enforce these rules. But, in any case, we're delighted to have you with us.

Dr. Hartronft, please go.

Dr. HARTRONFT. Thank you, sir.

PANEL I

STATEMENT OF SCOTTE R. HARTRONFT ACCOMPANIED BY ANNETTE BEYEA, DEPARTMENT OF VETERANS AFFAIRS

Good afternoon, Senator King. I appreciate the opportunity to discuss veterans' access to long-term care in institutional and non-institutional care settings.

I'm accompanied today by Dr. Annette Beyea, Associate Chief of Staff for Geriatrics and Extended Care at VA Maine.

As an agency dedicated to serving those who served our nation, VA recognizes the importance of ensuring that our veterans have access to the care they need, especially as they age and require long-term support. We are committed to delivering compassionate, person-centered care that meets the unique needs of each veteran we serve.

Aging and older veterans make up a significant proportion of VHA enrollees, with veterans over the age of 65 representing about 50 percent of all VHA enrollees. Additionally, 55 percent of current enrolled rural veterans are ages 65 and older.

Between fiscal year 2023 and 2035, it is projected that the number of enrollees age 85 and older will increase by 73 percent across the country. And the number of VHA women enrollees aged 85 and older will increase by a projected 127 percent during that same period.

VA, similar to the broader U.S. healthcare landscape, faces significant challenges in preparing for the growing population of older adults and their anticipated health care needs. Some of the biggest known challenges include ensuring an adequately trained and available workforce, addressing gaps in geographic coverage of care, particularly in rural areas, and providing specialized care for conditions like dementia and behavioral issues.

The majority of Americans prefer to age in place either in their homes or in the least restrictive setting possible. Supporting aging veterans is a priority for the VA. To fulfill this commitment, the VA provides a range of programs designed for the care and support for veterans of all ages across a range of care settings.

Currently, VA is undertaking one of the largest multi-year expansions of home and community-based services. The expansion includes programs such as veteran-directed care, medical foster home and home-based primary care programs which are all aimed at enabling veterans to age in place with necessary support and services.

VA has many multi-year projects dedicated to addressing the needs of aging veterans. These projects include pilots, initiatives and expansions that are either currently active or anticipated. The VA location in Maine is particularly active in this regard. These projects aim not only to expand access to services, but to ensure that our staff and facilities are well prepared to provide best care for aging veterans.

Some active or anticipated projects specifically related to the VA Maine include the Institute for Healthcare Improvements Age-Friendly Health Systems initiative, geriatric emergency department accreditation, multiple expansion sites of home-based primary care teams, an expansion of the existing Veteran-Directed Care Program, virtual geriatric specialty care services for rural veterans, an active pilot site for VA provided homemaker home health services, anticipated virtual mental health services, and we're also anticipating Redefining Elder Care in America Project pilot.

So a lot is going on, and many other things are anticipated here at VA Maine.

VA's various long-term care programs provide a continuum of services for aging veterans designed to meet their changing needs over time. The level of care is unmatched outside of the VA. Together, these programs greatly improve the well-being of veterans even during times of crisis.

These achievements would not be possible without the consistent commitment of Congress, both in the terms of attention and financial resources.

It is critical that we continue to build on the current momentum and preserve the gains made so far. The challenges mentioned earlier will require continuous innovation, assessment, adaptability, and allocation of resources. Your ongoing support is crucial in order to provide high-quality care for our nations' veterans and their families.

Senator King, this concludes my testimony. My colleague and I are prepared to respond to any questions you may have.

[The prepared statement for Dr. Hartronft appears on page 41 of the Appendix.]

Senator KING. Thank you.

Dr. Beyea, do you have a separate testimony?

Dr. BEYEA. I do not have a separate testimony.

Senator KING. Okay, thank you.

The first question is one that I think is going to come up over and over today which is workforce.

We can have all of the great programs in the world. If we don't have the people to staff them, it ain't gonna work.

Where are we in terms of workforce? And one of the concerns the committee has is the amount of time it takes to onboard somebody in the VA.

Talk to me about workforce.

Dr. HARTRONFT. Well, the VA faces significant challenges, both geriatrics and palliative care due to the—not only the workforce, it's a supply and demand issue in the overall health care market. But we also are in competition with local health care agencies and organizations for the same small supply of resources when it comes to those workers.

So, something that we are doing is competitive marketplace. So, what we're doing is trying to provide things such as retention, recruitment bonuses. We're doing the debt reduction programs. So, there's many things our human resources have been really doing as well as the PACT Act had many additional resources for the VA to implement.

Senator KING. I would suggest there's two ways to tackle this. One is what you were just saying in terms of incentives and loan forgiveness and those kinds of things, pay and benefits, but also the process itself. The length of time—the data we have at the committee is to get hired at the VA, something like 28 boxes have to be checked. To be hired at Northern Light Health, something like eight boxes needs to be checked. So that's something that's within the control of not your office but we—you're not going to be able to hire somebody no matter what the pay is if you say, oh, you gotta put your life on hold for nine months. We're not gonna get

those people. So, I hope that's something you can take back and begin to address.

Dr. HARTRONFT. Yes, sir.

Senator KING. We may get into this later. You're aware of the CMS rule about staffing ratios?

Dr. HARTRONFT. [Nodding.]

Senator KING. My concern about that—and we'll talk to others about it—this is a rule that the—CMS is the federal agency, it's the Center for Medicaid and Medicare Services. It basically issues the rules and the regulations for health care facilities that receive federal funds. So they have a great deal of power. And they recently have promulgated a new rule about staffing ratios in nursing homes which no one can argue with that you have a good staffing ratio, that's patient health and well-being, it's all good, except there's nobody to hire. And my problem with the regulation is it's the best being the enemy of the good because if the result is closed nursing homes and fewer beds, we haven't gained anything. We're not helping veterans if we have—if beds disappear.

And, by the way, 833 nursing-home beds have disappeared in Maine in the last 10 years. Almost a thousand beds have disappeared as our population is aging. And my concern about the staffing memo or the staffing rule is that it could have that further effect unless it's—unless it takes a cognizance of the workforce shortage.

Your thoughts on that subject.

Dr. HARTRONFT. Well, of course when it comes to the VA owned and operated community living centers, it won't be an effect because we currently have staffing that exceeds that. But one thing that we'll have to do is—it's really kind of hard to predict in each market, of course, how it will have an impact, especially with the mix of orality and the already existing low number of potential facilities in the area. So, what we would have to do in the VA is to really maybe expand the number of facilities in response to what we do see an impact. We're lucky in the State of Maine, we have great partnership with the State veterans homes. And, actually, there's more numbers of veterans being treated on an average daily census in our state homes than are in our community nursing homes or even our CLC. So, Maine specifically——

Senator KING. Well, I think that's—that's something that you're going to have to be thinking about because it ties back to the workforce problem.

Dr. HARTRONFT. Yes.

Senator KING. If you can't—if you can't get enough people, you're not going to be able to meet the staffing ratios which could mean a loss of capacity rather than a gain for the veterans.

How about home health? I used to travel with my DHS secretary in a room and say, how many of you want to go to a nursing home? Nobody answered. So the question is: What can we do? What can we do to expand and support home health services which I think everybody, including veterans, would prefer and really ramp that up. Talk to me about how you view that as part of the overall toolkit.

Dr. HARTRONFT. Yes, the VA has really started the initiation with, you know——

Senator KING. Can you move a little closer to the mic, please?

Dr. HARTRONFT. Oh, myself? Okay.

Really—we've really started the initiative of aging in place, and part of that is the multi-year expansion that I mentioned with Veteran-Directed Care, home-based primary care as well as medical foster home. But we're also expanding in many other areas including making sure that we have a broader net when it comes to other services like HHA. We're also doing those——

Senator KING. Could you define expansion? Are we talking 20, 30 percent, 40 percent? I mean——

Dr. HARTRONFT. Like Veteran-Directed Care, we're practically doubling the number of sites. There was only about 70 VAs prior to our expansion that had it, and then by the end of 2024, they're going to have medical—have Veteran-Directed Care at all VAs. And then such as Maine in this—we already had a Veteran-Directed Care, but we are currently providing additional funding and initiative to expand the existing program they already have here. And then we've expanded a couple of home-based primary care sites in addition, but there's a lot going on, and I'll let Dr. Beyea give us some specifics.

Dr. BEYEA. Yes. We've been very fortunate at VA Maine to expand our home-based primary care program. Specifically, we've added three additional teams in Caribou, Bangor and Augusta. We now have eight teams covering eight territories across the state. And just to put this into perspective, in FY '22, we had a hundred referrals to home-based primary care. In FY '23, we had over 400 referrals to home-based primary care. We now have over 300 veterans enrolled, we have 80 referrals pending so that program is growing.

As Dr. Hartronft mentioned, innovation is also imperative as we think about how to support age-friendly care at a population level in the oldest state in the nation. We are very fortunate at VA Maine to also receive funding to pilot a Homemaker Home Health Aide Certified Nursing Assistant program that will allow us to imbed certified nursing assistants as part of our home-based primary care teams, so they will be functioning as part of the team.

Additionally, we're expanding medical foster homes. We've allocated a coordinator to that program and actually have five homes with six veterans enrolled.

Furthermore, we acknowledge the important role of noninstitutionalized care community resources and programs, and have intentionally aligned resources and care coordination through subject matter experts who truly collaborate and work together to be able to meet the veterans' unique needs, whether it's homemaker home health aide or perhaps Veteran-Directed Care. For example, we're aware that we will be participating in a Veteran-Directed Care respite pilot that will allow veterans, through the caregiver support program, to receive supplemental funding and not have a reduction in their Veteran-Directed Care hours, so really aligning and coordinating across those programs and services to meet a Veteran's needs is important. Additionally, acknowledging that we have 3,700 geriatricians, the projected need is 12,000 by 2030 and there are less than 50 in the State of Maine, so, we need to get innovative.

Senator KING. I'm sorry, 3,700 in the whole country?

Dr. BEYEA. Correct. With an estimated growing need of 12,000 in 2030. So, the majority of age-friendly care is going to be delivered in primary care. So, what we're establishing in Portland is a geriatric patient-aligned care team that includes a true interdisciplinary, interprofessional team that will allow us to provide primary care to a cohort of veterans to establish best age-friendly practices so that we can, in a phased and strategic approach, disseminate those practices both in Portland and then to our more rural CBOCs.

Additionally, we acknowledge the need for telehealth to be a part of this hub and spokes-type model.

In FY '23, we received funding to establish a telehealth interdisciplinary model of care to extend age-friendly specialty services to our most rural veterans. We have successfully done that in Bangor.

Senator KING. It would be nice to have WiFi in the CBOCs; [Laughter.] just saying. Just a little parenthetical. Go ahead. That's not your problem.

Dr. BEYEA. So, again, really from a multi-modal perspective and approach, figuring out how can we meet the population need of aging veterans in Maine. And there is not just one solution, it's multifaceted.

In addition, we talked about recruitment. We know, in our CLC, we're approaching a 50 percent vacancy for our nursing assistants so we are working intentionally to create innovative programs like Grow Your Own where we can actually employ those in training to become nursing assistants and pay them simultaneously. So, there are lots of things that we're doing internally——

Senator KING. It's kind of an apprenticeship model.

Dr. BEYEA. Right.

The other is with respect to the shortage of geriatricians. We really prioritize our academic affiliates. And, so, with Maine Medical Center and Northern Lights, we are actually a primary teaching site for palliative medicine fellowship trainees. Also, with Maine Medical Center, we provide clinical training for Internal Medicine and geriatric residents at our Portland CBOC as well as geriatric medicine fellows.

Additionally, 15 minutes down the road from Togus is a geriatric medicine fellowship program with four accredited fellowship positions. We also serve as a training site for those fellows as well.

So, in thinking about recruitment, we see that fellows come, they train at the VA, and they want to stay at VA Maine. They see the priority and commitment to true interprofessional collaborative practice and interdisciplinary approaches to care.

Senator KING. And can I assume that the mission is also attractive?

Dr. BEYEA. Very, yes.

Senator KING. That's a big part of——

Dr. BEYEA. That's the primary attraction, yes.

Senator KING. Well, thank you. That was great, and a lot of good information.

One of the things that jumped out at me though is the complexity of the system and all of the various programs and how does

a veteran know what's available? First question is knowledge, and the second question—we were talking about this with the students—is do we have sufficient people I would call navigators, whether they're in the VSOs or—who can help a veteran say no, you're not—you're Montgomery or you're post-9/11. Where do you fit? What are the programs, home health—do you see what I mean? All of the programs in the world don't help if you don't know what they are and if the family can't find out what they are. How easy is it for a veteran to know the various options?

Dr. HARTRONFT. I guess we can never over-communicate the availability, what resources are available. I, myself, when I left the service, I worked with the VSO to get involved—you know, the VBA and other things. So, we—this really does take a lot of people, and working, strong relationships with other organizations such as VSOs or community partners. But also internally, there have been many things to where we try improving our care coordination. Intensive case management are the terms that we want to use, and incorporate more practices with interdisciplinary between nursing and social work. So, it's really difficult because we have a lot of programs, but many veterans need more than just one program to help them stay at home. They may need adult day health care, they might need some respite, they might need some homemaker home health aide. So, it's not a single one-size-fits-all for veterans. So many times if the veteran is not in the VA; we want to encourage them and help them find the resources to get enrolled. And then after that, it's really making sure that they establish with their primary care team to coordinate with their social worker and their physician or provider to get what services they need based on that individual veteran since we can't really paint with a broad brush what will individually affect others. So, there's always room for improvement, I think——

Senator KING. And the VSOs have an important role to play here it seems to be. They're representatives that can act as that navigator buddy system for an individual veteran.

A particular topic—this is sort of a narrow topic but one that I'm interested in is falls.

One out of four people over 65 have a fall in a year. And falls are often the beginning of the end and lead to a broken hip and hospitalization. What—are there—what can we do to be much more active in terms of fall prevention? I mean I would think that ought to be a sort of basic—somebody comes into your system, the first thing, are there grab bars in your shower? I mean talk to me about that.

I've told my staff I want to be the falls senator; without falling. [Laughter.]

Dr. HARTRONFT. Yes, sir, I understand, sometimes you don't want to be that kind of subject matter expert.

Actually for us, that's one of the reasons why we're——

Senator KING. By the way, I got a great piece of advice. Someone asked Buckminster Fuller, the famous architect, for advice on how to live a long life. His answer was "always use the bannister." [Laughter.] That's a pretty good rule, I think.

Go ahead, I'm sorry.

Dr. HARTRONFT. Definitely.

Basically, I think a lot of it is that, you know, many of it is prevention and practice, but one reason why we're incorporating an age-friendly health system from the Institute for Healthcare Improvement is you start imbedding that and weaving it across settings because it's—it's not a one-time assessment by one care setting. Because over time, a veteran goes to the hospital and they get deconditioned, they need to be assessed again. So, we're trying to make sure that every point of care that they come in contact with, that someone can have the mobility—either they're afraid of falling, or they are assessed for fall risk, and then they're able to be prescribed or put into physical therapy and other evidence-based practices. And a lot of times social isolation can happen because someone's just afraid of falling. Sometimes just a single fall can really impact someone's life to where they're afraid to do any other activities. So, it really is part of us making sure that at every point of contact within the VA, from primary care to inpatient, that they're assessed, and then we take that into account. With Age-Friendly, one of the "M's" is "What Matters." So, we want to find out what matters for that veteran, that's our first key. And then another "M" is mobility which includes falls and making sure that we're kind of proverbially "buffing them up", to help them to do——

Senator KING. There's a big prevention piece here.

Dr. HARTRONFT. Yes.

Senator KING. The cheapest health intervention is the one that doesn't happen.

Dr. HARTRONFT. Yes, sir.

Senator KING. The one that doesn't have to happen. And to the extent we can prevent falls—we know there's an epidemic of falls in this country. So I hope that that's something that VA nationwide would think about in terms of prevention of—we're all conscious of costs and costs to the system. So keep that in mind, please.

Dr. HARTRONFT. Yes, sir.

Senator KING. Assisted living. Again, we're talking about a continuum, and people don't necessarily need all of the services of a nursing home, but they need some level of services. Is assisted living a gap? Is that something we need to be thinking about and developing larger, greater capacity? Because that strikes me that doesn't really fit into the VA system very well.

Dr. HARTRONFT. You're correct. Assisted living is a care setting that we currently aren't authorized to provide room and board and other services. So—that's one reason why we've been really hyper-focusing on aging in place in the home itself. And then we have to kind of go over to more of the long-term care facility. But one thing we've been incorporating is for those veterans who do go to assisted living is making sure that we incorporate some of the home care services even into that setting, when possible.

Senator KING. Well, it seems to me that's an area that we should be talking about in Washington.

Dr. Beyea, do you agree?

Dr. HARTRONFT. The VA has issued support for the one bill that you mentioned, of course with available resources.

Dr. BEYEA. Yes, I do agree. Given the rising prevalence of neurocognitive disorders and need for memory care which often requires residential level of care or Adult Day services to remain in

the community. Access to these services would be incredibly helpful to delay nursing home placement and institutionalized care——

Senator KING. Right. Every day that you delay a nursing-home placement, the veteran is happier and the taxpayers are happier.

Dr. BEYEA. Absolutely. And in the interim period, as Dr. Hartronft pointed out, we really are investing in home care and community-based services for that subset of the population.

Senator KING. VA Maine is doing home care.

Dr. BEYEA. Correct. In addition to the expansion of home-based primary care, with our alignment and care coordination through care programs like Homemaker, Home Health Aide, Veteran-Directed Care, and Adult Day we are able to provide Veterans and caregivers with additional support and some respite——

Senator KING. And respite is——

Dr. BEYEA. Correct, yes.

So, as we expand home-based primary care, we acknowledge that the need for respite will also increase. And so, in our community living centers we're actually developing capacity to provide more respite care. Additionally, we look forward to that Veteran-Directed Care respite pilot which will allow us to provide caregivers respite when appropriate and needed so they can get away and see loved ones and do the things that refill their cup.

Senator KING. Everything we talked about still comes back to workforce, doesn't it? Home-based care, respite care. It's all having the people. Let's go back to that. We talked about incentives—by the way, I recently learned that no one in the Federal Government can make more than the President. That's true, isn't it?

Dr. HARTRONFT. Yes.

Senator KING. Well, that means you're asking a cardiologist to take about a 70 percent pay cut to come work for the VA. I think that's something we have to figure out how to waive or something. And that is not necessarily what we're talking about today, but it is—it's one more barrier if you're talking about high-level specialties. But I do want to push you on—and I realize you're not the one, but go back and say there's this senator up in Maine that's sort of half crazy about this human resources function and how long it takes. We've really got to work on that because it would be awful to have somebody who's ready, wants a mission, wants to do it but they can't wait for nine months or a year. So I hope that's something you can push on when you get back, and we'll push on it at the VISN level too.

Interagency cooperation, do you—how does the VA coordinate with CMS, for example? Because a lot of these placements are combined financing. Medicare, Medicaid, VA. Is that a seamless operation, or is that a bureaucratic nightmare? How is that?

Dr. HARTRONFT. Well, I think part of it too is really the choice or preference of the veteran as to which authority they want to use. Because, of course, many may have TRICARE, many may have Medicare, some have other avenues, but many times of course the VA is the primary payer in many cases. But I think there is an area for continued collaboration and improvement to make sure that veterans over age 65, especially—we're seeing the larger picture. Sometimes if they're on Medicare, we don't always see some of their care if they're on another or using another authority. So,

I think that is an area that we could continue to improve. We do meet with them; we do have a lot of interagency cooperation and collaboration groups, but I think that's just the nature of it, if people are—it would be the same case of somebody who is seeing multiple primary care providers or—you know, just trying to keep everything coordinated. It adds a little more complexity to try and coordinate care across those different agencies.

Senator KING. Dr. Beyea, help us out here. In your observation, are there gaps that we should be filling? In other words, like assisted living or payment for caregiving which I know is an available program, but what—now is your chance. What should we be attending to in the next round of VA and veterans' legislation?

Dr. BEYEA. Yes, I would most certainly advocate for assisted living facility level of care. I think in terms of the non-institutional care piece, we're very well equipped in growing and expanding programs and services as well with institutionalized care. We have great partnerships with our community contracted nursing homes and with our state veterans homes——

Senator KING. Certainly that's important. You have what amounts to a nursing home at Togus.

Dr. BEYEA. Correct—our community living center.

Senator KING. But you also contract with private sector nursing homes for veterans' care.

Dr. BEYEA. We do because often veterans want to remain close to their loved ones and close to home. And so, we want to create versatility and opportunity for them and to support what matters most to them. And with respect to the state veterans home, we recently hired a coordinator who is really facilitating that partnership between the management at the VA as well as the state veterans home, is providing education to the staff at the veterans home as well as the VA, supporting sharing agreements like with mental health. So in terms of our partnerships with respect to long-term care and institutionalized care, I think they're growing and we're very fortunate. Also, we have been very successful in terms of the non-institutional care programs to help veterans age in place, which is often what matters most to them, but an opportunity is certainly expanding access to assisted living facility care.

Senator KING. That's good.

Now, one of the things we haven't touched on or we should have talked about at the very beginning, only certain veterans are qualified for nursing home care, that you have to have—combat-related disability to a certain level or various rules, but a peacetime veteran, maybe 20 years, doesn't necessarily qualify for these services. What services do they qualify for?

Dr. HARTRONFT. Well, the nice thing is the home-care services aren't dependent on service connection——

Senator KING. So that doesn't have——

Dr. HARTRONFT. Home care——

Senator KING. Okay. So that's available to any—to all veterans?

Dr. HARTRONFT. As long as they meet the clinical needs, obviously, they need assistance with activities of daily living and they meet the clinical need. But when it comes to VA-paid nursing home and community—it is, you know, as you said, specifically tied to service connection or specifically to what winds back to needs of a

nursing home care, and it has to fit back to their other plan. Otherwise, many of the veterans that aren't qualified for like the VA, then they can go to the state veterans homes where we provide per diem—which helps try to provide part of the cost of care. So, they do have some avenues to kind of work and—that's why it's such a great partnership with the state veterans homes and other organizations.

Senator KING. By the way, they must have prepared you for a question from me about domiciliary care and the backpay that you owe us. [Laughter.] We only passed that bill I think it's two years ago this month. Could you speak to Brother McDonough about that for me?

Dr. HARTRONFT. I'll make sure we'll find out.

Senator KING. That's sort of an—it's not an in-joke, it's an in-irritation. That's something we need to attend to.

Sort of wrap-up comments. How would you—wave a wand and what would you like us to tackle in the committee?

Dr. HARTRONFT. Well, I think the continued support that you've already provided with us with resources and timely attention——

Senator KING. It would help if we had a budget, not a continuing resolution.

[Laughter.]

Dr. HARTRONFT. No comment. And then—but, yes, I think just having y'all's support has been critical. And, again, it will continue to be critical for your continued support and attention really as we—because we're gonna have to continually adapt and evolve to meet these needs as veterans so there's not one answer that fits all the problems, but we definitely continue your support——

Senator KING. Well, the best news I've heard so far is the expansion of the home-based care. I think that's really important because this is one of those things where we know a wave is coming at us, and shame on us if we're not ready for it because it's totally predictable. This isn't a surprising event like the storm two weeks ago. This is—those numbers are—you know, the actuaries will tell us what we're facing. So I think that we really need to do some hard thinking about what the gaps are, how we can help fill them. And, of course, the workforce issue applies across the board, not only for retirement.

Well, thank you both very much for being here, thank you for coming up, and I hope you listen in. And I do want to—what I always say at the end of a hearing, any ideas, pass them along online or offline. I can forget where I heard things, but you are in a position to help us, and we're all on the same side here. We're all in the same—have the same goal which is improving the lives of our veterans and particularly in this case, what we're talking about today, this population that is going to be more and more in need of these services. So thank you.

We're going to take a five-minute break which really will be a five-minute, and then we'll come back with our second panel.

Thank you all very much.

[Applause.]

[RECESS]

Senator KING. We now have the second panel. I'm going to ask each of our guests to introduce themselves and then—why don't we go down the row and introduce yourselves, and then we'll go back and have your testimony.

PANEL II

Ms. FUSCO. Good afternoon, everyone. My name is Sharon Fusco, and I'm the CEO at Maine Veterans' Homes.

Ms. HILTON. Good afternoon, I'm Colleen Hilton. I serve as the senior vice president for continuum care for Northern Light Health, and I oversee, as the president, home care and hospice.

Mr. POOLER. Mike Pooler, Afghan vet.

Mr. SANPEDRO. Steve SanPedro, I represent the VFW, and I also am the vice chair of the Maine Veterans' Home Board of Trustees.

Ms. BARRESI SAUCIER. Hi, I'm Joy Barresi Saucier, I'm the executive director of the Aroostook Agency on Aging based in Presque Isle, Maine.

Mr. SAUCIER. I'm Paul Saucier, I'm director of the Office of Aging and Disability Services at Maine Department of Health and Human Services.

Ms. SWINBOURNE. I'm Kathleen Swinbourne, and I'm a family caregiver to a Navy Veteran and a Vietnam vet.

Senator KING. Wonderful.

Sharon, why don't you lead us off. Do you have some prepared thoughts?

Ms. FUSCO. Of course.

STATEMENT OF SHARON FUSCO, CHIEF EXECUTIVE OFFICER, MAINE VETERANS' HOMES

Well, thank you for the opportunity to speak with you again today, Senator King; it's my pleasure to do so.

We've heard a lot today about workforce, and I'm going to get right to the bottom line because my written testimony is very detailed, and I don't want to read it to you.

Senator KING. The practice is you say, I move that my written testimony be submitted for the record.

Ms. FUSCO. There you go, I move that. [Laughter.] So—but I do want to give you sort of the bottom line up front. It's also what I'm known for.

So very bluntly, the nursing home industry is in crisis. We are on a precipice of collapse, and the reason for that is very simple. Yes, we have workforce issues, and I'm not going to underplay the importance of them, but more than that, our reimbursement rates fail to cover the total cost of care. We simply cannot afford to continue to steal from the future of our homes to pay for our present. And that happens because—again, it doesn't matter what rate we're talking about, whether we're talking Medicaid, Medicare, VA, all of them fail to fully cover the cost of care.

Senator KING. What's the gap? Could you put a number on it?

Ms. FUSCO. I can tell you that last year it was $17.1 million for the Maine Veterans' Homes.

Senator KING. What's that as a percentage?

Ms. FUSCO. It's about 15 percent of our budget.

Senator KING. In other words, if the cost of care is 100, what are you getting?

Ms. FUSCO. About 15 percent is the gap.

Senator KING. Fifteen percent is the gap?

Ms. FUSCO. Yes. And we don't have unlimited investment resources or capital replacement funds. I've got about a 36-month runway.

Senator KING. So that's compounded by additional regulations that increase cost but don't provide any additional funds; is that correct?

Ms. FUSCO. That is absolutely correct.

And so when we think about that, and as the executive charged with taking this organization into the future, I'm also thinking about, well, what comes next and how do I prepare for that? You're gonna hear today about wonderful collaborations that are bringing organizations together into partnership to address social determines of health such as transportation, social isolation, food insecurity; but are they adequately funded? And the answer is no. We've heard about great pilots and we're so proud to be a part of them, but are they adequately funded to help us think about the innovation we need to our programs to serve the next generation of veterans? And the answer is no. And my favorite, and I promise not to get on a soapbox, is technology. Technology will fundamentally change what it means to have a disability and to care for somebody with a disability. Technology for the person who can't see and helps them see. You talked about falls. What if we could predict them? Guess what? That technology is here today, but I don't have the investment funds available. I don't have the funding available to prepare my infrastructure to take advantage of that, and our veterans deserve that. So funding is the primary issue. You put a number on it, but I'd like to put a face on it.

I want you to envision Bart. Bart is a young man that's in his late 80s. He's one of the first veterans I met, was very proud to take me and show me his uniform and the whistle he used to translate commands from the captain to the crew. He's got his photographs, all of those memories that he's so proud of, but his memories are on a wall for a reason. Bart has dementia, and he needs 24/7 care that is just not possible in the home. He's not acute so he's not going to end up in a hospital. We need that step in between, and it needs to be funded for folks like Bart, and we need to do it in a way that honors them.

The rest of Bart's story is that about three weeks ago, I was in the home the day Bart died, and what I saw was absolutely heartwarming. I saw people who were visiting other residents come out of the hallway. I saw staff, who weren't addressing immediate care needs, come to the hallway, and as Bart's body came down that hallway, flag draped over the body, they stood at attention, they saluted, they put hands over hearts and then they got into cadence behind that body and they walked him out to the hearse for his final trip to his resting place. Now, isn't that the care that we want to be providing for our veterans? We need a sustainable system of care. And if we want that sustainable system of care, we have to fund it. Our veterans deserve it.

Senator KING. Could you not be so indirect?

Ms. FUSCO. Read my testimony.

[The prepared statement of Ms. Fusco appears on page 48 of the Appendix.]

Senator KING. Sharon, thank you. That's powerful and on point. I really appreciate it.

Colleen from Northern Light.

Ms. HILTON. Sure. Do I need to say that about the previous testimony—the testimony that I've submitted being read into the record?

Senator KING. Yes, if you want it in the record——

Ms. HILTON. Can I make that motion for everybody up here?

STATEMENT OF COLLEEN HILTON, PRESIDENT, NORTHERN LIGHT HOME CARE AND HOSPICE

Good afternoon, Senator King, and I appreciate the opportunity to participate today in this important hearing.

I want to mention, I also serve as the president for the Home Care and Hospice Alliance of Maine which includes all of the home care and hospice providers across this great state.

I've been a registered nurse and have dedicated my career to caring for patients in the home and in community-based settings. Our nurses, therapists and hospice clinicians care for patients throughout the State of Maine in both urban and rural settings. We have traveled 3.5 million miles last year to deliver that care. We are also a unique home care organization providing a number of public health services including vaccinations, homeless shelter nursing services and transportation of fresh food to patients at home addressing Maine's food insecurity challenge. As we know Maine is the oldest—has the oldest population in the country, and this includes our aging veterans.

Veterans receive their home care and hospice through a number of different benefits: Medicare, Medicaid as has already been stated, and through the VA Togus Medical Center. We cared for 489 veterans last year through the VA process. Our home health services focus on recovery, quality of life, independence with the goal to reduce emergency room visits and hospital readmissions. The number of patients cared for every day across Maine exceed all of the bed capacity in our local hospitals. I want to say that again. We care for more people in the home than all of our hospitals across the State of Maine. The level of acuity is also rising as more and more medical interventions are happening on an outpatient basis or a surgical procedure that once resulted in a prolonged hospital stay are now discharged on the very same day. Hospice care is also growing in Maine, and that is good news where once we were lagging in utilization in 2021, we ranked 13th. Maine has four inpatient hospices across the state, one in Presque Isle, Rockport, Auburn and Scarborough. I'm especially pleased to report that we have housed veterans whose families needed respite at our hospice houses. Using respite allows families and caregivers enough support to enable the patient to return home to live out the remainder of their life surrounded by their loved ones.

I am deeply concerned that the home care services for veterans and all individuals in need is at risk due to the significant payment reduction that CMS started in 2020 when a new payment model was implemented. Congress charged CMS with ensuring budget neutrality and give the agency authority to change payment rates in this model. The ongoing threat to home health payments is exacerbated to MedPac's annual recommendation to Congress for continued cuts. In January, MedPac voted to recommend to Congress that they reduce Medicare coverage for home health by 7 percent in 2025; 7 percent.

We're stuck in a vicious cycle——

Senator KING. Your costs didn't go down? Your cost didn't go down——

Ms. HILTON. Our cost went up, wage escalated, everything escalated, medical supplies escalated and reimbursement went down, as a recommendation.

This is just causing industry instability, payment reduction proposals that threaten access to care.

In the Senate, there is a bill titled Save the Medicare Home Health Program. The goal is to stop CMS from imposing certain cuts and direct MedPac to consider their analysis, the impact of all payers on access to care, for the home health benefit.

We anticipate that veterans, patients and families will experience historic access challenges to home health care. And it's not because there isn't a need or a demand for these services but rather due to the workforce crisis—and it is a crisis—high inflation impacting cost and Medicare payment reductions, they impact our ability to hire and retain staff.

Maine continues to struggle with the statewide shortage of RNs, currently projected to be more than 2,000 by 2025. One solution to resolving this nursing shortage is supporting nurse faculty, and I know that your office is working with Lisa Harvey-McPherson and working on this issue.

We already have regions in Maine with minimal or no access to home care services. In responding to payment rates below the cost of providing care, providers have reduced services to distant geographic regions and/or reduced the actual number of patients that they will accept in due care.

Due to the rural nature of our service area, we invested 15 years ago in the use of telehealth and remote patient monitoring to broaden our reach to serve seniors across the State of Maine. On any given day, we are caring for 500 patients from Fort Kent to Southern Maine who are taking advantage of this technology. Using this technology, we can support——

Senator KING. Do you find—excuse me. Do you find the patients are receptive to using telehealth?

Ms. HILTON. Very receptive. Eighty years old, 90 years old, they know how to use the equipment and it's easy to use.

Using this technology, we can support people suffering from chronic disease, and I believe that the pandemic truly demonstrated the value of using this technology in the home. When we were able to—when we were in the midst of the global pandemic, telehealth with video capability was incredibly beneficial. In 2023,

we cared for 260 veterans to enable them to age in place with the support of telehealth.

I urge this committee to focus on the impact that Medicare and Medicaid payment policy is having on veterans' access to post-acute care services.

Thank you.

[The prepared statement of Ms. Hilton appears on page 53 of the Appendix.]

Senator KING. Thank you, Colleen.

Mike?

Mr. POOLER. Yes, sir; my written testimony into evidence, please.

STATEMENT OF MIKE POOLER, ARMY VETERAN

Good afternoon, Senator King. I appreciate the opportunity to discuss veterans access to long-term care. And I really have to apologize to you up front, sir. As you can see here by this panel, I have the face for radio and the voice for print so bear with me for a while, and we'll get through this.

Senator KING. People have told me that too so——

[Laughter.]

Mr. POOLER. I know you work with Bernie Sanders, sir, so I'm sure you're used to it.

My name is Mike Pooler. My wife Sue was a resident of the Augusta, Maine Veterans' Home from October 2016 to April 2023. I'm also extremely fortunate to be on the Maine Veterans' Home Board of Trustees.

My wife Sue was diagnosed with dementia in 2013 at the age of 48 and needed full-time professional memory care by September of 2016.

In between these dates, I was fortunate to be able to privately hire caregivers to come to our home and look out for Sue during the day. These people, along with Sue's sister, provided daytime and some weekend care while I was working for the Maine Army National Guard. I had the night shift and weekends while I continued to work. During this home caregiving time, I never looked into any support from the VA for Sue's caregiving. I have a 90 percent disability rating from the VA, and my understanding is that there's no caregiving support for spouses of veterans.

In September 2016, we were extremely fortunate to the—we were extremely fortunate, the administration of the Augusta home was very prompt in responding to our needs. All of the stars aligned, and it took three to four weeks from the time I called MVH until Sue was admitted in October 2016.

During Sue's stay, it was obvious from the start that the staff at Augusta were and continue to be special people. One of the nurses I met, as she was talking to Sue, stated that she would never lie to Sue and would always tell her the truth. She was not going to tell Sue something just to calm her down. That's indicative of the dignity and respect the staff gives each and every resident. The staff takes great pride in the fact that they care for veterans and their spouses, many times usually sacrificing higher wages at other places to take care of them.

Over the years, and especially during the past three years, there have been tremendous staff turnover. As you may be aware, people with dementia need to see consistent faces to help them alleviate stress. Also each dementia patient has a unique need that staff learn during their time with the residents which leads to higher quality of care. Over the years of visiting our spouses—and we had a little coffee klatch of husbands there that would talk to each other—the staff became a second family to many of us. They would tell us how our spouses are doing, any trends they see, what made them laugh, what's working for them or any changes in behavior. Many weeks I spent more time with the staff than the rest of my family. Sue passed in 2023.

Senator King, what you need to do: Stabilize the workforce. This is directly tied to increased reimbursements, as you've heard, which need to be tied to inflation. A most stable workforce understands the residents better, notices things that are off sooner which could lead to finding problems before they cannot be resolved. These unresolved issues lead to worse outcomes and a higher cost down the road.

There needs to be a way to have national guardsmen and reservists who have not been on active duty or deployed to become eligible for access to the state veterans homes. Absent many more wars, this will only be the way to continue the viability of the Maine veterans home system.

I look forward to your questions. Thank you.

[The prepared statement of Mr. Pooler appears on page 56 of the Appendix.]

Senator KING. Thanks, Mike.

Steve SanPedro, thank you for joining us. Steve is in my office so often in Washington, the next time he comes, I'm going to charge him rent.

Mr. SANPEDRO. I'll be there in March.

[Laughter.]

Senator, I'd like to submit my written testimony for official record.

Senator KING. So moved.

STATEMENT OF STEVEN SANPEDRO, NATIONAL COUNCIL MEMBER, MAINE VETERANS OF FOREIGN WARS

Mr. SANPEDRO. Good afternoon, Senator King. It is my honor and privilege to address you today regarding access to long term care for veterans in Maine.

As a veteran myself, I have great concern for the future care of veterans here in Maine. These men and women have served their country and deserve to be cared for as the true heros they are. The Maine Veterans' Homes' ability to do this is very much in jeopardy due to today's rising healthcare.

Maine Veterans' Homes has a unique challenge of meeting requirements from both the state and the VA, adding the need for additional resources to cover expenses not incurred by similar facilities. Inflation and the skyrocketing increases in cost of goods have created a financial deficit that can't be met causing great hardship.

Reimbursement rates no longer are in line with today's cost of veterans' care. The current VA reimbursement rates are $115.62 for per diem care, and $49.91 for domiciliary care. These stipends in conjunction with Medicare, Medicaid, commercial healthcare insurance and private pay are all used to assist the veteran in paying for their care. However, funds still fall way short of the cost to care for these veterans. As a nonprofit entity, we are left to absorb this difference.

However, if you are rated at 70 percent or higher disabled by the VA, your care is taken care of by the VA with no stipend and at a lower rate of cost. The VA has set a price no matter what type of care the veteran receives if they are rated at 70 percent or more. Long term, skilled and assisted living care do not cost the same. There should not be a set rate.

Like many other things, the pandemic made an already strained healthcare system even worse. Over the last three years, we have seen a large increase of healthcare professional leave the field not to return. Many seasoned professionals chose to retire, others didn't want to endanger their families and chose to switch careers in an effort to be safe. This caused the medical field to see shortages like never before. As a result of this, organizations like ours are forced to participate in wage wars and hire more contracted nursing at double and triple regional rates in an effort to fill very necessary positions. A secondary effect of the staffing shortages is the workloads that have been much more to bear for the professionals——

Senator KING. So it's a vicious circle. The workload goes up, the staff burns out and leaves, and then you've got another gap.

Mr. SANPEDRO. Yes, Senator.

That concludes my comments.

[The prepared statement of Mr. SanPedro appears on page 58 of the Appendix.]

Senator KING. Thank you.

Joy. Thank you for coming from Aroostook.

Ms. BARRESI SAUCIER. You're welcome, my pleasure.

Thank you for the opportunity to testify today, and I'd like to submit my written testimony for the official record.

Senator KING. So moved.

Ms. BARRESI SAUCIER. Thank you.

STATEMENT OF JOY BARRESI SAUCIER, RN, MHA, FACHE, EXECUTIVE DIRECTOR, AROOSTOOK AGENCY ON AGING

At the Aroostook Agency on Aging, we know that people want to age in their home communities, and when they do so, they fare better and they also make their community stronger. Our core mission at Agency on Aging is to help this to occur.

Nationally, there are 622 Agencies on Aging funded in part by the Older Americans Act. Agencies on Aging provide a variety services and function as a national network with unique assets and flexibilities that address many challenges faced by older people including veterans.

All agencies serve as aging and disability resource centers providing confidential, unbiased information and support to older peo-

ple, those with disabilities and their caregivers. These agencies often act as the first and only responder to those with questions or challenges that impact their ability to live independently. The agencies intimately understand the complexities of public programs, rural challenges and the formal and informal community supports that exist at the local level. In Maine in fiscal year '22, the Agencies on Aging provided responses to over 291,000 requests for information and assistance.

At the Aroostook Agency on Aging, through over 20 programs and services that includes information, wellness—including falls preventions in-home services and respite services. We directly impact over 5,000 individuals each year, nearly 300 of which are veterans.

With more than 25 percent of Aroostook County over the age of 65, we're central to the well-being of our community——

Senator KING. I saw that in your testimony.

Take note of what she just said. Twenty-five percent of the residents in Aroostook County today are over 65. That's extraordinary.

Ms. BARRESI SAUCIER. We are where the nation is going. We are already there.

A recent Community Needs Assessment by the Aroostook County Health Improvement Partnership highlighted how several rural disparities, just a couple that I'll mention, is that in Aroostook County, the rate of disability is 25 percent higher than the statewide rate. Alzheimer's disease is the highest of any county in the State of Maine.

Nearly half of older adults living alone live outside of the service health communities, and over half of the population over 65 lack financial resources necessary to afford basic expenses.

These factors linked with other factors, like lack of access to primary and specialty care, limited access to public transportation, older housing stock, fewer community supports and the workforce challenges already mentioned.

We also, through this survey, gathered lived-experience information including the following statements from veterans: One said, "if I don't get the help I need, I go without. We're so isolated here. It's kind of hard if I need help or need to ask somebody a question." Another shared, "anytime you need medical attention, we have to travel somewhere," and he mentioned Bangor and Boston. A third commented, "the financial issues impact your psychological issues because you're worried about, do I have enough money to pay the bills, am I going to have enough food, am I going to be able to make my appointments?"

Due to the intensity of the challenges and the resource limitations in rural communities, I believe it's imperative to continue to leverage local assets and collaborations.

One excellent current example of such a collaboration is the Veteran-Directed Care Program which is conducted by VA Maine in partnership with three of the Agencies on Aging. We see the benefits of these programs and how they empower veterans to determine their own care plans as well as cover the cost of other goods and services specific to their needs.

Although we've had limited referrals to this program in Aroostook County, we believe it can be a good option. Some of the bar-

riers to participation include lack of awareness of the program, difficulty identifying a worker and challenges with managing the program on their own. Securing additional resources for targeted outreach by both the VA and agencies could improve the use as well as program revisions that would allow utilization of technology to enable distant caregivers to serve as authorized representatives may help.

In addition, there's a few other opportunities I'd just like to mention, between VA and Agencies on Aging that could happen that might strengthen navigation of community resources and integration of specialty services.

Again, we're aging and disability resource centers. We could leverage this resource to strengthen services for those living in rural communities where formal VA supports are limited.

In addition, we also could make connections with specialized community services. In Aroostook right now, through an ACL grant, we're developing a regional community-based memory center to serve those with dementia and their caregivers. I think this is an opportunity for a collaboration.

In closing, there are many other opportunities to address these rural disparities. They are innovative, we are innovative, the VA is being very innovative. The Agencies on Aging stand ready to further partner with the VA to improve awareness of services and access to these services, which are issues that often prove challenging to those living in most rural areas of America.

Thank you for the opportunity.

[The prepared statement of Ms. Barresi Saucier appears on page 60 of the Appendix.]

Senator KING. Thanks, Joy.

Paul?

STATEMENT OF PAUL SAUCIER, DIRECTOR, OFFICE OF AGING AND DISABILITY SERVICES, MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. SAUCIER. Good afternoon, Senator King, and thank you for providing this forum to talk about this important issue for veterans.

I will use the broader term, long-term services and supports, to describe a continuum of services that includes caregiver support, home care, adult day services, assisted living, residential and nursing facilities.

MaineCare, Maine's Medicaid program, is the largest payer of long-term services and supports in the state. This is true nationally as well. In 2021, Medicaid paid for 44 percent of national expenditures, and the VA paid less than 2 percent. Many Maine veterans rely on MaineCare for long-term services and supports including 42 percent of Maine Veterans' Homes nursing home residents.

Although the federally administrated VA system and the state administered MaineCare program operate independently from one another, they face similar challenges in this post-pandemic era. Attracting and maintaining a well-trained workforce is the single greatest challenge facing long-term services and supports in Maine. This is an area in which the Federal Government can have mean-

ingful impact through a substantial and sustained effort in partnership with states and providers.

The need for long-term services and supports will continue to grow as Maine's population ages, and the single biggest constraint to growth is the availability of workforce. Maine has invested more than $300 million with funding provided through the American Recovery Plan Act, enhanced Federal Medicaid match, Federal CDC grants and other one-time sources. This federal funding has been put to good use and is greatly appreciated, but Maine's structural workforce challenges are not going away. This is a long-term problem that will require sustained federal support over time.

Pay is certainly important, and Maine has made a significant commitment to this area by adopting payment policy that assures rates will cover wages for direct support workers that are at least 125 percent of the State's minimum wage. The State's minimum wage is indexed to inflation and as it rises, so will Maine's LTSS rates.

Pay is not the only factor influencing the supply of direct support workers. Availability and portability of training is another key factor. To that end, Maine is adopting a universal direct support worker credential that will enable workers to apply their expertise across home and facility settings for individuals with physical, intellectual or age-related needs. This complements efforts in small house models and elsewhere toward universal workers who engage with residents to assist with multiple needs and preferences including personal care, meal preparation, laundry and social activities. The approach is more person-centered, efficient and satisfying to both the worker and the resident which has been associated with higher quality care. Green Houses, one specific form of small-house model, had documented staff turnover rates that are half those of traditional nursing homes. This is a very promising area to which the VA could contribute with more research and development from its own experience. The VA has funded the construction of several small-house models across the country including one right here in Augusta. We would all benefit from understanding the outcomes and operational best practices emerging from these homes.

Maine has also seen that self-directed care can be an important part of the workforce solution by expanding and providing more information about our self-directed home care options. Maine has grown this option during and after the pandemic. In most cases, self-directed care is provided by a family member, but the use of non-related caregivers is also rising. This is another area in which the VA can assist, and we welcome the expansion and availability of its Veteran-Directed Care programs.

I'd like to conclude with some thoughts about system balance. The VA and Maine state long-term service and support programs share an interest in ensuring a system that has a necessary balance of home—and community-based services and institutional services. Older adults have consistently expressed an overwhelming preference for aging in their own homes, which is reason enough to pursue more HCBS options. But we also learned during COVID that having an appropriate balance contributed to the resilience of our system. Maine's nursing homes have not yet been able to return to pre-pandemic occupancy levels. They're serving fewer peo-

ple today than they did before the pandemic. Fortunately for Maine, the story's been quite different in the home care sector. To be sure, home care has also experienced workforce challenges, yet Maine's three largest home care programs grew by 17 percent during the pandemic, serving nearly a thousand more individuals today than they did at the pandemic's onset.

The VA has recognized the importance of balance, projecting increasing growth of its HCBS options over time in a recent government accounting office report. To date, the VA's current balance lags Maine's and most states, and Maine welcomes a significant increase in VA home care options.

Thank you for the opportunity to testify today.

[The prepared statement of Mr. Saucier appears on page 64 of the Appendix.]

Senator KING. Thank you.

Kathleen. And, Kathleen, don't we know each other? Did you go to Mt. Ararat?

Ms. SWINBOURNE. Uh-huh.

Senator KING. With one of my sons, I think.

Ms. SWINBOURNE. James.

Senator KING. James, James. That's Maine, isn't it?

Ms. SWINBOURNE. He and I were Senate Pages together——

Senator KING. Oh, that's right, that's right.

Go ahead, Kathleen.

STATEMENT OF KATHLEEN SWINBOURNE, FAMILY CAREGIVER

Ms. SWINBOURNE. Good afternoon, Senator King. Thank you for the opportunity to participate in this Senate Veterans' Affairs Committee field hearing on long-term care services for veterans in Maine.

I'm from Topsham, I'm a registered nurse, licensed massage therapist, long-time yoga instructor and previous business owner. I'm here to share my experience as a family caregiver for my father Clare John Swinbourne, an 85-year-old Navy veteran with 20 years of service and three tours in Vietnam. My dad was exposed to Agent Orange and suffers from Parkinson's, dementia and PTSD.

In 2012, my dad was diagnosed with Parkinsonism systems, and from the instruction of the family physician, he was encouraged to apply to the VA for disability but was denied due to the diagnosis "Parkinsonism" rather than Parkinson's disease.

My active care began in 2019—I'm about to describe a fall. At that point, my dad had been living with Parkinson's symptoms for seven years. His gait was off, and he walked with a cane. He was struggling with his executive function, and experiencing intense mood swings and long bouts of depression. One day in December of that year, he suggested we hang wreaths in the front of my parents' home. We walked to the front, and he gestured for me to walk ahead of him. He was often self-conscious of his slow and laboring walk. I went ahead and in moments, I was startled by his yells behind me. I turned to see my dad lying on the ground with blood on his hand and knee. I ran to help him. I could tell by the blood and shock in his eyes had he had no warning that his body was

going to give out on him. He was embarrassed and apologetic, and I helped him to his feet. I know not to do this now, but I put my arm in his and aborted the wreath-hanging and led him inside so that I could care for his wounds. We walked down the stairway—or, excuse me—we walked down the driveway to the garage and took one step in the door, and we both crashed down onto the cement. My dad landed on the same bloody knee and hand. The fall happened so quickly, I had no opportunity to brace myself or protect him from falling. This time he was sobbing and in shock. I held my dad for a long time as he cried. I can't say I knew how he felt, but I realized with the Parkinson's disease it was progressing, and the body he knew and trusted his whole life was beginning to betray him.

I eventually got him to his feet. Inside, I cleaned and dressed his wounds, and put him in his comfy recliner. All the while he was apologizing to me still for falling. I told him it wasn't his fault. And once I got him settled, I went downstairs in a separate room and cried uncontrollably. I sat there for a long time crying and praying because I knew I needed to figure out how to care for him with this disease, but it was overwhelming.

The next day I called his primary care doctor and put in a request for an urgent referral for home care, and the next day they sent Chan's, which was wonderful, and began with a social worker who interviewed my parents and I about my father's needs as well as needs of the home. And at the end, she pulled me aside and said, we are more than happy to help you but because he's a veteran, I really encourage you to apply for his disability because he will be taken care of so well.

So the next day I got in touch with the American Legion, and a representative at the health administration—excuse me, the business administration side of the VA and she was wonderful, and she gave me a long list of appointments and to-dos that took me a little bit over a year and a half to complete. Mind you, it was the start of the pandemic so we'd have appointments scheduled and we'd show up and we weren't supposed to be there, or it was canceled, or there was an outside agency in Florida scheduling us in Maine and sending us to Massachusetts. And I would try to reschedule and spend a week trying to figure out who to talk to and how to change it.

During this time of pursuing the disability, which is more of the administrative piece, I was also trying to figure out how to teach my parents about the disease, and make sure that we were having somewhat of harmony and support within the home.

And if anyone has been with someone whose mind is going into dementia and Parkinson's, it's brutal. So I think during the year and a half of the pandemic, I didn't really sleep because I was awoken by night terrors and my mom wouldn't sleep so I was always running on empty. So I'd call this poor woman at the administrative side and cry and ask her, is there any way that I could get help? And she turned me on to the 1–800 line, the VA, which I will tell everyone about, who can access, because it's incredible. And I remember that conversation, she calmed me down, and told me about the caregiver program up in Maine and literally connected me while we were on the phone, and that was a game

changer. And they told me about the program. The next day—that's my thing—the next day I applied and in a few months, became part of the family caregiver program so that I could get a small stipend, but I was more interested in having the educational support and counseling so that I was doing an okay job, if I could, in taking care of my dad.

Also the help with the caregiver program, they told me about handicapping the home. I pursued the HISA grant which was similar to the disability process. It took me about a year, and only because there was one hang-up in sending the right faxed form from the outside occupational therapy practice to the VA. But they had sent an OT team to our home to evaluate what my dad needed, and then they sent the write-up back to the primary care office. And then I would wait. And then I would call them, did you send the form? Yes. Call the primary care at the VA. Did you receive the form? No, we haven't. So that went on for weeks and finally I was like, who is telling me the truth? And I talked to the manager of the OT practice and she said, I know someone at the VA, I'm going to figure out what the halt is, and it was a specific form that they needed to fill out that they didn't know. Finally got that through and within a year or so, I handicapped the home. And I want to just give credit to the VA and the prosthetics department. They're incredible. Just like the business administration side, they gave me everything I needed to do, it's just very time consuming.

Senator KING. So the problem wasn't the service, it was the time to get the service; is that correct?

Ms. SWINBOURNE. Yes, and doing the right steps and telling the right people, yes.

Um—sorry. As I was getting this all figured out, we were also realizing my dad's needs were increasing so I began the process of applying for the re-adjudication of his benefits when he was denied in 2012. And also the administrative side helped me with the right forms to fill out. We submitted them, and waited a long time for a response. And this poor representative, I called her every week, what's happening, are we going to find out? Because I was trying to plan for the future, and I knew that we were going to use the money to pay for the rest of the construction to handicap the home, and also to pay for an additional caregiver alongside my mom and I.

So I reached out to your office, and that's when I connected with your staff, and they were incredibly supportive in helping me figure out and locate where the application was. And within two weeks, we had the backpay.

So after that, I then applied for full-time status with the caregiver program and I was denied. There wasn't, in my experience, a lot of evaluation or assessment to why I was denied, but we were denied, and the stress was increasing. I'm just—I'm going to advance a little bit. The stress sort of was coming from the progression of my father's disease. And we realized this past summer, he probably needs to be in a home, even though that's not something we wanted to do. So we moved into the Maine Veterans' Home, which is beautiful, and we joke in the family, it's the Hilton of elderly spaces. But his dementia is so severe that he needs more intense observation and care.

I was trying to collaborate with the primary care team at the VA, and it was a little bit difficult to close that circle in getting support in I guess you would say taking away his rights to make decisions so that we could make sure he'd stay there safely because he wanted to leave. Every day he was calling me, "Kath," and causing a lot of ruckus. And we brought him home for Christmas, and he ended up not going back. Very long story short, he's now at the long-term care at the VA. We're very happy. One of the first things that he said to me when I went to visit him is, "I feel safe," and that's important.

I'm here today to share this story of caring for veterans for—to share this story so that other people caring for veterans don't give up. I'm also here to share the things that I feel need improvement at the VA. I'm so happy with the benefits we've received, even though many times it felt like I was trying to bust down a brick wall. But once the wall came down, I was able to tap into the wealth of resources for my dad and myself.

I wish I had a case manager or a medical social worker to guide me through the appropriate channels and check points to regularly evaluate my dad's conditions and needs, and to make sure his medical records were alwaysup-to-date to help us move through this stage from being at home to the nursing level of care.

I know this is the intention of the VA to provide a medical social worker. We were assigned one, but this wasn't our experience. It was very difficult for me to connect to the primary care team, and also with them to communicate with the caregiver program. We often fell upon our next steps through crisis, and I was regularly asking for help, but so often my phone calls weren't returned. When my dad went into rehab, I was undergoing extensive months of a long process to re-apply for the full-time care, and also Vet Direct care. By the time there was a decision, simultaneously my dad was in the hospital and then ended up at MVH.

In an ideal world, veterans and families would benefit from the medical social worker to educate them on the process of the disease and its progression, to guide them through the proper channels in moving from the home to the nursing home.

Additionally, the medical social worker can bridge the families to the providers for regular geriatric evaluation and management and the caregiver program upon immediate diagnosis of the war-related disease.

I feel the VA has all the big pieces that can help. It's the little stuff connecting the dots between the programs where I feel it falls apart.

I'm so grateful for your office, Senator King. I contacted them again for assistance when I was unable to receive return calls or clear guidance from the staff at the VA. I'm certain the support of your office is what allowed me to experience progress and momentum in my dad's care. However, I don't feel veterans and families need to take it to this level. Calls should be returned, guidance needs to be available, and the application process is too extensive for aging veterans who don't have a young family member or advocate who can give them—who can give up their job to pursue their benefits and care. For five years, I temporarily gave up my career and income for my dad because I love him, and I believe in hon-

oring those who fought for our freedom, but I've greatly compromised my financial, physical, mental and also emotional stability due to the constant stress and time commitment.

If I had been compensated for the care for his full-time needs, I may have felt differently or may feel differently, but I was doing full-time work for part-time pay and also trying to go to nursing school. It was an idealistic hope that I could take care of him if need be.

I believe the VA is a wonderful organization with an abundance of resources for families and veterans, and I'm hoping that the refinement of better communication and correspondence and leadership from the primary care team can create positive change for veterans and families.

Thank you.

[The prepared statement of Ms. Swinbourne appears on page 67 of the Appendix.]

Senator KING. Thank you. That was very moving and important for us to hear. Thank you.

It seems to me to start with your testimony, as I mentioned, the problem that you had with the VA wasn't with the programs or the adequacy, it was the time, and I'm delighted my office could help, but it shouldn't take that step to get that help.

Was this—did you get the sense this was a lack of, again, of workforce? Just too much burden on the people at the VA?

Ms. SWINBOURNE. Yes.

Senator KING. I'm sorry nobody said we're not gonna return these phone calls, it just didn't happen.

Ms. SWINBOURNE. Yes. I think it was a lack of staffing which I feel very empathetic toward, yes.

Senator KING. Let me move, Joy, to something that you touched on very briefly. One of the concerns—and I've heard this when I've met with their agencies, particularly in rural Maine, is an epidemic of loneliness. Could you talk about that, and the fact that so many of our seniors are isolated with very little—I remember being in Washington County and there was a lady there who said the only person she ever sees is the Meals on Wheels driver. Talk to me about that problem. It doesn't strictly relate to the VA, but I think it touches on what we're talking about. There are certainly veterans who are in this category.

Ms. BARRESI SAUCIER. Yes, we definitely hear this in rural Maine and nationally too. This is really becoming its own form of an epidemic, the epidemic of loneliness. The rural community Health Improvement Partnership project that we have just been undertaking with some state funding brings 20 community partners together to talk about social determinates of health. And the needs assessment that we did found that this is not only the issue of social isolation, but the issue of belonging is a challenge in our rural communities. And so we've prioritized that as one of the four areas that we'll be focusing on in our Community Health Improvement Partnership.

In Aroostook County, a couple things we are doing, because we do understand that with distance comes disparities. You know, I tell people that driving from the top of Aroostook to the bottom is like driving from Albany to Boston. It's very hard to conceptualize

that until you do it in a day. We all have done it in a day before——

Senator KING. I think Brunswick or Portland is halfway between Madawaska and New York City. People don't realize how tall Maine is.

Ms. BARRESI SAUCIER. It's a big space. It's sparsely populated, but yet we believe that no matter what community you live in in Aroostook County, that you need access to services.

We recently received, through congressionally directed spending, thanks to Senator Collins and Senator King, a project called Access Points for Aging where we're collaborating with 20 communities in Aroostook County, these are primary and secondary service-hub communities, to install an actual footprint in that community, an existing community space, where there can be a partnership between the community, age-friendly community, municipality, Agency on Aging, healthcare, other social service agencies to have a place where people can go to access information. These are outfitted with technology. All 20 will be able to be linked together. So if you're in Danforth, you can provide a Tai Chi presentation to Fort Kent.

Senator KING. Will that access information include information about VA availabilities?

Ms. BARRESI SAUCIER. As I said in my written testimony, I think this is a great opportunity to link the VA into that network in our area. This isn't something that all AAAs have. It really is a demonstration pilot. We expect that others will want to follow suit, and already another agency is trying to follow suit with this concept as well.

And then in addition, we have—related to social isolation, I believe it was 2020, we were the recipient of a community care corp grant which allowed us to develop and establish a program called Friendly Volunteers. We have friendly visitors, callers, helpers and techies. These are trained background check volunteers, community volunteers, that we match to older people that need a connection. It's a very, very popular program. The challenge with this type of program though is that that was one-time funding, that was one-time two-year funding and now we're faced to try to—well, how do we piece this back together without a full-time coordinator to do this work? This is another great example of an existing resource that could be tweaked to match veterans with veterans. The infrastructure is all there. We just need resources to continue to make these type of programs run.

Senator KING. Thank you.

Steve, I noted you nodding during Kathleen's testimony. Can the VSOs serve as navigators, helpers? Is that a function that would be useful in the situation of the delays and the unanswered phone calls?

Mr. SANPEDRO. You're referring back to Kathleen's testimony?

Senator KING. Yes.

Mr. SANPEDRO. I'm sure we can advocate.

Senator KING. That's what I'm suggesting.

Mr. SANPEDRO. Absolutely. I don't know if we would change it, but I mean I will tell you personally that Ryan, Tracy and Jennifer, you guys do a tremendous job providing healthcare and benefits.

Just two days ago——

If you don't mind me sharing, Jennifer.

—I reached out to Jennifer about a veteran that had an issue with her claims process, and she felt she wasn't being heard and she wasn't being taken care of. A different regional team was looking into it. Jennifer's team took over it, and long story short, this veteran walked away feeling like she was heard and that she was cared for and she's very happy, and I told Jennifer that before.

So I think we have—the overall thing that I hear from veterans across the state is they do believe in that VA healthcare, they do want to use it. The national VFW did a survey, and overwhelmingly veterans want to use VA healthcare. Is it perfect? No. But tell me a healthcare system that is.

I believe that we have leaders there that want to help us, they care. They truly enjoy their jobs——

Senator KING. For the record, I totally agree with that statement.

Mr. SANPEDRO. Yes. What I would have done, if she reached out to me or—you know, I would have reached out to them because that's typically what I do. I don't—you know, I don't—I know everybody doesn't have that access, but I do, and that's what I do. I just say, Jennifer, can you help me? Here's another one. This isn't the first time Jennifer has helped me. And I've reached out to Tracy and when Ryan was here, I worked with Ryan. They are great partners with the VSOs, and they truly believe in taking care of veterans. So I simply would have advocated for her, and I believe that it would have been taken care of. However, there is a problem with some of the processes. I mean they're labor intense.

You know, one of the things that I would have said, if you asked about veterans, how do they feel, most veterans want to stay at their home. But if they can't, they—a lot of them prefer to go to Maine Veterans' Homes. Not because I sit on the board but because that's true. However, a lot of them are not close to a Maine Veterans' Home, and they want their families to be able to visit. So the VA contracted homes, many people don't even know about them. There's 10 of them in the State of Maine, and most veterans don't know about them.

Senator KING. These are the private nursing homes that are contracted for by the VA?

Mr. SANPEDRO. Correct. But most of them don't know about it, and who do they turn to, you know, and how do they learn about it? So there's definitely an education problem. Not in the State of Maine, in the whole Nation, on what the VA can do for ya. Whether it's just getting out of the military or filing a claim or getting your healthcare, a lot of people just don't know what the VA has for them, and there's so many programs that they provide for our veterans and no veteran should——

Senator KING. So awareness is a big part of the issue?

Mr. SANPEDRO. Yes. And, you know, like thank you for signing the bill that I came to you in September or sponsoring the bill that I came to you in September about the TAP program——

Senator KING. The President signs the bills.

[Laughter.]

Mr. SANPEDRO. Right. We're working on it, right?

But that simple thing of allowing the VSOs to come in during TAP, it costs the United States zero dollars. And you take——

Senator KING. TAP is the Transition Assistance Program?

Mr. SANPEDRO. Transition Assistance Program. You would think that that would be a simple thing, but we have to get a law to pass to let the VSOs to come in during TAP to show—to help start the claim process.

Senator KING. To make the contact?

Mr. SANPEDRO. Correct. So education to me, I think, would solve a lot of our problems, and I do think that it would solve Kathleen's problems.

Senator KING. Thank you.

Paul, I want to talk a bit about reimbursement. What's the—for MaineCare, which is a lot of what we're talking about, what percentage of those dollars are federal, and what percentage is state?

Mr. SAUCIER. So Maine gets about 62 percent federal these days. And, as you know, that changes with economic conditions in the state. Administrative costs are 50 percent federal and 50 percent state.

Senator KING. So on a dollar to a nursing home, the State of Maine puts up roughly 40 percent, the feds 60?

Mr. SAUCIER. That's right.

Senator KING. Sharon, you said something, and we sort of blew by it, and I want to get back to it. You said—I think you said I have a 36-month runway. What did you mean by that?

Ms. FUSCO. What I meant by that was that we are in a situation where we have to use funds that we reserve for capital replacement. Like rehabbing buildings, maintaining buildings, keeping our infrastructure in good shape. Those funds today are being used to pay for services today.

Senator KING. So you're using capital to pay operations?

Ms. FUSCO. Correct.

Senator KING. Always a bad place to be.

Ms. FUSCO. Yes. And understand that, you know, because we are a private nonprofit, we're a little different as a state veterans home. We are charged to do that. The state doesn't pay for our buildings and our replacement buildings and things of that nature. So we've done the right thing over the years, right? We've invested that money so that we have a pool so that when we need capital replacement, we can do it. But when we have to make payroll and it's the choice between making payroll or not.

Senator KING. You're dipping into savings to pay the rent.

Ms. FUSCO. Exactly. And that steals from our future, and it also means I can only do that so long before I have to say, I got to close the doors because I can't make payroll. And that runway is 36 months. We've done what we can to extend it.

Senator KING. So the 36 months is when you run out of your——

Ms. FUSCO. Yes, at current spend rates, yes.

Senator KING. That's a scary thought, isn't it?

Ms. FUSCO. It is.

Senator KING. We don't have a representative on the panel, the private nursing home industry, but, Sharon, you're in this. Tell me your thoughts on the CMS staffing role.

Ms. FUSCO. I think it's bad policy. And it's not because I don't believe that, yes, if we had more staff and more people available, that's great. But it's bad policy because, one, we don't have the workforce, and if we learned nothing else through the pandemic when we had a mass exodus of the workforce from this industry, what we learned was we had companies swooping in to save the day by charging us three to four times for those nurses.

Senator KING. These are the traveling nurses companies?

Ms. FUSCO. And these are those traveling nurses. And what happens in that situation is they are not committed to quality as MVH defines it. They're fine individuals. If you're a traveling nurse, this isn't about you. But what it's about is that you don't know why we do things the MVH way. We got to five stars as a CMS rated nursing home because we have quality standards that we expect all of our employees to meet. And when you're a traveling nurse, you're there for what; 60, 90 days? You're not vested in my quality program. And you heard Mike say how difficult it is to build a relationship with somebody who's not vested in the mission. And you're creating a culture where I've got some employees that I can pay my rate, and others that I have to pay three and four times that rate. Imagine what it's like standing next to somebody who's doing the same job as you who's getting three times what you're being paid. It's criminal.

Senator KING. It's not exactly a morale booster.

Ms. FUSCO. No, it's not. Now, I will say, we have done a great job of working to eliminate temporary staffing in our homes. But with work—if CMS comes down and says, "hey, you have to do this, you have to have this", we will be right back to temporary staffing. I mean those private nursing homes are gonna be back to it.

Senator KING. They're also going to be facing closure; aren't they?

Ms. FUSCO. They already are. And now CMS is going to impose a staffing mandate that will increase their cost not just because they have to hire more people, but because we're going to be in this competition for people.

Senator KING. Colleen?

Ms. HILTON. Yes, I'd like to add to that.

In Northern Light Health, we have eight nursing homes, six we jointly own with another healthcare company. Prior to the pandemic, we would advertise for a nurse in Lincoln, Maine; three years not a single applicant. Three years, no applicant. That nursing home eventually we converted to residential care. Seaport in Ellsworth just closed. Deer Isle, during the pandemic, right at the tail end of the pandemic closed. There's now not a nursing facility or a skilled nursing facility in Hancock County.

Senator KING. I don't think there's one in Washington County either.

Ms. HILTON. There's Milbridge right on the edge, but people in Hancock County will now have to travel to Milbridge or to Bangor. And so it is baffling at a time when five nursing homes I think have closed since the pandemic, and you mentioned the 800 and something beds that have disappeared in the last five years that we are——

Senator KING. As the population ages.

Ms. HILTON. As the population ages, as the needs are increasing that we are actually mandating 24-hour nursing care when we can't produce it and we have a projected shortage, and you can't fast track a nurse. You know, your wife's a nurse. You can't fast track a nurse to fill that gap, and we're all dealing with, in every sector of healthcare, those tough questions of do we pull in that contracted labor for three times the cost, or do we say to this family, this patient, we can't provide care to you?

Senator KING. Sharon, don't you have a whole wing at the—we had a hearing at the Augusta home, and there was a part that isn't open, right?

Ms. FUSCO. Well, we have since, I'm happy to say.

Senator KING. You staffed it up?

Ms. FUSCO. We staffed it up, and we're actually near capacity in that home, but it took us a year and a half to do it.

Senator KING. Well, I thought Mike made an important point because we're all talking about hiring people but, Mike, you made the point about stability and retention.

Mr. POOLER. Yes, sir. Yes, the folks that are there, great. You know, with dementia patients, like I said, they need to have that stability with the staff so they can, you know—they're never gonna get better, but they're not—the decline will be less. And if they can find issues sooner, they can fix them sooner before they have to travel to the hospital for an operation. So that stability from the family level is critical.

Senator KING. If retention is the goal, one of the ironies is that as you have gaps and you have longer hours and—that is a vicious downward spiral because people burn out.

Is that your experience, Colleen?

Ms. HILTON. It's just a phenomenon of what we're dealing with. And I think it did actually truly start right before the pandemic, but certainly exacerbated by the pandemic. There are—you know, there are significant needs across our state, and people do chase money. And if they can go 30 miles over here and increase their wage, I can't begrudge them for that. But we've seen wage escalation, in some of the nursing homes, up to 20, 30 percent, and it's still not enough to retain——

Senator KING. To hold the people.

Ms. HILTON. To retain the people. Every one of us are focused on retention. That's really where we spend the vast majority of our time, but the workforce is very migratory right now because of, I think, the socioeconomics and the workload which is so intense and hard.

Senator KING. The good is we have a historically low unemployment rate, but that creates the question of the migratory workforce.

I'm not going to make light of this issue, but I'll share a story.

The first month that I was Governor, we had a retreat for the cabinet where we went out to Newry, Maine where they had a ropes course, and ropes courses do various things. It's to build teams and those kinds of things. And part of it was to go way up on a rope and have a rope around your waist and fall off and have the person below hold you. It was, you know, trust and all that.

Well, it happened the guy who was holding me was a guy named John Orestis who happens to be a nursing home owner. And so I'm falling off and dangling 40 feet above the ground and I had been down here for about a month and John said, Governor, what do you think of nursing home reimbursement rates? [Laughter.] I said, whatever you need, John, let me down. [Laughter.] But it is—it is a serious problem. And you're squeezed, you have increasing expenses and virtually no increase in revenues. I mean that can't work for very long.

Ms. HILTON. No.

Senator KING. Other thoughts before we conclude?

Thank you all. This has been wonderful testimony.

By the way, this is my favorite part of my job is hearings and asking questions and learning and writing down ideas. I have lots of things for Tester and Moran to work on when we get back.

Other thoughts you want to be sure to get on the record?

Paul, you would like a greater increase of federal funds for MaineCare?

Ms. SAUCIER. One of the very efficient ways to distribute federal money is by providing a special federal matching rate for targeted activities, and that's one of the things I would recommend. It would be very efficient for CMS to, for example, give a 75 percent federal match rate for any workforce related activities and make that very broad. The workforce money that we received through the recovery act and others has been put to great use. That was a very large $130 million bonus program here in Maine that went to all HCBS, Home and Community Based Service providers, for example. Those—many of those are small providers that are not in a position to write a grant or to HRSA or, you know, otherwise directly receive federal funds. But through the state, I think that could be very beneficial.

Senator KING. I like the idea. In other words, additional federal funds not generally but targeted toward workforce retention?

Mr. SAUCIER. Targeted—right, right. Yes, I think that would be one—one way to go with it. I mean just to give you a sense of how big this problem is, senator, in the CMS proposed rule that you've been asking about, there was notice that HRSA would invest $75 million as part of the regulatory—the new regulation. Maine invested $300 million, one small state, in the last three years. My belief is that it helped stabilize the workforce. It did not fix it, and that's just one state. So the $75 million that HRSA would be offering is—I mean it's——

Senator KING. For the whole country?

Mr. SAUCIER. For the entire country. Which is why I say, I mean HRSA does certain things really, really well and——

Senator KING. Define HRSA.

Mr. SAUCIER. Health Resource Service Administration. They're the federal agency that focuses on the healthcare workforce, and they're—especially larger providers can benefit a lot from HRSA grants. The state has—you know, the universal benefit—the universal curriculum, that I mentioned, was funded with HRSA funding, but it's out of reach for a lot of these small providers that we really depend on. Home care providers sometimes are two employees. And so, you know, we really need to be able to reach them.

Senator KING. By the way, that's a problem across the board. We had an Armed Services Committee hearing this week about the inability of many small businesses to interact with the Pentagon. It's just too much, too much paperwork, and we're losing innovation and capabilities that we need.

Final point on that, it suggests itself. How about innovation and technology? Are there ways to deliver services more efficiently and effectively at the same or less dollars? In other words, is that another way to approach this?

Colleen, you're nodding.

Ms. HILTON. Yes, I'd love to take——

Senator KING. The record doesn't show when you nod. That's why——

Ms. HILTON. Oh, sorry.

We invested, probably 15 years ago, in technology so we pay for it. It's not reimbursed. It's not covered by the Medicare benefit. There are small parts of—bits and pieces that they may cover but we are—and, again, this was clear through the pandemic when we couldn't get into some homes, we could drop ship equipment to a home, and could get video eyes on people in their home and do assessments as best we could. So it is a helpful additive to what we do. It can't replace someone that needs personal care assistance and toileting and those sorts of things, but it's typically not covered by most of the insurances. So for an organization like mine which has done, over time, pretty well—we go from, again, Fort Kent to Kittery, coverage. Last year we were 10 million in the hole, 10 million to the negative, a very efficiently run organization, and we are gambling on our investments in technology because it has to—reimbursement has to catch up with it because it is one of the solutions to the workforce shortage.

Senator KING. One of the things—during the pandemic, there were rules waived for reimbursement for telephone and telehealth, and they were—we've been fighting—we want to keep that permanent.

Ms. HILTON. We do too.

Senator KING. Because telehealth is a huge opportunity. And as I think one of you mentioned, the patients are okay with it. And I understand that there's a lower appointment-missing——

Ms. HILTON. Correct. For home visits and for behavioral health, it's often preferred.

For us using it with chronic care disease management, congestive heart failure, we can catch things early, treat them early with preestablished protocols, and that person never goes to the hospital, doesn't have to take up time in an office. They can be treated at home and continue on their——

Senator KING. Prevention, prevention, prevention.

Ms. HILTON. Prevention, public health.

Ms. BARRESI SAUCIER. Can I add to the telehealth comment?

Senator KING. Please.

Ms. BARRESI SAUCIER. I just want to mention our evolving memory care center in Presque Isle, is a collaboration between the Aroostook Agency on Aging and Acadia Mood and Memory Clinic in Bangor. And this model creates a comprehensive hub for Aroostook County where we can do everything from work with Acadia

on early diagnosis and treatment through service coordination, family caregiver support, community education, and respite care. And the telehealth components are going to allow us, with Dr. Singer who has a 600-person wait list, to fast track one person from Aroostook County every week into his program using telehealth. So we're really excited about this opportunity to—as a community-based organization to be a hub for a telehealth project.

And just my other comment, I'm so excited to hear about everything that the VA is doing related to the community-based programs, and I just want to remind about the fact that Agencies on Aging have across the country these amazing assets and established infrastructure that if we can partner together, we can do great things so look us up across the country. There are 622; it's just a great use of existing resources rather than recreating resources when this network already exists so thank you.

Senator KING. I want to thank all of you. This has been very informative. I've got lots of notes. As you drive home tonight, when you think of oh, I should have said this, send it forward. Be in touch with my office so that we can have the benefit of your thinking.

It's wonderful to see all of you, most of you I know and have seen before.

Kathleen, I will tell James I saw you.

And it's been very, very helpful and informative.

Thank you so much. Thank you all.

[Whereupon, the above-named hearing was concluded at 4:02 p.m.]

A P P E N D I X

Prepared Statements

STATEMENT OF
SCOTTE R. HARTRONFT, M.D., MBA, FACP, FACHE, CPE
EXECUTIVE DIRECTOR,
OFFICE OF GERIATRICS AND EXTENDED CARE
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
LONG-TERM CARE FOR VETERANS IN MAINE
January 26, 2024

Good afternoon, Senator King. I appreciate the opportunity to discuss Veterans' access to long-term care in both institutional and non-institutional settings. The Department of Veterans Affairs (VA) programs provide care and support for Veterans of all ages through a spectrum of home and community-based services (HCBS) to include inpatient and long-term care. I am accompanied today by Dr. Annette Beyea, Associate Chief of Staff, Geriatrics and Extended Care and Community Living Centers.

The older population in America is growing. For the first time in the history of the United States, adults over 65 are on pace to outnumber children under 18 by 2034. With this shift in demographics comes a greater demand for health services and a need to innovate care delivery to meet those demands. As Veterans age, approximately 80% will develop the need for long-term services and support. Most of this support in the past has been provided by family members. Veterans over 65 represent about 50% of the Veteran Health Administration (VHA) enrollees, and this patient population is a greater proportion than that observed in other health care systems. It is projected that between fiscal year (FY) 2023 and FY 2035, the total number of Veteran enrollees nationally will decrease by 8%, but during this same period, the number of enrollees who are 85 and

older will increase by 73%. The number of VHA women enrollees aged 85 and older is projected to increase by 127% during that same time period.

The VA health care system, like the larger U.S. health care environment, faces significant challenges when preparing for the increased number of older adults and their expected health care needs. Some of the biggest known challenges include having an adequately trained workforce to provide care to older adults, addressing the gaps in geographic access to care (including rural areas), and the need for more specialized care such as for dementia. These challenges will require significant and continuous innovation, assessment, and adaptability.

Home and Community-Based Services (HCBS)

An estimated 90% of Americans prefer to age in place, in their homes or in the least restrictive setting possible, as long as it is safe to do so.[1] VA supports Veterans' expressed desire to remain in their own homes for as long as possible. VA provides and purchases a large array of Home and Community-Based Services (HCBS) from qualified providers through community care network contracts and Veterans care agreements. In FY 2022, VA served approximately 411,900 unique Veterans and spent $3.9 billion on home and community-based care. Personal care service programs assist Veterans with self-care and activities of daily living. Evidence demonstrates that the appropriate use of the programs and services available through VA, especially those services that are provided in HCBS, can reduce the risk of preventable hospitalizations and delay or prevent nursing home admissions and associated costs. While VA has increased access to HCBS over the last decade, there is an urgent need to accelerate the increase in the availability of these services. In the immediate term, VA will focus actions on the following strategic initiatives: (1) expand HCBS to better allow Veterans to age in place; (2) modernize systems for healthy aging by creating, testing, supporting, and disseminating evidence-based best practices in geriatric care throughout the enterprise, which includes becoming the largest age-friendly health

[1] Aging in Place (2020). "Aging In Place Vs. Assisted Living." Retrieved from: https://www.aginginplace.org/aging-in-place-vs-assisted-living/.

system (AFHS) based on the Institute for Healthcare Improvement (IHI) Standards; (3) ensure access to modern facility-based long-term care for those who require it; (4) expand access to geriatric, palliative, home, and long-term care with the use and expansion of telehealth services across all care settings, and locations; (5) train, recruit, and retain a workforce of geriatric and palliative care staff across all disciplines; and (6) provide geriatric and palliative care training to primary care and specialty care providers of all disciplines.

Facility-Based Care

When options for living at home are no longer feasible for a Veteran's care, VA can offer the Veteran care in a nursing home setting in which skilled nursing care, along with other supportive medical care services, is available 24 hours a day. VA obligations for nursing home care in FY 2022 reached $7.3 billion. If nursing home utilization continues at the current rate among Veteran enrollees, the total costs for all long-term services and support are estimated to rise to more than $15 billion per year within the next decade without consideration of inflation.

VA will need to continue using a mix of VA community living centers (CLC), community nursing homes (CNH) and state Veterans homes (SVH) to meet the needs of current and future Veterans for two reasons. First, each meets the needs of certain Veterans better than others, and second, the broad network allows for better geographic location of care choice for Veterans and their families. VA operates 134 CLCs across the country and has agreements with over 6,000 CNH facilities for short stay therapy and over 2,000 CNH facilities for long stay needs. To assist with future expected increased demand, we are currently working to increase the number of CNH facilities that can provide long stay care. All Veterans receiving nursing home care through VA, whether provided in a VA-operated CLC or purchased by contract in a CNH, must have a clinical need for that level of care. Mandatory eligibility under 38 U.S.C. § 1710A for nursing home care is established for those Veterans with service-connected disabilities rated at 70% or higher or who need nursing home care for service-connected conditions. Veterans with mandatory nursing home eligibility can receive care in a VA

CLC or a CNH under VA contract. The Veteran's preferences based upon clinical indication and/or family/Veteran choice are always a consideration. Most Veterans do not meet the mandatory service connection eligibility for nursing home care at VA expense, but they may still receive nursing care under 38 U.S.C. § 1710 based on the available resources.

Qualifying Veterans can also choose to receive nursing home care at an SVH facility which is owned, managed, and operated by the states. However, the SVH and VA collaborate to share the costs of care. Unlike with the CNH program, VA provides quality oversight of SVHs and multiple significant resources, including but not limited to, construction grants covering up to 65% of the project costs, per diem grants to cover part of the cost of care for each eligible Veteran, nurse recruitment, and retention grants. VA also offers the opportunity for SVHs to enter into a medical sharing agreement with their local VA medical center (VAMC) of jurisdiction to purchase specialty care and medications from the VA formulary with significant cost savings. Through these efforts, states provide care to eligible Veterans across a wide range of clinical care needs through nursing home care, domiciliary care, and adult day health care programs. VA also routinely collaborates with and supports the National Association of State Veterans Homes (NASVH) through regular meetings, conferences, and other interactions. Currently, there are 164 SVHs with 157 providing nursing home care including 47 that are combined with domiciliary care and 7 SVHs providing only domiciliary level of care across all 50 states and Puerto Rico.

Improving High-Quality Care and Access

VA is undertaking many significant initiatives to prepare our staff and facilities to provide better care for aging Veterans. There is a significant multi-year effort ongoing to implement the IHI AFHS initiative, which focuses on evidence-based care practices related to what matters most to the Veteran such as medications, mobility and mentation. As of January 8, 2024, VA had 132 VAMCs earning IHI AFHS recognition in 305 care settings, and we have a new FY 2024 group of 410 teams from 126 facilities

about to start their community of practice to gain recognition. VA is on its journey to become the largest age friendly integrated health system.

VA is also working to make its emergency departments to become geriatric emergency departments accredited by the American College of Emergency Physicians (ACEP). As of December 2023, VA had 68 of its 111 emergency departments (EDs) accredited by ACEP, with 9 additional ED's pending accreditation and more applications are pending.

Additionally, VA is currently undertaking one of the largest multi-year expansions of HCBS to better allow Veterans to age in place. VA is implementing a plan to accelerate the roll-out of the Veteran Directed Care (VDC) Program. Under the plan, all VAMCs will have VDC Programs by the end of FY 2024. VA is in the process of adding 75 new Home-Based Primary Care (HBPC) teams. This expansion will focus on VAMCs with the highest unmet need. By end of FY 2026, all VAMCs will be required to have a Medical Foster Home (MFH) Program. The HBPC Homemaker-Home Health Aide (HHA)/Certified Nursing Assistant Pilot supports the needs of aging Veteran population by improving coordination of care, access to care and quality of care provided to Veterans in their own homes. Access to caregivers in the home supports a Veteran's desire to age in place in their homes. The VA Maine Healthcare System has hired one 0.5 Full-Time Equivalent (FTE) Registered Nurse Coordinator to oversee the program and is recruiting for five FTE nursing assistants for this pilot.

Further, VA is conducting multiple pilots related to HCBS to find new possible programs to better serve Veterans. The pilots include, but are not limited to, the Redefining Elder Care in America Project (RECAP) Pilot, currently operated at three VAMCs that uses predictive analytics to identify Veterans at highest risk for nursing home admission in the next 2 years and proactively aligns the Veteran with needed HCBS to delay or prevent nursing home placement. Early results have been positive with the increased utilization of HCBS and positive feedback from Veterans and caregivers. As more Veterans are seen in the pilot, VA will be collecting additional data

on outcomes. A RECAP site is anticipated in 2024 at the Maine VA. The Nursing Home to Home Pilot, currently operated at three VAMCs, focuses efforts on low-need Veterans residing in VA-paid CNHs who wish to return to their home setting. Nursing Home to Home Pilot staff work with the individual Veteran to identify if a safe transition to home can be accomplished and, if so, coordinate the necessary care to ensure a successful return to home. A new co-employer option model called the Technology Enabled Homecare Model Pilot will test a hybrid of the current HHA and VDC Programs to see if it is a better model for Veterans. Planning for this pilot is still underway, and VA is working with available community providers and networks to implement it. VA is also testing a new model of HHA services at four VAMCs (including Togus) where the services are being provided directly by VA-hired staff and not a community agency. In Maine, there are already active VDC, MFH and HBPC Programs, and VA is adding another HBPC team at three sites (Togus, Caribou, and Bangor). The existing VDC program in Maine is also having a multiyear funded expansion.

As for facility-based care, VA has multiple interdisciplinary improvement and modernization projects underway. VA significantly invested in VA SVH oversight by creating and staffing four regional teams with members from the Per Diem Program, Construction Program, clinical and quality-related staff, an education point of contact, and an identified NASVH regional liaison. There are also multiple interdisciplinary projects in VA CLCs and CNH Programs.

Implementation of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022

As required by section 161 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (the Cleland-Dole Act; Division U of P.L. 117-328), VA is working to accomplish the following: (1) identify current and future needs of Veterans for long-term care based on demographic data and availability of services; (2) identify current and future needs for both institutional and non-institutional long-term care, and (3) address new and different

care delivery models. VA will provide its report to Congress later this year, as required by law.

In accordance with section 163 of the Cleland-Dole Act, VA also implemented the 2-year Geriatric Psychiatry Pilot Program at SVHs in December 2023. This pilot program will recognize both the importance of interprofessional geriatric mental health services to meet the mental health needs of the SVH Veteran population and the reality of severe geriatric psychiatry (and other geriatric mental health) workforce shortages. VA plans to offer interprofessional geriatric mental health, including geriatric psychiatry, telehealth services to Veterans and teleconsultation to SVH teams in select SVHs through one or more the Veterans Integrated Service Network Clinical Resource hubs.

Finally, VA is implementing section 165 of the Cleland-Dole Act by establishing provider and payment processes that will be used to pay for care in MFHs. VA is reviewing current processes and working to develop a unique process for MFHs that matches the requirements of the authorization. Due to the complexities of the various processes for contracting, ordering and paying for this new and unique service, VA is still working to formalize a final projected date for Veteran enrollment.

Conclusion

VA's various long-term care programs provide a continuum of services for aging Veterans designed to meet their needs as they change over time. Together, they have significantly improved the care and well-being of aging Veterans, even during times of crisis. These gains would not have been possible without consistent Congressional commitment in the form of both attention and financial resources. It is critical that we continue to move forward with the current momentum and preserve the gains made thus far. Your continued support is essential to providing high-quality care for the Nation's Veterans and their families.

This concludes my testimony. My colleague and I are prepared to respond to any questions you may have.

MAINE VETERANS' HOMES
caring for those who served

January 26, 2024

The Honorable John Tester
Chair, U.S. Senate Committee on Veterans' Affairs
412 Russell Senate Office Building
Washington, D.C. 20510-6050

Subject: **Testimony for the January 26, 2024, Senate Committee on Veterans' Affairs Field Hearing regarding long term care for Veterans in Maine.**

Dear Members of the U. S. Senate Committee on Veterans' Affairs,

It is my pleasure to be speaking with you about Veterans' access to long term care and my experiences. My name is Sharon Fusco and I am the CEO of Maine Veterans' Homes, a private nonprofit established to operate six homes across the state in both rural and urban settings. Last year, we served 1005 Veterans, spouses, and Gold Star family members. Our facilities are known nationally for providing high quality care for over 40 years. We have earned four five star ratings and one four star rating from CMS in our nursing homes and one silver and three gold awards for quality from the American Health Care Association.

My testimony begins with the story of Bart.

Bart is a Navy Veteran who served in WWII. He was the sailor whose whistle communicated the captain's command to his fellow seaman. Bart was quick to show me his whistle, his uniform, and his room. Bart is slim and he carries a baseball bat covered with stickers, including one of "his Marilyn Monroe." Bart has dementia. He is unable to remain safely at home and has no one who can provide the 24-hour care and monitoring he needs. He is not acutely ill, so he doesn't qualify for a hospital stay. Maine Veterans' Homes assisted living unit provides a place for his memories to hang on a wall and a caring team of qualified care professionals to make sure he's safe.

Although there are many seniors that share Bart's story in Maine, his is unique. Most individuals who enter a nursing home eventually end up on Medicaid after they have exhausted their savings to qualify. However, as a resident of MVH, Bart is not on Medicaid. Nor does he privately pay for services or receive Medicare funding. Because of a service-connected disability that qualifies him for benefits under the VA's 70% program, the VA pays MVH for his care. No other source of insurance is allowed, including private pay. This means that neither the individual nor the state pays for their care, allowing Bart to keep his savings and pass it on to his family, if he chooses.

Unfortunately, the system of care that Bart relies upon is threatened as we are facing unprecedented challenges. These include: 1) lagging reimbursement rates, 2) inflation, particularly wage inflation, and 3) workforce shortages. Our business model does not work because we are not reimbursed for the true cost of providing care. We are further threatened by unfunded, minimum staffing mandates proposed by CMS and temporary staffing agencies which charge price-gouging fees and deplete the labor pool. These challenges were heightened by the pandemic when record numbers of employees left the medical field. These departures caused sharp declines in our census, which has been slow to recover because of the

shortage of staff members to care for those needing our care. Our finances are further challenged by costly VA regulations specific to Veterans' homes that don't apply to other nursing homes. We estimate that VA requirements unique to State Veterans' Homes cost MVH $2.7MM annually (excluding capital projects and mandates which cannot be easily quantified).

In FY2023, MVH lost $14MM and in FY2022, MVH lost $16MM. We have drained our capital replacement funds to cover the cost of operations by over $13MM in the last three years. This means we are stealing from our future to pay for our present.

The fix to the financial crisis in our industry is simple: fund the true cost of care. Medicaid and Medicare rates, VA Stipends, and VA Prevailing rates must be increased. These rates need to be tied to inflation indices to keep pace to mitigate the risk of falling behind year over year. Next, fully fund the VA Capital Grant Program so that we can continue to make improvements to our facilities. Finally, review and reduce unfunded regulations that increase cost. If you desire homes dedicated to providing high quality care for Veterans, then we must fund them adequately.

Staffing shortages are more complex, but there are steps that we can take:

1. Fully fund career pathways for individuals employed in the long term-care industry. Funding programs like "Earn While You Learn" increase the capacity to offer career pathways for individuals interested in health care professions.
2. Place an immediate halt to CMS's proposed minimum staffing rules. I appreciate that the committee has already opposed these rules and recognizes the detrimental impact these rules will have on the industry if passed.

As we stabilize the industry, we can begin to look at the initiatives which will ensure a sustainable system of care for older Veterans and their families, in both rural and urban settings. We have opportunities to invest in technology, collaborations across the continuum of care and innovative models of care and technology. These investments will yield better healthcare outcomes and quality of life for Veterans and their families. Investing in programs and ideas such as these means we can continue to lead the nation in services for Veterans as they age:

- MVH's newest facility is in Augusta and is built under the Small House Guidelines from the VA. This model of care is showing great promise of improved quality outcomes and staff retention. It is also providing a built environment which appeals to residents and their families. This is the future of care; however, this care is extremely expensive. Our annual budget increased from $16MM to $27MM. Please refer to the attached document for details.
- The Aroostook County Health Improvement Partnership which works to connect resources across the continuum of care. The Aroostook County Health Improvement Partnership is a Maine DHHS grant-funded demonstration project that's bringing together more than 20 partners in the public health, health care, and social services sectors, with a goal of reducing social barriers care – issues like transportation challenges, food insecurity, housing instability, and social isolation. The project, which is in its planning phase, is prompting deep investigation and discussion of how unmet social needs adversely impact the well-being of Aroostook County residents, as well as stimulating collaborative and creative problem-solving as the partners look to transform systems to deliver comprehensive, whole-person care.
- MVH is partnering with the VA on a pilot program through the Cleland Dole Act which is designed to enhance mental health services through the use of telehealth. We need more funding like this that builds capacity for mental health services. We know that the needs of Vietnam

Veterans are dramatically different than our WWII and Korean War Veterans. We need programs that will help us retool to better meet these needs.

- Create centers of excellence in the use of technology. Technology has the power to change what it means to have a disability and how we serve individuals with disabilities. There has been an explosion of technologies that are life changing for individuals with disabilities. Consider as an example technology that helps a blind person see or restores fine motor skills to someone with Parkinson's The use of integrated technology, AI, and robotics all suggest new ways of providing innovative, person-centered care to our residents at a lower cost. But, we need funding to modernize our care models and infrastructure for the future of Veterans' care.

It is critical that as we work to build and strengthen services across the continuum of care, we recognize that building up services may require expanding our investments, versus diverting them. For example, building up home and community care is essential. Done well, these investments can delay entry into Medicaid and into more costly care settings. However, doing so, will increase the acuity of patients entering nursing homes – and there will always be a need for higher levels of care than can be provided at home. Hence, we cannot fund one end of the spectrum in lieu of the other. We need a system of care for Veterans as they age.

While our industry is in peril, I have HOPE.

- We have a mission that **honors** the commitment made to serve Veterans when they committed their lives to serving our nation.
- We have **opportunities** through partnership, collaboration, innovation, and technology to provide the right care at the right time in the right setting to serve as many people as possible with the tax dollar. If there is a place that can effectively tackle the issues brought forward, test new ideas and ways of delivering care, and building a model of care for others to follow, it is Maine.
- We have **people** who choose to care for Maine's Veterans, and who do so with passion, integrity, teamwork and joy. They are the heart of the mission.
- The service we provide defines **excellence**.

A quick update on Bart. Not long ago, Bart passed away peacefully. I happened to be on site as his body, draped in an American Flag, was wheeled down the hallways filled with staff standing at attention, some saluting, others with hands over their hearts, to honor Bart has he began his journey to his final resting place. *This is our mission in action* – we help Veterans at the end of their life. We perform this mission with excellence, honor and compassion. While we face challenges, we offer a system of care worth preserving. With your help, we can ensure facilities, like Maine Veterans' Homes, are here for years to come to serve Veterans, like Bart, who gave their all for this country.

Respectfully submitted,

Chief Executive Officer
Maine Veterans' Homes
460 Civic Center Drive
Augusta, ME 04330
207-215-4000
sharonfusco@mainevets.org

MAINE VETERANS' HOMES
caring for those who served

The VA Small Home Model: A Modern Approach to Veteran Care

MVH Augusta is a proud example of the VA Small Home Model of care, established in March of 2021. This model is significantly different than traditional care.

*Picture 1 - **Traditional Nursing Home** (MVH - Caribou)*

*Picture 2 - **Small Home Concept** (MVH - Augusta)*

Unlike the traditional home with long hallways, the small home concept has homes with 10-14 rooms that encircle a living room, dining room and kitchen – all designed with the look and feel of a house. The footprint of the MVH Augusta facility totals over 180,000 sq. ft. with 130 total beds that are organized into 12 unique neighborhoods to cater to a variety of care needs, including long-term care, memory care, assisted living, and skilled nursing.

This model is producing **positive** results!

- Reduction in falls
- Increase in food intake and weigh gain
- Decreased use of medications
- Decrease in staff turnover

Understanding VA Community Living Center Design Guidelines

At the time the MVH Augusta Home was constructed, the VA required all new construction to incorporate small-house principles of design and care delivery to qualify for matching federal construction grants. Some of the VA Small House requirements include:

- All private resident rooms with dedicated bathrooms
- 10-12 bed households with their own kitchens, living rooms, dens, spas, and personal laundry.
- Community centers with shared services and social spaces.
- Minimum of 1,000 S.F. per resident total net square feet.

Cost Implications of Providing Care in a Small Home

There is no doubting the benefits of a small home design. But modern care comes at a cost. The small-house more than doubled the overall footprint of the former MVH Augusta Home, built within the traditional model of senior nursing care.

Because of the increased size and decentralized layout, these facilities are more costly to build and operate. After more than a year of operation, costs associated with both staffing and building operations are being understood with greater clarity.

- **28% more staff** are needed
- **140% increase in square footage** required resulting in an increase of **125% in facility costs** (heating, cooling, electric, water, sewer)

	Traditional Home - **Former Augusta**	Small Home – **New Augusta**	Traditional Home - **Bangor**	Traditional Home - **Scarborough**
Total Beds	150	138	150	150
Budgeted Staff	168	216	178	169
Annual Staff Budget	$8,659,000	$12,877,000	$10,408,000	$8,904,000
Staff Budget (per Bed)	$57,727	$93,312	$69,387	$59,360
Square Footage	69,615	167,233	93,740	72,060
Annual Facility Cost (Heating, Cooling, Maint., etc.)	$272,595	$614,692	$287,087	$199,834
Annual Facility Cost (per Square Foot)	$3.92	$3.68	$3.06	$2.77
Annual Facility Cost (per Bed)	$1,817	$4,454	$1,913	$1,332
Annual Total Cost	$16,993,000	$27,042,000	$19,494,000	$22,957,000
Annual Total Cost (per Bed)	$113,287	$195,957	$129,960	$153,047
	FY2021 Data	FY2023 Data	FY2023 Data	FY2023 Data

The Way Forward: Continuing to Care Those Who Served

As Maine Veterans' Homes continues to learn about the benefits and impacts of the VA Small Home model of care, we strive to work towards efficiencies and best practices that will allow us to continue upgrading our six Homes models that will support affordable, high-quality care for Maine's Veterans and their families for years to come.

Introduction Comments – Colleen Hilton
President, Northern Light Home Care and Hospice
Senate Veterans Affairs Committee Field Hearing
January 26, 2024

Good afternoon Senator King, I want to thank you for the opportunity to participate in this Senate Veterans Affairs Committee field hearing focused on long term care services for veterans.

My name is Colleen Hilton. I serve as the Northern Light Health Senior Vice President for Home Care, Hospice and the Continuum of Care. I also serve as the Board President for the Home Care and Hospice Alliance of Maine. I am a registered nurse and I have dedicated my professional career to caring for patients in their homes and community-based settings. Northern Light Home Care and Hospice is a member of Northern Light Health, a statewide not for profit integrated health care system. Our home nurses, therapists and hospice clinicians care for patients throughout the State of Maine serving urban and remote rural communities. Our staff travel 3.5 million miles, caring for 11,187 patients annually. Caring for patients living on islands off the coast of Maine requires creative partnerships, lobstermen and women are often a critical transportation resource for our staff.

We are also a unique home care organization providing a number of public health services including vaccinations, homeless shelter nursing services and transportation of fresh food to patients at home addressing Maine's food insecurity challenge.

Maine has the oldest population in the country, this includes an aging veteran's population. Veterans receive home care and hospice services through their veterans' health benefits and/or Medicare insurance coverage. On average we cared for 489 veterans in our home care and hospice programs, these are the services authorized by the Togus VA Medical Center. I know that many of our Medicare patients are also veterans, we don't have a way to precisely quantify this number.

Our home health services focus on recovery, quality of life and independence with the goal to reduce emergency room visits and hospital readmissions. The numbers of patients cared for every day across Maine exceed all the bed capacity in our local hospitals. The level of acuity is also rising as more and more medical interventions are happening on an outpatient basis or a surgical procedure that once resulted in a prolonged hospital stay are now being discharged on the same day.

Hospice care in Maine is growing and that is good news. Where Maine once was lagging in utilization of hospice – in 2021 Maine ranked 13th in the country for hospice utilization. What that means if about half of all dying Mainers die in hospice, remarkable support. Maine has four inpatient hospices across our state, one in Presque Isle, Rockport, Auburn and

Scarborough. I am especially pleased to report that we have housed veterans whose families needed respite at our hospice houses. Using respite allows families and caregivers enough support to enable the patient to return to the home setting to live out the remainder of their life surrounded by their loved ones.

I am deeply concerned that home care services for veterans and all individuals in need is at risk due to the significant payment reductions that the Centers for Medicare and Medicaid Services (CMS) started in 2020 when a new payment model – the Patient Driven Groupings Model (PDGM) was implemented. Congress charged CMS with ensuring budget neutrality and gave the agency authority to change payment rates in the PDGM model.

In November of 2022 CMS finalized a payment methodology that resulted in a permanent -7.85% percent cut to Medicare home health payments. In the calendar year 2024 proposed rule CMS recommended increases in the cuts to a new total permanent cut of -9.36% and other temporary claw backs. Due to significant outreach and advocacy by the National Association of Home Care and Hospice, state association and home care providers throughout the nation the 2024 final payment rule published by CMS did not have another payment reduction but rather a very minor 0.8% aggregate payment increase. The cuts CMS planned to implement will simply be pushed out to future years. The ongoing threat to home health payments is exacerbated by the Medicare Payment Advisory Commission (MedPAC) annual recommendations to congress for continued cuts. On January 11th, MedPAC voted to recommended that Congress reduce the Medicare payment rates for home health services by 7 % for calendar year 2025. We are stuck in a vicious cycle of industry instability and payment reduction proposals that threaten access to care, we are at an inflection point within the home health delivery system.

In the Senate a bill titled "Save the Medicare Home Health Program" (S2137) will stop CMS from imposing certain cuts and direct MedPAC to consider in their analysis the impact of all payers on access to care for the Medicare home health benefit.

We anticipate that veterans, patient's and families will experience historic access challenges to home health care. It's not because there is not a need and demand for home health services, but rather due to a workforce crisis, high inflation impacting the cost of medical supplies, and Medicare payment reductions for home health that impact our ability to hire and retain staff to deliver care in the home. Maine continues to struggle with a statewide shortage of RN's, currently projected as a shortage of 2250 nurses through 2025. We already have regions in Maine with minimal or no access to home care services. In other regions like Hancock County our home care program has only 1 RN to serve the entire county due to the significant shortage of nurses in that particular region. In responding to payment rates below the cost of providing care providers have reduced service to distant geographic regions and/or reduced the actual number of patients that will be accepted into care.

Due to the rural nature of our service area, we invested 15 years ago in the use of telehealth and remote patient monitoring to broaden our reach in serving seniors across the state of

Maine. On any given day, we are caring for 500 patients from Fort Kent to southern Maine who are taking advantage of this technology. Using technology, we can support people suffering from chronic heart and lung diseases. I believe the pandemic truly demonstrated the value of the vision we've had for the use of technology in the homes. When we were in the midst of the global pandemic, telehealth with video capability was incredibly beneficial.

Managing chronic health conditions can mean frequent trips to the doctor or hospital to monitor vital signs. Northern Light's Telehealth Program does the monitoring right from the patients home. Important health data is then transmitted to our homebased team where registered nurses can advise patients on the best course of treatment. With this support, we can keep many of our patients out of the hospital by early intervention of problematic symptoms all based on protocols established by the primary care provider. In 2023 we have cared for 260 veterans to support their aging in place with the support of telehealth.

Nursing homes in Maine are also experiencing significant challenges that impact veterans access to care. The potential closure of Maine Veterans Home locations highlighted the impact that staffing challenges and inadequate reimbursement is having on long term care. Veterans are cared for in nursing facilities throughout the State of Maine and all are experiencing the same challenge. Approximately 20% of nursing facility beds are empty due to lack of staff, other facilities transition their license to a lower level of care and for the 10-year period (2012-2022) closures resulted in the loss of 833 nursing facility beds. The CMS proposed staffing rule will require facilities to staff RN's 24 hours per day 7 days per week. This rule creates a perfect storm with regulations that require facilities to hire hundreds of nurses that simply don't exist given the shortage of nurses. Should this rule become final nursing facilities in rural and urban communities will close due to lack of RN availability and the predatory pricing practices of temporary staffing agencies that is unsustainable.

The solution to the nursing shortage is supporting Maine's nursing education programs to hire the number of faculty needed to expand student capacity and graduate nurses needed to fully replace the retiring out of our nursing staff. The Maine Nurse Educator Loan Repayment program is helping new faculty to teach full time by paying off master or doctoral degree debt for faculty. Unfortunately the national nurse faculty loan repayment programs managed by HRSA are not a good fit for rural states like Maine. I know Lisa Harvey-McPherson is working with your staff to reach out to HRSA to resolve the barriers.

I urge this committee to focus on the impact that Medicare and Medicaid payment policy is having on veteran access to post acute care services.

Thank you.

STATEMENT OF

MICHEAL POOLER, COLONEL, RETIRED

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ON

LONG-TERM CARE FOR VETERANS IN MAINE

January 26, 2024

Good afternoon, Senator King. I appreciate the opportunity to discuss Veterans' access to long-term care.

My name is Mike Pooler, and my wife Sue was a resident of the Augusta Veterans Home from October 2016 to April 2023. I am extremely fortunate to be on the Maine Veterans Home Board of Trustees. This is my and Sue's story.

I earned a reserve commission as a second lieutenant from the University of Maine at Orono in 1986. In 1990, I transferred to the Maine Army National Guard until my retirement from federal civil service and the Maine Army National Guard in 2019. In late 2007, I volunteered to deploy to Afghanistan, was in country from April to November of 2008 and returned home in January of 2009. These statuses and timelines are pertinent to my wife's long term care story.

My wife, Sue, was diagnosed with dementia in 2013 at the age of 48 and needed full time professional resident care by September of 2016. In between these dates, I was fortunate to be able to privately hire caregivers to come to our home and look after Sue during the day. These people, along with Sue's sister, provided daytime and some weekend care while I was working for the Maine Army National Guard. I had the night shift and weekends while I continued to work. During this home caregiving time, I never looked into any support from the VA for Sue's caregiving. I have a 90% disability rating from the VA and my understanding was there is no caregiver support for spouses of Veterans.

As I explored options for her future nursing home care, the Maine Veterans Home option rose to the top of the list. Thankfully, MVH reserves 25% of their beds for spouses of veterans. The reason she was eligible for a bed was because of my deployment. As a national guardsman generally unless one deploys, they are not eligible for a veteran's home placement. I know many guardsmen who served twenty to forty years and have never been deployed, and they are not eligible to use the MVH system. As the number of veterans declines over the next twenty plus years, the number of people eligible for MVH will decline. This seems to be the only business model where the customer base will decline, absent another few ten to twenty plus year wars.

Again, we were extremely fortunate the administration of the Augusta home was very prompt in responding. It took three weeks from the time I called MVH until Sue was admitted in October of 2016. I placed Sue on two other local nursing home lists as we went through the admission process and six months after Sue's placement, I heard back from one of them.

During Sue's stay, it was obvious from the start that the staff in Augusta were and continue to be special people. One of the first nurses I met, as she was talking to Sue, stated that she would never lie to her and would always tell her the truth. She was not going to tell Sue something just to calm her down. That is indicative of the dignity and respect the staff gives each resident. The staff takes great pride in the fact they care for veterans and their spouses, many times sacrificing higher wages at other places to care for them.

Over the years, and especially during the past three years, there has been tremendous staff turnover. As you may be aware, people with dementia need to see consistent faces to help alleviate stress. Also, each dementia patient has unique needs that staff learn during their time with the resident, which leads to higher quality care. Over the years of visiting our spouses, the staff become a second family to many of us. They tell us how our spouses are doing, any trends they see, what made them laugh, what is working with them or changes in behavior. Many weeks I spent more time with the staff than the rest of my family.

As Sue declined, the Augusta home worked very well with hospice and the local hospital, at times telling the hospital what needed to be done for Sue. During Sue's last week, they continued to closely monitor her and made her as comfortable as possible. When she passed at midnight on April 26th, 2023, the staff lined the halls, some crying harder than I was, as I wheeled her out.

Recommendations:

1. Stabilization of the workforce. This is directly tied to increased reimbursement rates, which need to be tied to inflation. A more stable workforce understands the residents better, notices things that are off sooner which could lead to finding problems before they cannot be resolved. These unresolved issues lead to worse outcomes and high costs down the road.

2. Cover the cost of VA and federal mandates.

3. There needs to be a way to have national guardsman and reservists who have not been on active-duty d or deployed become eligible for access to a state veterans' home. Absent more wars, this will be the only way to continue the viability of the MVH system.

Thank you for the opportunity to provide personal insight into veteran long-term care in Maine.

Veterans of Foreign Wars
Of the United States

VFW
VETERANS OF FOREIGN WARS.

Department of Maine

STATEMENT OF
STEVEN J. SANPEDRO FIRST SERGEANT, RETIRED
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
LONG-TERM CARE FOR VETERANS IN MAINE
January 26, 2024

Good afternoon, Senator King and Members of the U.S. Senate Committee on Veterans' Affairs

It is an honor and a privilege to address you today regarding access to long term care for our Veterans in Maine. My name is Steven SanPedro, I am currently the National Councilman and a Legislative Committee Member for the Veterans of Foreign Wars representing Maine. I served as the Maine State Commander of the VFW in 2016-2017. In addition, I have served on the Maine Veterans Home Board of Trustee from 2015 to present and currently serve as Vice Chair of the Board.

As I have traveled throughout Maine, I have heard nothing but great things about the Maine Veterans Homes. It is clearly the choice of most Veterans.

However, as a Veteran myself, I have great concern for the future care of all Veterans throughout the nation but particularly, right here in Maine. These men and woman have served their country and deserve to be cared for as the true heroes they are. The Maine Veterans Home's ability to do that is very much in jeopardy due to today's rising costs of healthcare.

Maine Veterans Homes is a non-profit organization providing quality care for over 40 years. We operate six facilities throughout the state, many of which have received National accolades. CMS has rated four of our homes with five stars and one home with four stars. Three of our homes have held the gold standard level of care, and another one was given silver by The American Health Care Association. We take great pride in what we do.

Three main areas that need to be addressed for us to overcome the challenges we face are: the effects of inflation, current reimbursement rates, and staffing.

Cost of Care – Maine Veterans Homes have the unique challenge of meeting requirements from both the State of Maine and the VA, adding the need for additional resources to cover expenses not incurred by similar facilities. Inflation and the sky-rocketing increase in costs of goods has created a financial

deficiency that can't be met, also causing great hardship. This has caused many other nursing homes in Maine to consider closing their doors and could cause Maine Veterans Homes to consider the same thing.

Reimbursement - Reimbursement rates are no longer in line with today's costs of a Veteran's care. The current VA reimbursement rates are $115.62 for per diem care and $49.91 for domiciliary care. These stipends, in conjunction with Medicare, Medicaid, commercial health insurance and private pay are all used to assist the Veteran in paying for their care, however funds still fall way short of the total cost. As a non-profit entity, we are left to absorb this difference. We ask that these stipends be raised to adequately provide quality health care to the Veteran and more accurately reflect the true cost of their needs.

However, if you are rated 70% or higher disabled by the VA your care will be taken care of by the VA with no stipend at a lower rate of cost of care. The VA has a set price no matter the type of care a Veteran receives if they are rated at 70%. Long Term, Skilled and Assisted Living care for a Veteran do not cost the same. This needs to be changed to reflect the different types of care and the cost of those services provided.

Staffing – Like with many other things, the pandemic made an already strained healthcare system even worse. Over the last three years we have seen a large increase in health care professionals leave the field, not to return. Many seasoned professionals chose to retire, others didn't want to endanger their families and chose to switch careers in an effort to be safe, this caused the medical field to see shortages like never before. As a result of this, organizations like ours are forced to participate in wage wars and hire more contracted nurses at double and triple regional pay rates in an effort to fill very necessary positions. A secondary effect of these staffing shortages is that workloads have been too much to bear for the professionals that have remained leading to burn out and more turnover. This can be seen not only in Maine, but throughout the entire nation.

No one can see the future but we must fix what is in front of us right now. This can be done by paying the true cost of care in all areas. To provide this quality healthcare it cost money and it needs to be provided appropriately. Stop unfunded regulations that increase cost to execute them. Fund education to help with staffing issues.

Respectfully Submitted

Steven J. SanPedro
VFW National Council Member – Maine
VFW National Legislative Committee Member – Maine
VFW Department of Maine Legislative Chairman
Sanpedro105@roadrunner.com

Written Testimony of
Joy Barresi Saucier, RN, MHA, FACHE
Executive Director, Aroostook Agency on Aging
Before the United States Senate Committee on Veterans' Affairs Field Hearing
January 26, 2024
Augusta, Maine

Senator King, thank you for the opportunity to testify today. It is an honor to join you, Veterans, other esteemed guests, and my fellow panelists for this hearing.

I am Joy Barresi Saucier, the Executive Director of the Aroostook Agency on Aging based in Presque Isle, Aroostook County, Maine. I am grateful for the opportunity to delve into challenges facing older Veterans in rural Maine and emphasize how collaboration between Veterans services and community-based programs can strengthen the response to these challenges.

At the Agency, we know that as people age, they want to make their own decisions and live independently. When they age in their home community, they continue to contribute their knowledge and talent to make their community stronger. The core mission of Agencies on Aging is to help this to occur.

Nationally, there are 622 Agencies on Aging funded in part by the Older Americans Act through the DHHS Administration for Community Living. Agencies on Aging provide a variety of services and function as a national network of supports with unique assets and flexibilities that address many challenges faced by older people, including older Veterans.

All Agencies serve as Aging and Disability Resource Centers (ADRCs), as designated by the Administration for Community Living, providing confidential, unbiased telephone and in-person information and support to older people, those with disabilities and their family caregivers. These agencies often act as the first and only responder to those with questions or challenges that impact their ability to live independently. They intimately understand the complexity of programs, rural challenges, and the formal and informal community resources that exist at the local level. In FY2022, Maine's Agencies on Aging provided responses to over 291,000 such requests for Information and Assistance.

The Aroostook Agency on Aging serves approximately 5,000 residents of Aroostook County each year, nearly 300 of which are Veterans. The Agency offers over 20 programs and services, such as nutrition, transportation, caregiving, volunteer opportunities, information, and referral. In addition, our consumers may require home-based care, including personal support, which is provided by the Aroostook Agency on Aging or other personal care providers in the region. The Agency also serves as the Veteran-Directed Care provider for Aroostook County.

With more than 25% of Aroostook County residents over the age of 65, the Agency is central to the well-being of our communities. Recently as the lead entity for the Aroostook County Health

Improvement Partnership (ACHIP), a one-year planning project funded by Maine DHHS, the Agency completed a community needs assessment that provides a window into the challenges and disparities faced by older people, many of which are heightened by the realities of life in our rural region. To highlight just a few of our findings:

- The older adult population of Aroostook County has a rate of disability that is 25% higher than the statewide rate, with significant differences in cognitive and self-care disabilities – 21.2% and 44.1% higher, respectively (U.S. Census Bureau, 2021). The prevalence of Alzheimer's disease among Aroostook County residents is 10.7%, the highest of any county in Maine; it is the fifth leading cause of death for County residents (Maine CDC, 2022).
- Socioeconomic data from the United Way's ALICE initiative shows that 56% of Aroostook County's population aged 65+ lack the financial resources necessary to afford basic expenses (United for Alice, 2023). These challenges are exacerbated for the 48.5% of Aroostook County's older adults who live alone (U.S. Census Bureau, 2022). Confirming this, the Elder Index (2023), a measure of the income that older adults need to meet their basic needs and age in place with dignity, calculates that the income needed by a single adult aged 65+ in Aroostook County significantly exceeds the median income for this population, leaving financial gaps many struggle to address.
- Of older adults living alone in The County, 45% live outside of the "service hub" communities; 26% live in communities with fewer than a thousand residents (U.S. Census Bureau, 2022). These dynamics, coupled with the fact that older adults are less likely to drive, often make it more difficult to establish and maintain social connections – as well as access key services. Although virtual interactions have become more commonplace, particularly during the COVID-19 pandemic, 34% of older adults in The County do not have Internet or computer access in their homes (U.S. Census Bureau, 2021).
- Finally, older adults in Aroostook County frequently experience challenges in meeting their home maintenance and modification needs. Nearly 75% of the homes owned by older adults were built before 1980 – qualifying them as "aging housing stock" (U.S. Census Bureau, 2022). A lack of affordable housing leads many older adults to remain in homes of poor quality, ill-suited to safely aging in place (Maine State Housing Authority, 2023).

Compounding these basic factors, our rural region is further challenged by lack of access to primary and specialty care, limited access to public transportation, scarcity of affordable housing, fewer community supports, and workforce challenges, especially related to direct care in-home support workers.

As part of the ACHIP community needs assessment, lived experience information testimony was gathered, including the following from Veterans:

Veteran, 63 years old: "If don't get the help I need, I go without, but we're so isolated here, it's kind of hard if I need help or need to ask somebody a question. It's usually I have to go a hundred and something miles to Bangor to see somebody, or I could call them on the phone if I could get the answer over the phone."

Veteran, 82 years old: "In the future perhaps I can see having trouble getting transportation because I live twelve miles outside of Caribou. Well, it kind of gets back to the same thing in transportation. Anytime you need medical attention, well we have to travel somewhere, I have traveled as far as Bangor for some surgery on my leg. I have blood clots in my leg, and I've also got as far as Mass General in Boston for some internal consultations, I guess."

Veteran, over 65 years old: "I have a pipe coming out from underneath my house, running back down the concrete slab and then out into the yard to dump the water from the washing machine. I got the piece. I've called, I'm going to say about eight people. Okay, well, we'll call you back and we'll get that taken care of, I'm still with that pipe out in my stinking yard, they won't call back, man. I haven't figured that one out yet. I can't get under there because of my knees, they replaced both of them. My back is messed up and that's all from the military, so I can't get under there and take care of it. … I got a few friends, but they're older, just like me, all older, and they can't do stuff, so I just live with it."

Veteran, 62 years old: "The financial issues impact your psychological issues because you're worried about, "Do I have enough money to pay the bills? Am I going to be able to keep vehicle insurance? Am I going to be able to pay the vehicle loan? Am I going to have enough food for me? Am I going to have enough food for the animals? Am I going to be able to make my appointments?" Because a lot of my appointments are dealing with the VA that's down Bangor or Togus. But I get mileage paid but that takes anywhere from 4 to 6 weeks to get that mileage back. You end up taking two trips down there. That takes $200 to $300 out of my monthly income, and I have to wait 6 weeks to get that back. That means I have to adjust my lifestyle. That means either I cut here a corner or cut there a corner to less somewhere."

Due to the intensity of the challenges and resources limitations in rural communities, I believe it is imperative to continue to leverage local assets and collaborations. The ACHIP partnership has highlighted the strength of our local community-based assets, which at times may be underutilized.

One excellent current example of such a collaboration is the Veteran-Directed Care Program, which is conducted by the VA Maine Healthcare System in partnership with three of the state's Agencies on Aging. Agencies on Aging see the benefits of this program related to empowering the Veteran to determine their own service plan, as well as cover the cost of other goods and services specific to their care needs.

Although we have had limited referrals to this program in Aroostook, we believe this program can be a good option for Veterans who want to self-direct their services. Some barriers to participating in the program include lack of awareness of the program, lengthy enrollment process, difficulty identifying a worker, challenges with self-managing the program, and lack of a local personal support structure. Additional resources for targeted program outreach by both the VA and Agencies could prove beneficial to increasing utilization. Program revisions that allow for the utilization of technology to enable distant caregivers to serve as authorized representatives would also increase the value of the program.

Additional opportunities for collaboration between the VA and Agencies on Aging exist in other areas, such as strengthening partnerships focused on navigation of community resources and integration of specialty services.

Given that Agencies on Aging are Aging and Disability Resource Centers (ADRCs), they could be strengthened and leveraged to provide additional supports targeted to Veterans, especially those living in rural communities where formal VA community supports are limited. As part of our ADRC functions at the Aroostook Agency on Aging, we are implementing a Congressional Directed Spending project to establish Access Points for Aging in about 20 communities throughout the region. These Access Points will bring additional resources and technology to facilitate outreach and service delivery addressing barriers and easing access to needed services. Collaborating with the VA, we could leverage these sites to enhance offerings for Veterans. This is just an example of how the VA and Agencies on Aging could cooperate and utilize existing community assets to better support Veterans.

Likewise, Agencies on Aging also create connections with specialized community services, which may prove beneficial for Veterans. In Aroostook, through designated ACL funding, we are developing a regional, community-based Memory Center to serve those with dementia and their caregivers. I anticipate that there could be opportunities to collaborate with the VA to leverage this new center or develop other specialty offerings to serve Veterans.

In closing, I see great opportunities to address our rural disparities and further develop responsive services through innovation and collaboration between the VA and community-based organizations like Agencies on Aging. Agencies on Aging stand ready to further partner with the VA to improve awareness of and access to services, issues that often prove challenging to those living in rural America.

Thank you for your consideration and unwavering dedication to those who have served our nation.

Joy Barresi Saucier
Executive Director, Aroostook Agency on Aging
joy.b.saucier@aroostookaging.org

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel; (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay)

STATEMENT OF PAUL SAUCIER, DIRECTOR, OFFICE OF AGING AND DISABILITY SERVICES
MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEFORE THE
FIELD HEARING OF THE UNITED STATES SENATE COMMITTEE ON VETERANS' AFFAIRS
"THE STATE OF VETERANS LONG-TERM CARE IN MAINE"

AUGUSTA, MAINE
JANUARY 26, 2024

Good afternoon Senator King, and thank you for providing this forum to discuss long-term care for Maine's veterans. I appreciate the opportunity to discuss Maine's system and how it relates to the Department of Veterans Affairs' offerings. I will use the term long-term services and supports (LTSS) to describe a range of services including caregiver support, home care, adult day services, residential facilities and nursing facilities.

MaineCare, Maine's Medicaid program, is the largest payer of LTSS in the State. This is true nationally as well. In 2021, Medicaid paid for 44.3% of national LTSS expenditures, and the VA paid less than 2% (Congressional Research Service, 2023). Many Maine veterans rely on MaineCare for LTSS, including 42% of Maine Veteran's Homes (MVH) nursing home residents. Although the federally-administered VA system and the state-administered MaineCare program operate independently from one another, they face similar challenges in the post-pandemic era. ***Attracting and maintaining a well-trained workforce is the single greatest challenge facing LTSS in Maine. This is an area in which the federal government can have meaningful impact through a substantial and sustained effort in partnership with states and providers.***

Expanding and Retaining a Well-Trained Workforce

The need for LTSS will continue to grow as Maine's population ages, and the single biggest constraint to growth is the availability of workforce. Maine has invested more than $300 million with funding provided through the American Recovery Plan Act, enhanced federal Medicaid match, federal CDC grants and other one-time sources. This federal funding has been put to good use and is greatly appreciated, but Maine's structural workforce challenges are not going away. ***This is a long-term problem that will require sustained federal support over time.***

Pay is certainly important, and Maine has made a significant commitment in this area by adopting payment policy that assures rates will cover wages for direct support workers (DSWs) that are at least 125% of the State's minimum wage. The State's minimum wage is indexed to inflation, and as it rises, so will Maine's LTSS rates.

Pay is not the only factor influencing the supply of DSWs. Availability and portability of training is another key factor. To that end, Maine is adopting a universal DSW credential that will enable workers to apply their expertise across home and facility settings for individuals with physical, intellectual or age-related needs. This will be more accessible for workers first considering the direct support profession, especially younger adults and others newly entering the job market. It also complements efforts in small house models and elsewhere toward universal workers who engage with residents to assist with multiple needs and preferences, including personal care, meal preparation, laundry and social activities. The approach is more person-centered, efficient and satisfying to both the worker and resident. It results in significantly more staff time spent in direct contact with residents, which has been associated with higher quality care. Green Houses, one specific form of small house model, have documented staff turnover rates that are half those of traditional nursing homes. ***This is a very promising area to which the VA could contribute with more research and development from its own experience.*** The VA has funded the construction of several small house model homes across the country, including one right here in Augusta. We would all benefit from understanding the outcomes and operational best practices emerging from these homes.

Maine has also promoted healthcare and direct support professions with marketing campaigns, including Caring for ME, which is specifically targeted to direct care and support professions. Through focus groups and surveys of workers, we learned that individuals drawn to the work are compassionate and committed. These themes run throughout the campaign, which takes individuals from a traditional or social media ad to an informational website that includes worker testimonials and job postings from the Maine Department of Labor's JobLink.

Maine has also seen that self-directed care can be an important part of the workforce solution. By expanding and providing more information about our self-directed home care options, Maine has grown this option during and after the pandemic. In most cases, self-directed care is provided by a family member, but the use of non-related caregivers is also rising. ***This is another area in which the VA could assist, by expanding the availability of its Veteran-Directed Care program.***

Balancing our System

The VA and Maine's state LTSS programs also share an interest in ensuring a system that has a necessary balance of home and community-based services (HCBS) and institutional services. Older adults have consistently expressed an overwhelming preference for aging in their own homes, which is reason enough to pursue more HCBS options. But we also learned during

COVID that having an appropriate balance contributed to the resiliency of our system. Just before the pandemic, Maine's nursing home occupancy was 90%. In the depths of the pandemic, it dropped as low as 74%, and is now hovering at about 80%, where it has been for several months. Despite available capacity, most of Maine's nursing homes have not been able to return to full staffing, and are serving fewer people today than they did before the pandemic. Fortunately for Maine, the story has been quite different in the home care sector. To be sure, home care has also experienced workforce challenges, yet Maine's three largest home care programs[1] grew by 17% during the pandemic, and are now serving nearly 1,000 more individuals than they did at the pandemic's onset. We do not know if this shift toward HCBS was a result of increasingly strong preference for home care in the face of COVID, or declining availability of nursing facilities. Likely it was influenced by both factors. What is clear is that the growth in home care was able to soften the impact of reduced access to facility beds. The VA has recognized the importance of balance, projecting increasing growth in its HCBS options over time in a recent GAO report. ***To date, the VA's current balance lags Maine's and most states', and Maine would welcome a significant increase in VA home care availability.***

Thank you for this opportunity to discuss the status of Maine's LTSS system and its role in serving veterans.

[1] The three programs are the MaineCare HCBS waiver program for older adults (Section 19), the MaineCare State Plan home care option (Section 96, Private Duty Nursing), and the State General Fund home care program (Section 63).

Statement of

Kathleen Swinbourne, Family caregiver to

Navy Retired Vietnam Veteran, Clare John Swinbourne

Before the Committee on Veterans' Affairs

United States Senate

On Long-term care for Veterans in Maine

January 26, 2024

Good afternoon, Senator King, thank you for the opportunity to participate in this Senate Veterans Affairs Committee field hearing on long term care services for veterans in Maine. My name is Kathleen Swinbourne and I'm from Topsham, Maine. I'm a Registered nurse in the State of Maine, License massage therapist, longtime yoga instructor and business owner. I'm here to share my experience as a family caregiver for my father, Clare John Swinbourne, an 85-year-old Navy veteran with 20 years of service and three tours in Vietnam. My dad was exposed to Agent Orange; and suffers from Parkinson's dementia and PTSD.

In 2012 my dad was diagnosed with Parkinsonism symptoms and from the instruction of a family physician he was encouraged to apply to the VA for disability but was denied due to the diagnosis "Parkinsonism" rather than Parkinson's disease.

My active care for my dad began in 2019. At that point, my dad had been living with Parkinsonism symptoms for 7 years. His gait was off, and he walked with a cane. He was struggling with his executive function and experiencing intense mood swings and long bouts of depression. One day in December of that year he suggested we hang outdoor wreaths at my parents' home. We walked to the front of the house, and he gestured for me to walk ahead of him. He was often self-conscious of his slow and laboring walk. I went ahead and in moments I was startled by his yells behind me. I turned to see my dad lying on the ground with blood on his hand and knee. I ran to help him. I could tell by the blood and shock in his eyes that he had no warning that his body was going to give out on him. He was embarrassed and apologetic and I helped him to his feet. I put my arm in his and aborted the wreath hanging to lead him inside to care for his wounds. We walked down the driveway to the garage, and he took one step into the door and we both crashed down on the cement. My dad landed on the same bloody knee and hand. The fall happened so quickly, I had no opportunity to brace myself or protect him from falling. This time, he was sobbing and in shock. I held my dad for a long time as he cried. I can't say I knew how he felt, but I realized with him that the Parkinson's disease was progressing and the body he knew and trusted his whole life was beginning to betray him.

I eventually got him to his feet. Inside I cleaned and dressed his wounds and settled him on his comfy recliner. All the while he apologized for falling, which I told him wasn't his fault. Once I got him settled, I went downstairs in a separate room and cried uncontrollably. I sat there for a long time crying and praying. I knew I needed to figure out how to care for him with this disease and felt overwhelmed.

The next day I called his primary care doctor and reported the event and requested urgent assistance with my dad's mobility and safety. His doctor put in a referral for homecare. Within a day Chan's of Maine came to my parent's home. The process began with a social worker who interviewed my parents and I and assessed my father's needs. At the end of the conversation the social worker took me aside and explained that her organization can help my dad, but since he was a veteran, she felt he would get better care through the VA. She spoke highly of the VA and all the services offered to veterans. She told me it would be very difficult to get his disability and will become a full-time job. She cautioned me that I may feel like giving up during the pursuit, but don't. The social worker was right about everything!

I followed her advice and immediately pursued my dad's disability with the American legion at the VA in Togus, Maine. We submitted the application and then attended many medical appointments to fulfill the requirements. Two months into the process the pandemic began. Consequently, appointments were cancelled, and I was regularly and persistently trying to reschedule them. It took about a year to complete this and finally my father was determined to be 100% disabled in August 2021. As soon as my dad's disability was granted, we applied for readjudication of his benefits under the Nemer Settlement.

During the year of pursing his disability I had many conversations with the American Legion representative. I felt overwhelmed with my dad's care needs and uncontrollable rages due to Parkinson's dementia. Falls were happening more often, and I felt ill equipped to manage the progression of his disease and maintain harmony at my parents' home. The representative suggested I call the VA help line for caregivers, so I did. The trained worker on the line calmly listened to me as I cried and tried to explain the stressful circumstances of caring for my dad with this degenerative disease. At the end of the call this kind woman connected me directly to a social worker at the VA Togus who was part of the Family caregiver program. I will never forget this conversation as it brought me a feeling of hope that I wasn't alone and there are resources at the VA to help families care for their loved ones. She told me about the family care giver program and how to apply to be a paid caregiver. I quickly applied and after a few months was accepted into the program in March 2021 as a stipend part time caregiver. I took advantage of counseling for caregivers and joined many support groups to learn as much I could about Parkinson's dementia. Through her guidance I enrolled my dad in the healthcare system at the VA and gradually moved his medical care from the community to the VA throughout the next two years.

Based upon what I was learning I realized the need to handicap my parent's home, so I applied for a grant at the VA to do this. This process was almost as arduous as applying for his disability. I needed to coordinate with outside contractors to give me estimates for construction. I had to meet with a VA contracted physical occupational therapy practice who assessed the needs at the home. They wrote up an assessment and faxed it to my dad's primary care at the VA and then I waited months for a reply. I kept calling primary care and they told me they hadn't received a fax. Then I would call the physical therapy practice and they insisted they sent it. After this back and forth went on for two months I asked to speak with the manager at the practice and she said she had a contact at the VA and would get to the bottom of this. Turns out, a form was being faxed numerous times, but it wasn't the right form, and this wasn't being communicated to them nor me. As soon as the form was corrected the VA evaluation began and I submitted a detailed application for the grant. Once the grant was approved in a few months I then hired outside contractors to do the work and after almost a year we installed a handicap shower, wheelchair ramp, stair glide, widen doors and grab bars throughout the home.

In February 2022 we hadn't heard a response from the claim we filed a year before for the readjucation. I called our American Legion representative many times to receive the same response, it hasn't been processed yet. I then contacted Senator King's office for help on this delayed response to my dad's claim and within two weeks my dad's application was located and he received his back pay, which we immediately began to use for a paid part time caregiver we hired. My dad's needs were steadily increasing, and both my mom and I were feeling the mental, emotional and physical stress of caring for my dad around the clock seven days a week. Even though I was a paid part time caregiver this wasn't enough for me to live off, so I simultaneously pursued nursing school with the intention of caring for my dad. I also began to investigate into ways for more help from the VA. I applied for full time status with the caregiver program and was denied. I attempted to call the Vet direct care program over 50 times in a few months and never received a call back. I called my caregiver appointee and director of the caregiver program numerous times desperately asking for more assistance. I was informed it maybe time to look at nursing homes for my dad, but we didn't want to do that. I felt if we could get more money for home care, we could make it work. As my dad's dementia increased this quickly showed us, we were in this over our heads as he kept calling 911 during mental rages and bouts of agitation. After numerous ER visits and eventually a hospital stay it was recommended, he enter a rehab facility. During rehab he received the maxumus assessment and was assessed at long term care. Miraculously a bed opens at MVH in Augusta and my dad was moved into one of their wings.

MVH is a beautiful facility and has amazing offerings: a chapel, theater, gym and pub with regular events and live music. To me and my family it was a Hilton hotel for the elderly. However, with my dad's severe and unmanaged dementia it was scary for my dad to be there. His current condition needs constant care. His change in personality and temperament is often unbearable to be around for staff members who aren't trained to manage his disease and these circumstances created a lot of stress for him, their staff and our family. He repeatedly threatened to leave and would regularly tell me he was terrified to fall asleep at night because he thought the staff was going to hurt him. We tried to reassure him, but its difficult to rationalize with someone who has dementia. I had regular conversations with the primary care team at MVH to figure out how we could create more ease for my dad and address why he was being told he could stay or go at will. To my family and I we knew he didn't have the capacity to make his own decisions, but I was informed by the primary care team at MVH that they didn't want to the be the ones to initiate taking away his right to decide and our family similarly was apprehensive. MVH reached out to my Dad's VA primary care team at the height of my dad's threat to leave and the social worker was able to speak with my dad and then contacted me. It was clear to both of us my dad was ill equipped to think rationally. This was before Christmas, and I was told that the primary care team was going to meet and figure out the next steps. I still haven't heard back. Two days before Christmas my dad called a cab at MVH. The staff called my 84-year-old mom and she drove to pick him up. With his dementia mind he promised my mom he would return to MVH after Christmas. Unfortunately, when the time came, he refused to return. Without proper medical guidance we ended up feuding as a family trying to figure out our next steps. We were told he couldn't return to MVH as he exceeded his allotted days away, but we didn't know who to turn to. After a couple of uncomfortable days for my dad he ended up back in the local ER and eventually transferred to the Togus ER and is now in Long-term care at Togus VA.

My siblings and I have many conversations trying to figure out what we could've done differently. As much as we loved MVH it wasn't the type of skilled setting my dad needs for advanced Parkinson's

dementia. When I visited him at Togus the first thing he said to me was, he feels safe there. He's monitored regularly by doctors and nurses and the setting is more controlled for his current needs. I recognize that chaos can eventually lead to order, but walking alongside him through this difficult disease has truly been a grueling process.

I'm here today to share my story to tell others caring for Veterans, to not give up. I'm also here to share the things that I feel need improvement at the VA. I'm so happy with the benefits we've received. Even though many times it felt like I was trying to break down a brick wall, once the wall came down, I was able to tap into a wealth of resources for my dad and myself to support his disease process. I wish I had a case manager or medical social worker to guide me through the appropriate channels and check points to regularly evaluate my dad's condition and needs and to make sure his medical records were always up to date and to help us move through the stage from being at home to nursing level of care. I know this is the intention of the VA to provide a medical social worker and we were assigned one, but this wasn't our experience, and it was very difficult for me to connect the primary care team with the caregiver program and it was also challenging to know the path to follow and the steps to take and to get a call back from the social work team. We often fall upon the next steps through crises. I was regularly asking for help, but so often my phone calls weren't returned. When my dad went into rehab, I was undergoing an extensive months long process to re-apply for full time caregiver status as well as Vet directed care. By the time there was a decision my dad simultaneously was admitted to the hospital. Why is there such a long wait to apply for support? I realize there's a staffing shortage but meanwhile families and caregivers are suffering trying to care for the veterans with little pay. It's a huge sacrifice and although my father chose to serve in war, my mother and I didn't yet we've been paying the price for my dad's war related disease as I've given up virtually my 40s to care for my dad and my mother has compromised her own health in the process.
In an ideal world veterans and families would benefit from a medical social worker to educate them on the process of the disease and its progression and guide them through the proper channels in moving from the home to nursing level care. Additionally, the medical social worker can bridge the families to the providers for regular geriatric evaluation and management and the care giver program upon immediate diagnosis of a war related disease. The VA has all the big pieces that can help. It's the little stuff, connecting the dots between the programs, where things fall apart.

I'm so grateful to your office Senator King, as I regularly contacted them for assistance when I was unable to receive return calls and clear guidance from the staff at the VA. I'm certain the support of your office is what allowed me to experience progress and momentum in my dad's care. However, I don't feel veterans and families need to take it to this level. Calls should be returned. Guidance needs to be available, and the application process is too extensive for aging veterans who don't have a young family member or advocate who can give up their job to pursue their benefits and care. For five years I temporarily gave up my career and income for my dad, because I love him, and I believe in honoring those who fought for our freedom, but I've greatly compromised my financial, physical, mental and emotional stability due to the constant stress and time of this commitment. If I had been compensated for caring for his full-time needs, I may feel differently but I was doing full time work for part time pay and balancing nursing school to responsibly pursue a line of work I was hoping to use in the care of my dad. I believe the VA is a wonderful organization with an abundance or resources for families and veterans and I'm hoping that the refinement of better communication and correspondence and leadership from the primary care team can created positive change for veterans and their families.