Providing Health Care for Aging Veterans

Susan G. Cooley, Ph.D., Marsha E. Goodwin-Beck, RN-C, MA, MSN, and Judith A. Salerno, M.D., M.S.

For more than 20 years, the United States Department of Veterans Affairs (VA) has faced the growing challenge of planning for a veteran population that is aging faster than the general U.S. population. Even though the overall size of the veteran population has declined since the Korean War, the proportion of older veterans has increased dramatically. The median age of veterans is now approximately 58 years, compared to a median age of approximately 35 years for the general population.

The number of veterans aged 65 or older is expected to peak this year at 9.3 million, with World War II and Korean War era veterans comprising the majority of these individuals (Sorensen & Field, 1994). 66% of all males aged 65 and over in the United States are veterans. A second peak of almost 9 million veterans aged 65 or older is expected to occur about 2015, as a result of the aging of Vietnam War-era veterans (Sorensen & Field, 1994). By the year 2020, 51% of the entire veteran population (an estimated 8.2 million of the total 16.1 million veterans) will be 65 years or older (VA National Center for Veteran Statistics and Analysis, 1994).

As in the general U.S. population, the old-old (i.e., persons aged 80 and over) are the fastest-growing segment of the veteran population (continued on page 8)
A Tribute: In Gratitude To Aging Veterans
“For purple mountain’s majesty...”
Saint Louis University and the Missouri Gateway Geriatric Education Center have a history of developing innovative games for training health care professionals. These include Geropady, The Geriatric Medication Game, Senior Safety Solitaire, and our ever-popular Crossword Puzzles. We reviewed the theory of utilizing gaming for education in *Aging Successfully* Vol. 8, No. 1.

Dr. John E. Morley, Dammert Professor of Gerontology, has developed a web-based, interactive educational game, “Longevity” for geriatrics caregivers and educators. More than 200 questions are distributed over eight game levels. Test your knowledge of geriatrics diagnostics and management as you help patients move from the ICU to Assisted Living. Game success is measured by maximizing “longevity points” for your patients.

Like other electronic games, players can compare themselves against all previous players or compete against fellow group members (for example, classmates, workmates, etc.). Highest scorers receive the acclaimed Methuselah Award. “Longevity” can now be played online at [www.healthandage.com](http://www.healthandage.com).

In addition to automatic text-based and audio feedback on all questions and answers provided by Dr. Morley, players can chat online with Dr. Morley about any and all geriatrics issues.

There is a $40 fee to play “Longevity,” which is accredited by the Albert Einstein College of Medicine for 4 hours in Category I credit towards the AMA Physician Recognition Award.

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**Topic: Mental Health/Treatment**

An 82 year old presents with a 50 pound weight loss, atrial fibrillation and proximal muscle weakness. His eyes are hooded. He is depressed. He has a history of smoking two packs per day and has COPD. A cortisol level is 27 mg/dl. Which of the following tests would be most helpful in making the diagnosis?

- A. Birmingham Apnea Score
- B. Epworth Sleepiness Apnea Score
- C. Polysomnography
- D. London Sleep Score
- E. Presence of obesity

Score: 23400  
Level: 8  
Question: 10/10

Top scores:
1. Christophson  560000000  
2. Jane Doe  560000000  
3. Jane Doe  560000000  
4. Jane Doe  560000000  
5. Jane Doe  560000000

submit
ACROSS

3. Chromosome 21 is associated with Alzheimer’s disease and this congenital condition
6. This test for dementia involves putting marks in a circle
8. This condition is diagnosed in persons with cognitive impairment that is not severe enough to warrant the diagnosis of dementia
11. This neurotransmitter has historically been associated with Alzheimer’s disease
13. The core of the plaque in Alzheimer’s disease
15. This gene leads to the production of an enzyme that cleaves to amyloid precursor protein
16. In persons with agitated dementia, this drug causes less tardive dyskinesia than haloperidol
17. This couple was instrumental in the development of the Mini-Mental Status Examination
19. Persons with Alzheimer’s disease can often present with this symptom
20. A dementing disease of New Guinea tribe members
21. A dementia often associated with abnormal behaviors is characterized by deposition of these bodies in the brain
22. The first name of an herbal product used to treat dementia
23. Dementia due to multiple strokes is now called ___ dementia

DOWN

1. The first name of Alzheimer
2. The development of this condition is a major reason for the admission of demented persons to a nursing home
4. This compound is elevated in the blood of persons with dementia who have folate or vitamin B12 deficiency
5. This acid is elevated only in persons with vitamin B12 deficiency
7. Generic name of a new drug to treat dementia
9. This condition is associated with many “I don’t know” answers on the Mini-Mental Status Examination
10. Alzheimer’s disease is characterized anatomically by plaques and neurofibrillary ___
12. The protein involved with neurofibrillary tangles
14. ___ Spongiform Encephalopathy is a disease associated with cows
16. A president of the United States who developed Alzheimer’s disease
18. Pseudobulbar palsy can be recognized when a person ___ when he or she means to cry

Puzzle answer is on page 23.
Living Longer....Living Stronger

This column seeks to answer questions, provide information, and to challenge each of you to live longer and stronger. In each issue, Dr. John E. Morley pens some of his suggestions.

Q

What is prostatism?

A

Prostatism is a term used to define a group of symptoms that occur in older men with problems associated with urination. The symptoms reported include incontinence, frequent urination, the need to get up at night to pass urine (nocturia), and a weak urinary stream. Additionally, males with prostatism often find that they have trouble controlling their urine once they get the urge to go. In general, prostatism is associated with enlargement of the prostate, often due to benign prostate hypertrophy, though this is not true for all men. There are now a number of drugs available for the treatment of these lower urinary tract symptoms. Estrogen will also decrease menopausal symptoms, such as hot flashes, and appears to decrease the risk of subsequent heart disease. Some recent studies have suggested that more than 5 years beyond menopause, the decision of whether or not to take estrogen should be driven by your bone mineral density. This can be measured by a test called a DEXA. If you have a value below the midpoint of bone mineral density for healthy young persons, I would recommend that you consider taking estrogen for five to ten years. Breast cancer risk appears to increase after ten years. If you have a very strong family history of breast cancer, you may want to consider taking Evista (raloxifene) instead. Evista decreases the chance of developing breast cancer but appears not to have as positive an effect on the heart. If your DEXA gives you a diagnosis of osteoporosis, you should take alendronate (Fosamax). If you take any of these, you still need to make sure you have an adequate amount of calcium and vitamin D in your diet.

Q

I'm a woman in my late fifties. I've never taken hormone replacement therapy. Should I consider taking it now?

A

The major reason for taking estrogen is to delay the loss of bone that occurs during menopause.

Q

My husband is 65 years old, somewhat overweight, and snores very loudly at night. I have noticed that while sleeping, he appears to have periods when he stops breathing. He has also been complaining that he is tired during the day. Recently when we had friends over, he fell asleep while they were talking. Should I be concerned?

A

The symptoms you describe are classical of sleep apnea. This is a condition characterized by temporary absence of breathing during sleep that lasts for at least 10 seconds and occurs multiple times during the night. It is associated with severe daytime drowsiness. It is a very common condition occurring in up to one-half of all people over 60 years of age. It is particularly common in moderately overweight men with large necks. It is a serious condition that can eventually lead to hypertension, heart failure, and abnormal heart rhythms (arrhythmias). The diagnosis requires monitoring of breathing during sleep in a sleep laboratory. Treatment can be as simple as weight loss, sleeping in specific positions, and avoidance of alcohol. However, the majority of people with sleep apnea require the use of a machine at night that blows air through the nose under positive pressure, thus preventing collapse of the airway. This is called a continuous positive airway pressure or...
CPAP machine. In some cases, surgery may be necessary. Your husband needs to see a physician as soon as possible.

My husband was admitted to the hospital because he vomited up some blood. He was diagnosed as having an infection and given antibiotics. Does this make sense?

It is likely that your husband had a Helicobacter pylori infection. These bacteria have been shown to produce ulcers and irritation of the stomach lining. Both of these conditions can result in bleeding. The appropriate treatment is an antibiotic together with a medicine that blocks production of acid in the stomach.

I have mild arthritis which is particularly troublesome in the mornings when I first wake up. Is there anything I can do to wake up without pain and stiffness?

The best way to stop morning symptoms is to take a medicine the night before to prevent the pain from starting during the night. Many of my patients have found that taking 2 Tylenol ER® (extended relief) before going to bed works extremely well to stop them from having pain the next morning. To be effective, this needs to be done every night.

My wife recently read an article that said that church-going folks live longer than those who are not religious. Is there any truth to this?

There are a number of studies that show that religious people have fewer disabilities and live longer. The reasons for this are unclear, but include a tendency for religious persons to have a more positive attitude toward disease and the social interaction involved in regular church attendance. Depression is also associated with greater frailty, and spiritual persons tend to be less depressed.

I'm a 73-year-old woman who has been widowed for 12 years. I'm about to get remarried. My previous husband and I had an active sex life, and I am looking forward to resuming this with my new husband. Is there anything I should do before my marriage to prepare for this?

The lack of estrogens following menopause can lead to dryness and contraction of the vagina. This can be particularly severe when a person has not had intercourse for a number of years. To prevent pain with intercourse, it is useful to see if your vagina can admit two fingers before you resume sex. To allow this to happen, you may need to slowly stretch your vagina, covering your fingers with a lubricant, such as Astroglide™. If your vagina is very dry, you may also need to apply some Astroglide™ to your vagina before intercourse. Some women find estrogen vaginal creams are helpful in stretching the vagina and making intercourse a more pleasant experience.

I understand that there is now a new food pyramid for older persons. How does it differ from the pyramid for younger persons?

My friend, Robert Russell, MD, at Tufts University, has created the new food pyramid for older persons. Here are the differences: Its base now includes eight glasses of fluids, as many older persons do not drink enough. The pyramid also recommends that energy-dense foods are more appropriate as we age because older persons often under eat. Finally, a flag on the top of the pyramid suggests that many older persons need to take vitamin D, vitamin B12, and calcium supplements.
tion. In 1996 the number of veterans aged 80 to 84 years old and 85 years or older increased 15% and 13%, respectively, over the previous year (VA, 1997). With the increased probability of multiple comorbidities and fewer social and economic resources, individuals in these oldest age groups may be particularly vulnerable, requiring more medical and social services than younger individuals. By 2005, over half of the older veteran population will be aged 75 years and older, and by 2020, 15% of older veterans will be aged 85 and older. Table 1 shows the size of the veteran population currently over the ages of 65, 75, and 85. Table 2 (on page 18) shows the projected changes in those population sizes between 2005 and 2020.

Figure 1 represents the data in Tables 1 and 2, showing the changes in population size as a percentage of the entire veteran population. The projected percentages increase for all three age groups with the greatest change seen in the 85+ age group.

Although the vast majority of veterans are male, the number and percentage of female veterans are increasing. In 1996, 4.7% (approximately 1.2 million) of the total veteran population was female, and the median age of female veterans was 45 years (VA, 1997). Of all female veterans, an estimated 328,000 were aged 65 or older, representing 3.6% of the entire older veterans population (Sorensen & Field, 1994). By the year 2020, 8.1% of an estimated 1.3 million veterans will be female. 336,000 of them will be women over 65 (4.1% of all veterans aged 65 or older)(VA National Center for Veterans Analysis and Statistics, 1994). Figure 2 shows the percentage of female veterans who were over the age of 65 in 1996 and the projected percentage for that age group in 2020. Because of the increasing percentage of women becoming veterans, the percentage of all female veterans over 65 will not increase at the alarming rate found in male veterans.

In response to this aging demographic trend, the VA has developed a comprehensive approach to meeting the needs of an aging veteran population, including innovative healthcare program development, research, and professional education activities which are discussed below.

**CLINICAL PROGRAMS IN AGING**

In response to significant increases in the number of older veterans, the VA has developed an extensive continuum of clinical services including specialized and primary geriatric care, residential rehabilitation, community and home-based long-term care and nursing home care programs. The following are brief descriptions of VA clinical programs designed primarily to meet the needs of chronically ill, disabled, elderly veterans and their family caregivers.

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**TABLE 1. Veteran population in 2000 by selected older age groups.**

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<tr>
<td>65 and older</td>
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Source: Sorensen & Field (1994)

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**Figure 1.** The percentage of male veterans over the age of 65 increases over the next 20 years.
My Story

By Frank Tumosa

I spent four years in the Army, two of them in combat. My father had taught me never to volunteer for anything, but a bunch of us got together right after Pearl Harbor and decided that if we didn’t volunteer, we would be drafted, so we volunteered.

I did my basic training in Camp Drumm, New York. That’s where I met my best friend, Johnnie Cytajlo. We called him Sir Jello. Damned if I can remember why. After basic training we spent some time in 29 Palms in the middle of the Mojave Desert in California, training to enter the fight in Africa. By the time we had gotten trained though, the fight in Africa was over. So we were shipped off to England to await the D-Day Invasion.

The 4th Armored Division entered Europe at Normandy Beach, 6 days behind the original troops.

I commanded a tank destroyer so it didn’t take long to catch up with the front. We fought every day for 11 months from Brittany to Bavaria. By the time the Germans surrendered we were in Czechoslovakia, 1000 miles from where we had started.

The training we got in 29 Palms came in handy when we were fighting in those snowdrifts in Bastonne in December of 1944. It was so cold that we needed to remember the heat of Desert Valley to warm ourselves up. We were being shelled one early morning just outside of a small town in Belgium, not far from the Luxembourg border. We couldn’t get word to the units in back of us because communications were down. My buddy and I found where the wire was disconnected and I volunteered to climb a pole to reattach the wire. I’d wait for a break in the shelling and then climb up the pole. The shelling would start and I’d drop to the ground. The shelling would stop and up I’d go again. This went on for some time. I finally got tired and decided I would get that wire reattached even if I had to do it through the shelling. I told my buddy “when I get up that ladder this next time I am going to get that wire up before I come down.”

I waited for a break in the shelling and I got up there. All of a sudden the shelling started again just as a jeep drove up with two men in it. One of the men yelled up, “Having a good time soldier?” And I said, “If you think this is so much fun why don’t you come up here and help me?” My buddy was making shushing sounds so I asked him “What the hell’s the matter with you? Can’t you keep still?” It got quiet on the ground.

I looked down and the guy who has spoken to me was grinning from ear to ear. He said, “Carry on.” I did and I got that wire attached. When I finished he said, “Have a good day soldier” and he drove off.

When I got down on the ground my buddy said to me, “You are the only soldier I know who ever swore at General George Patton and didn’t get busted. You are one lucky son-of-a-gun.” Actually, he didn’t call me that but you get the idea. So that is how I got to be famous. I became known as the only man who had a fight with George Patton and won.

Mr. Tumosa just celebrated his 84th birthday. He now lives with his daughter in St. Louis, where he finds the summers to be cooler than those in the Mojave Desert and the winters to be warmer than the one he experienced at the Battle of the Bulge.
Aging Through the Eye of the Artist

Rembrandt van Rijn was born in 1606 in Leiden, Holland and died 63 years later. His first self-portrait was painted at the age of 23 years. Over his lifetime, he painted at least 40 self-portraits and etched himself 31 times. He painted 3 self-portraits 40 years after his first in 1669, the year of his death. It has been claimed that these were pictures of “a lonely old man communicating with himself while he painted.” These series of paintings magnificently display the physiological aging process. Our outward features are a reflection of our inner aging process. In addition, his portraits at the end of life (although preferred by John Morley personally) depict the aging of the visual process with less attention to fine detail. This lack of detail led to his last paintings less clearly showing facial expression. Romantics have interpreted his lack of detail to connote a world-weariness but realists are quick to counter that we are merely observing the failing skills of an older man.

One of our Own Returns

The Division of Geriatric Medicine at Saint Louis University warmly welcomes the return of Margaret-Mary Georgina Wilson, M.B., B.S., M.R.C.P. (U.K.).

Dr. Wilson completed her geriatric subspecialty residency at Saint Louis University in 1997 then went on to Downtown Hospital at New York University to complete her Internal Medicine residency, where she scored a perfect 100% on her in-service exam.

Dr. Wilson was born and educated in Nigeria, receiving her Bachelor of Medicine and Bachelor of Science in 1983 from the College of Medicine at the University of Ibadan, Nigeria. She then went on to the United Kingdom and was a member of the Royal College of Physicians of the United Kingdom. She has received many academic awards and honors, including the Alice Moboade Akinyele Prize, awarded by the University of Ibadam, Nigeria to the best graduating student in internal medicine.

Dr. Wilson is seeing patients in the general geriatric medicine clinic at Saint Louis University. If you wish to make an appointment with her, please call 314-577-6055.
Jefferson Barracks opened in 1826 as the site for the first “Infantry School of Practice” in the United States and to replace Fort Bellefontaine (est. 1805), which had been located in an unhealthy location near the confluence of the Missouri and the Mississippi Rivers and had fallen into disrepair. Jefferson Barracks was to serve as the primary training site and gathering place for the Army of the West. The site, selected by Generals Henry Atkinson and Edmund Gaines, consisted of 1,702 acres previously a part of the common fields of the village of Carondelet. Seeing a ready market for their produce, the leading citizens of the community offered the land to the U.S. Government for use as a military post.

The deed for the land was signed on July 8, 1826, and two days later, Stephen Watts Kearny led units of the First Infantry to occupy the site. Watts called their camp “Cantonment Adams” in honor of then President John Quincy Adams. Other early names included “Camp Miller” (for Missouri’s Governor) and “Camp Barbour” (for the Secretary of War). The installation was officially named “Jefferson Barracks” in October 1826 to honor ex-president Thomas Jefferson, the architect of the Louisiana Purchase, who had died July 4, 1826.

Though the Infantry School officially closed in 1828, Jefferson Barracks continued to play a vital role in the westward expansion and military success of the nation throughout its 120-year history. In the years before the Civil War, troops gathered at the post to pacify hostile Indian tribes, to protect merchants and emigrants heading west on the various trails, and to establish and garrison other frontier outposts. By the time of the Civil War, nearly every regiment in the Army had been stationed, at least in part, at Jefferson Barracks. Nearly every major leader during the Mexican and Civil wars spent part of their careers at Jefferson Barracks. Both Robert E. Lee and Ulysses S. Grant served at Jefferson Barracks.

Jefferson Barracks is now the site of one of the leading VA hospitals in Geriatric Care.
“To care for him who shall have borne the battle and for his widow and his orphan...”
For all these reasons, it is with great pleasure that I dedicate this issue of AgingSuccessfully to the older veteran.

The defining experience of their lives. It is to these veterans that we dedicate this issue of Aging Successfully. Our older veterans came before the baby boomers and were the reason for America’s boom in the last half of the twentieth century. Now, as they reach the end of life’s journey, we salute them.

I have worked all my career in the United States, at least partly in the Veterans Administration. This has given me the opportunity to allow my respect for veterans to grow, and also to develop the realization that the scars of battle, both physical and psychological, can come back to haunt the aged warrior. The recurrence of flashbacks in older persons and accelerated frailty related to a war wound stand out as just two dramatic examples. However, more subtle changes such as the effects of free cigarettes given to the troops, severely impaired hearing secondary to explosions, and depression or anxiety triggered by reminiscences remain equally important hindrances in the pathway of the successful aging of the veteran.

Just as my respect has grown over the last 20-plus years for the aging veteran, so has it grown for what is now the Department of Veterans Affairs. It is the VA that has almost single-handedly taken the United States from a country whose approach to the older person was virtually non-existent to the leadership role it now plays in geriatrics throughout the world. On a personal note, it is the VA that was responsible for my transformation from an endocrinologist to a geriatrician.

It was the development of the Geriatric Research, Education, and Clinical Centers (GRECCs) that catapulted research into the aging process forward in the United States. The concept of marrying basic research, clinical care, and education on the problems of the elderly into elite units strategically placed around the country turned out to be the jumpstart that the development of geriatrics required. The VA then funded the early geriatric medicine fellowships, thus creating the next cadre of leaders in the care of the elderly. It was the VA that was responsible for the refinement of the concept of geriatric assessment through the development of Geriatric Evaluation and Management Units (GEMUs). The VA also pioneered the training of geropsychiatrists and through its development of the interdisciplinary team training in geriatrics programs, it was at the forefront of the development of the realization that it takes a team to provide appropriate high-touch care for older persons. It was the presence of the GRECCs that in most cases drove the development of the elite departments of geriatrics at the nation’s universities. It was the VA through its training programs that first introduced geriatrics to the majority of medical students and residents around the country. Finally, because of the Congressional mandate that GRECCs must train not only VA personnel, but also other health professionals, the VA has developed conferences that have been responsible for providing geriatric knowledge to all health care professionals throughout the United States.

In the modern era, the VA is pioneering the recognition of pain as the Fifth Vital Sign. They are involved in developing the appropriate use of Hospice Care. They continue to provide leadership in clinically relevant basic and epidemiological research in gerontology.

For all these reasons, it is with great pleasure that I dedicate this issue of Aging Successfully to the older veteran – my friends and saviors; the VA – who made me what I am today; and the Veteran’s Organizations who have fought the good fight and kept the VA strong, and on the right course through multiple Congressional and leadership challenges. Thank you, one and all, for today, giving me the privilege to serve you.
Services of the Division of Geriatric Medicine, Saint Louis University Health Sciences Center include clinics in the following areas:

• Aging and Developmental Disabilities
• Bone Metabolism
• Falls: Assessment and Prevention
• General Geriatric Assessment
• Geriatric Diabetes
• Medication Reduction
• Menopause
• Nutrition
• Podiatry
• Rheumatology
• Sexual Dysfunction
• Urinary Incontinence

Call 314-577-6055 to make an appointment.

Products

• GEROPADY
• Senior Safety Solitaire
• ACE Unit Video
• Aging Successfully Newsletter
• Books

Call 314-577-8462 for more information.

To order:
Please send check or money order to:
SLU-HSC
Senior Safety Solitaire
Division of Geriatric Medicine
1402 S. Grand, Room M238
St. Louis, MO 63104
For more information, please call 314-577-8462.

Questions? FAX: (314) 909-0443 • email: agingsuccess@slu.edu
The 1999 MOGGEc Needs Assessment was sent to 30,000 health care providers in Missouri and Illinois. Respondents indicated a need for further training in the topics listed below. The Gateway Geriatric Education Center of Missouri and Illinois (Gateway GEC) will provide continuing education programs in each of these topics during the next five years.
It’s GEROPADY!

GEROPADY, the game that tests your knowledge in geriatrics and gerontology, is again available! The game uses the format of the popular television game show, Jeopardy. The GEROPADY kit includes loose-leaf notebook, instructions, questions and answers, five game board transparent overheads, a “Final GEROPADY” overhead, and materials.

To receive your GEROPADY kit, send a check for $25 and your address to:

Saint Louis University Health Sciences Center (SLU-HSC)
Division of Geriatric Medicine
1402 S. Grand Boulevard, Room M238
St. Louis, Missouri 63104

Make checks payable to: SLU-HSC – Geriatrics

GEROPADY is produced by the Missouri Gateway Geriatric Education Center, the Division of Geriatric Medicine at Saint Louis University, and the Geriatric Research, Education, and Clinical Center (GRECC), St. Louis Veterans Affairs Medical Center.


Have you just been caught reading someone else’s mail?

If you are reading someone else’s copy of this newsletter, don’t panic. We won’t call the police, notify the post office, or haul you off to jail. Now that you know there’s no penalty, if you wish to receive your own copy of Aging Successfully, we’re happy to oblige.

Please fax or mail your name and address (complete with ZIP code) to:

Carolyn Phelps, 1025 Windemere Avenue,
St. Louis, MO 63131 (FAX: 314-909-0443)
Specialized and primary geriatric care

The Geriatric Evaluation and Management (GEM) Program. Currently, 121 VA facilities have GEM programs that include inpatient units and/or outpatient clinics, as well as consultation services. The GEMs provide both specialized and primary care services to frail, elderly patients. An interdisciplinary team of geriatric experts performs comprehensive, multi-dimensional evaluations in order to improve functional status; to stabilize the acute and chronic medical conditions and/or psychosocial problems; and to discharge the patient to home, residential care, or to the least restrictive environment feasible. The GEM program provides excellent geriatric training and research opportunities for physicians in training and other health care professional students engaged in clinical training in the VA.

Alzheimer and related dementia care programs. Approximately 56 VA facilities have developed specialized programs for the care of veterans with dementing illnesses. These programs include inpatient and outpatient dementia diagnostic programs, behavior management programs, adapted work therapy programs for patients with early to mid stage dementia, Alzheimer’s special care units within VA nursing homes and transitional care units, and a model inpatient palliative care program for patients with late stage dementia. Programs for family caregivers of dementia patients include support groups and caregiver education, as well as respite and adult day health care services for the patient that allow “free time” for the caregiver. Many of these specialized programs for patients with dementia have been developed by the VA’s Geriatric Research, Education and Clinical Centers (GRECCs) (see below).

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Residential rehabilitation

Community residential care/assisted living. This program provides room, board, personal care, and general health supervision for veterans who, because of health conditions, are not able to live independently and have no suitable family or social support system to provide needed care. A multidisciplinary team of VA staff inspects private homes that provide residential care/assisted living services prior to including the home in the VA program and annually thereafter. Payment for services provided in a residential care home is the responsibility of the individual veteran.

Domiciliary care. Domiciliary care is provided in the VA as well as in state veterans’ homes (long-term care facilities established and operated by individual states) that receive assistance from the VA. Although the average age of veterans in VA domiciliaries is 59 years, increased attention is being focused on older veterans. While receiving services in the domiciliary, these elderly patients are encouraged to become involved with programs in the community, such as senior centers, Foster Grandparents and others. These activities have facilitated continued community involvement as well as reintegration into the community.

Community and home-based long-term care

Home-Based Primary Care. This program provides in-home primary medical care to home-bound veterans with chronic diseases as well as to patients with a terminal illness. The patient’s family provides the necessary personal care under the coordinated supervision of the individual veteran.

Figure 2. The percentage of female veterans over age 65 changes very little in the next 20 years

Geriatric Research, Education, and Clinical Centers

Geriatric Research, Education, and Clinical Centers (GRECCs) have become leaders in the integrated research, education and clinical systems providing care to older veterans (Goodwin & Morley, 1994; Haber & Moravee, 1982). The Veterans Administration (VA) developed out of the “Old Soldiers Homes” at the end of the 19th century. The VA became a separate entity in 1930, and following World War II, it began affiliating with medical schools and emphasizing teaching and research as a way to enhance care of the veteran. In 1964, an executive order by President Kennedy and Public Law 88-450 directed the development of long-term care programs within the VA. Recognition of the rapid growth in the aging veteran population, with the prediction that 37% (9 million) of the veteran population would be over 65 years of age by the year 2000, led to increased enthusiasm for the development of expertise in geriatrics within the VA in the early 1970’s. At the instigation of Paul Haber, MD, Congress authorized the establishment of five GRECCs. Congress specifically stated that these GRECCs should not only serve the VA but also provide education for health care professionals caring for the aged in the general population. By 1980, eight GRECCs had been established: in Boston, MA (Bedford and Brockton/West Roxbury); Little Rock, AR; Minneapolis, MN; St. Louis, MO; Seattle, WA (Seattle and American Lake); and Palo Alto; Sepulveda; and West Los Angeles in California. In 1984, Durham, NC, and Gainesville, FL, were added. Since 1987, further GRECCs have been opened: Ann Arbor, MI; San Antonio, TX, Madison, WI; Miami, FL; Salt Lake City, UT; and Baltimore, MD. Public Law 99-166, passed by Congress in 1985, has authorized an increase in GRECCs to a total of 25. The latest four to be added are Bronx, NY; Pittsburgh, PA, Cleveland, OH, and Nashville, TN. GRECCs are under the direction of the Office of the Assistant Chief Medical Director in the VA central office. Since 1980, GRECCs have also been regularly reviewed by the Geriatrics and Gerontology Advisory Committee (GGAC). All GRECCs are affiliated with a medical school (the Boston GRECC with two schools and Sepulveda and West Los Angeles with UCLA) and have provided a major stimulus in developing geriatric programs at major universities throughout the United States.

The concept behind the GRECCs was that bringing together a cadre of basic and clinical researchers with a focus on aging would stimulate a rapid increase in clinically useful knowledge about the older person. The GRECCs were then required to develop clinical demonstration units to test these concepts. The educational component was responsible for the rapid dissemination of this knowledge throughout the VA and the private sector. Clearly, the most successful example of this strategy was the development of the Geriatric Evaluation and Management Unit (GEMU) at the Sepulveda GRECC, demonstrating its efficacy and its rapid dissemination throughout the VA (133 programs). GRECCs have proven to be a highly successful research model, with research funding averaging over $3 million per GRECC and each GRECC producing over 50 scientific publications in 1991. The scientific contributions of the GRECCs have been numerous. They include description of Syndrome X (hypertension, hyperinsulinemia, and (continued on page 21)
Providing Health Care for Aging Veterans  (continued from page 18)

vision of an interdisciplinary treatment team based at a VA facility. The team plans and provides for the needed medical, nursing, social, rehabilitation, and dietetic regimens and trains family members and the patient in supportive care.

Fee basis home care. The VA also arranges with community home health agencies to provide skilled home care services for veterans. Under this program, the VA pays a per-visit rate to the agency providing the service. Approximately 15,000 veterans are served annually in this program.

Homemaker/home health aide (H/HHA). This program enables selected patients who meet the criteria for nursing home placement to remain at home through the provision of personal care services. The H/HHA services are purchased by the VA from public and private agencies in the community. Case management is provided directly by the VA staff.

Respite care. This program also enables the chronically-ill, disabled veteran to live at home longer than would be otherwise possible. It is designed to reduce the caregiving burden of the spouse or other caregiver by admitting the veteran to a VA hospital or nursing home for planned, brief periods, totaling no more than 30 days per year. During the inpatient stay, patients are also provided with evaluative and treatment services needed to maintain or improve functional status, thus prolonging the veteran’s capacity to remain at home.

Adult day health care (ADHC). This therapeutically-oriented program provides health maintenance and rehabilitation services to veterans in a congregate, outpatient setting. The VA operates some of its own programs but also contracts with non-VA agencies for ADHC services.

Hospice care. All VA facilities have an interdisciplinary hospice consultation team that is responsible for planning, developing and arranging for the local provision of hospice care. The program offers pain management, symptom control, and other medical services to terminally ill veterans, as well as bereavement counseling and respite care to their families. Education and training have also been provided to facilitate the incorporation of hospice concepts into each VA facility’s approach to the care of the terminally ill. The VA also arranges for hospice services through community-based agencies.

Nursing home care

The VA supports the provision of nursing home care for more than 80,000 veterans each year. Care is provided in VA-operated nursing home care units (NHCUs), through contracts with community nursing homes, and in state veterans homes.

Nursing home care units (NHCUs). These units are based at VA hospitals and provide skilled nursing and related medical services through an interdisciplinary approach to meeting the multiple physical, social, psychological and spiritual needs of patients. Many also provide sub-acute and post-acute care.

Community nursing home care. The VA contracts with community nursing homes to provide nursing home care for veterans making a transition from the hospital to the community. Each community nursing home is evaluated and inspected by VA staff prior to selection as a contract facility, and VA staff provide regular follow-up visits to assess the progress of veterans admitted to the facility and to monitor the overall quality of care.

State veterans’ nursing homes. The VA supports state veterans’ homes (long-term care facilities established and operated by individual states) through two grant-in-aid programs. The construction grant program provides up to 65% federal funding to states to assist in the cost of construction of new nursing home and domiciliary facilities, or expansion or remodeling of existing facilities. The VA per diem grant program assists states in providing domiciliary and nursing home care for veterans through partial payment of per diem costs.

RESEARCH PROGRAMS IN AGING

The VA’s intramural research program includes basic biomedical and clinical medicine research, health services research, rehabilitation research, and cooperative studies. The diverse nature of diseases associated with aging make it difficult to define precisely the content of the aging research portfolio.

VA personnel research conditions directly associated with aging as well as diseases (e.g., cardiovascular) that are highly prevalent among the elderly and other health problems of the elderly, including cancer, stroke, degenerative bone and joint diseases, dementias, and diabetes.

In 1975, the VA established centers of excellence in geriatrics called Geriatric Research, Education, and Clinical Centers (GRECCs) (continued on page 22)
GRECCs (continued from page 19)

hypertriglyceridemia), demonstration (by computer analysis of its receptor structure) that amyloid-beta protein produces amnesia, the finding that 1-alpha-hydroxylase enzyme activity in the kidney is reduced with aging, description of the detrusor hyperactivity and impaired contractility syndrome as a cause of incontinence, pioneering observations on age-related alterations in the immune system, discovery of the key role of protein energy undernutrition in poor outcomes associated with hospitalized older persons, linkage analysis of some familial forms of Alzheimer’s disease to chromosome 21, definition of the causes of the anorexia of aging, and the finding that older males develop secondary hypogonadism.

Besides GEMUs, GRECCs have pioneered the development of other clinical demonstration units, including academic nursing home units, special care units, specialized exercise programs, medication reduction clinics, sexual dysfunction clinics, clinics for older persons with spinal cord injuries, a preventive gerontology program for older veterans in the community, and an adapted work therapy program for persons with early dementia. GRECCs, together with other VA sites, have played a leading role in developing interdisciplinary team training.

GRECCs have also played an important role in disseminating geriatric knowledge to health professionals of a variety of disciplines and have played a key part in developing the physician geriatric fellowship. They have developed two novel educational games: Geropady and the Geriatric Challenge Bowl, and have been key in introducing the Aging Game to medical students. GRECCs play a major role in continuing education, with over 5,000 educational activities each year. GRECCs have developed a variety of patient education clinics and a series of videotapes.

GRECCs represent an exciting success story. They have developed key clinical demonstration units and have been leaders in the training of health professionals in gerontology. GRECC scientists are among the leaders in geriatric research. The GRECC integration of research, education, and clinical care into “centers of excellence” has played an important role in probing the mysteries of aging and providing insights into the appropriate care of our graying population. ■

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**Upcoming Programs**

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<td><strong>The 20th Annual GRECC Symposium on Pain Management</strong>&lt;br&gt;December 8, 2000&lt;br&gt;Call 314-894-6510 for more information.</td>
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<td><strong>Conquering Incontinence Across the Continent Conference</strong>&lt;br&gt;January 19, 2001&lt;br&gt;For more information, please call (314) 577-8462.</td>
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<td><strong>The Twelfth Annual Saint Louis University Summer Geriatric Institute</strong>&lt;br&gt;June 13-15, 2001&lt;br&gt;For more information or to be added to the mailing list, please call (314) 577-8462.</td>
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<td><strong>The Twelfth Annual Saint Louis University Symposium for Medical Directors in Nursing Homes</strong>&lt;br&gt;December 9, 2000&lt;br&gt;For more information or to be added to the mailing list, please call (314) 577-8462.</td>
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**Aging Successfully, Vol. X, No. 3** 21
tion and Clinical Centers (GRECCs). The mission of the GRECCs is to improve the health and care of elderly veterans through research, education and training, and the development of improved clinical models of care. There are currently 20 GRECCs throughout the VA system, each with a distinct programmatic focus (e.g., interdisciplinary approaches to treatment of prostate cancer; neurobiology, epidemiology, and management of dementia; falls and instability; geropharmacology; cost-effective delivery of health care services to the elderly; and bioethical aspects of medical decision-making in aging). Research activities include basic biological, applied clinical, rehabilitation, and health services delivery investigations. GRECCs are widely recognized as having provided leadership in geriatrics and gerontology throughout the nation, as well as within the VA. For further details on achievements of the GRECC program, see Goodwin and Morley (1994).

EDUCATION AND TRAINING PROGRAMS IN AGING

The training of health care students and professionals in geriatrics and gerontology has been a priority for the VA since the mid-1970s, when three major initiatives were implemented. The first was the establishment of the Geriatric Research, Education and Clinical Center (GRECC) Program in 1975 (see above). This was followed by the development of a geriatric physician fellowship program in 1978 and the designation of 12 VA Interdisciplinary Team Training Programs (ITTPs) in Geriatrics that same year. Comprehensive geriatric training for residents and associated health students was initially provided at GRECC and ITTP sites but subsequently has been replicated at more than 40 VA facilities nationwide. Special fellowship programs in geriatrics have been designated for psychiatrists, dentists, nurses, and psychologists. Beginning in 1994, additional positions have been allocated to support residency training in long-term care. Of the more than 100,000 health professions students annually who receive clinical training experiences in VA facilities, many gain experience in care of the elderly by rotating through one or more of the VA’s geriatrics and extended care clinical programs.

Education and training opportunities are also provided for VA employees. Continuing education programs are conducted at all VA facilities, in addition to regional and national training conferences planned, implemented and evaluated by VA faculty. GRECCs conduct, co-sponsor or provide faculty at over 5,000 VA educational programs yearly that are focused on geriatric care. Resources related to the care of the elderly, including videos, journals, textbooks, conference tapes, clinical practice guidelines, and other health education materials developed by VA and non-VA sources, are available at VA libraries.

REFERENCES


New Book: The Science of Geriatrics

This book, published in September by Serdi, covers the interface between the basic scientific knowledge of aging and clinical geriatrics. It has 55 chapters containing 760 pages and is heavily illustrated. It was developed as a collaborative project of Saint Louis University, the Missouri Gateway Geriatric Education Center, and the Geriatric Research, Education, and Clinical Center of the St. Louis VA Medical Center. The editors are John E. Morley, H. James Armbrecht, Rodney Coe from Saint Louis University and Professor Bruno Vellas from the University of Toulouse in France.

New Product Available Soon

The Gateway GEC is proud to announce a new educational tool available January 1, 2001: A book containing the crossword puzzles published in Aging Successfully plus other puzzles of geriatric interest. The cost will be $16.50. The puzzles are suitable for classroom teaching as well as individual challenge. To purchase, send check for $16.50 payable to Saint Louis University, Division of Geriatric Medicine, 1402 S. Grand, Room M238, St. Louis, MO 63104

Been Here? Done This?

Offering regular updates on geriatrics, Cyberounds, an internet-based educational program for physicians and other health providers, is edited by Dr. John E. Morley. The internet address for Cyberounds is: www.cyberounds.com

A cybersite for seniors has been developed in collaboration with Saint Louis University and the Missouri Gateway Geriatric Education Center. Besides articles written by geriatric experts, this site provides health updates and an interactive question and answer section. The address for this site is www.thedoctorwillseeyounow. See you in cyberspace!
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