Occupational Therapy in the Department of Veterans Affairs: Focus on Health Care of the Elderly Veteran

Linda B. Thalheimer

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The Department of Veteran Affairs (VA) operates the largest integrated health care system in the world (VA, 1989), with designated departments and programs designed to meet the long-term care needs of the aging veteran. Occupational therapy is an important intervention to maximize the quality of life of older persons. Because of the increasing number of aging veterans and the national shortage of occupational therapists, the VA has been devising programs to recruit and retain occupational therapists in VA medical centers. The combination of long-term care programs and the VA's commitment to ongoing research, education, and occupational therapy services points to a promising outlook for care of our aging veterans.

The Structure, Programs, and Services of the VA

On March 15, 1989, the structure of the Veterans Administration was changed. The previously independent Veterans Administration was replaced by the Department of Veterans Affairs and elevated to a cabinet-level department in the Executive Branch that reports directly to the Office of Management and Budget (Keenan, 1989; VA, 1989). The acronym for the Department of Veterans Affairs remains VA.

The Veterans Health Services and Research Administration (VHS&RA), one of four divisions of the VA, is responsible for (a) developing, maintaining, and operating a national health care provision system for eligible veterans; (b) providing ongoing education and training programs for its health care personnel; (c) maintaining a program of medical research and development; and (d) furnishing health services to members of the armed forces during periods of war or national emergency (Office of Geriatrics and Extended Care, 1985).

The VA is the largest integrated health service provision system in the world (VA, 1989). Its potential to provide a continuum of care is manifested in its myriad long-term-care programs. In addition to the VA medical centers, which may provide acute medical, chronic medical, and rehabilitative services, the VA operates several types of extended-care programs—both institutional, to help veterans who are unable to continue residing in the community, and noninstitutional, to help veterans who wish to continue living in the community. Eligible veterans thus have access to the complete spectrum of the health care resources that are especially important to the geriatric population.

Linda B. Thalheimer, OTR/L, is Gerontologic Rehabilitation Therapist, Geriatric Research Education and Clinical Center, Brockton/West Roxbury Department of Veterans Affairs Medical Center, 1400 VFW Parkway, West Roxbury, Massachusetts 02132.

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There are 172 VA medical centers that operate independently of one another, each with its own budget and administration. Although each facility is required to follow federal regulations, each has the power to set its own policies and decide how to use its resources. Thus, VA programs vary in emphasis from facility to facility. Many of the facilities have been designated as specialty centers (e.g., spinal cord injury, cardiac, head injury, or geriatric). Accordingly, such designated specialty centers may emphasize that particular population in their support programs. The role of the staff in each hospital and in each hospital's programs may also differ depending on the preferred concentration of services at the hospital. In essence, "If you've seen one VA hospital, you've seen one VA hospital" (Friedlander, as cited by Sunshine, 1990, p. 103).

**Extended-Care Programs**

The federal government takes veterans' benefits seriously and is acutely aware of its responsibility to provide health care to the rapidly growing number of aging and eligible veterans. Unfortunately, in spite of the great depth and breadth in the variety of VA long-term-care programs, occupational therapy is not considered a fundamental entity in many of them. Whether this is due to the decreased supply of therapists from problems of recruitment or retention or due to lack of appreciation of the benefits of occupational therapy, many of the hospitals and long-term-care programs are short of occupational therapists.

**Institutional Extended-Care Programs**

The VA's institutional extended-care programs for veterans who are unable to continue living in the community include Nursing Home Care Units (NHCUs) located on the grounds of the medical centers; community nursing homes, on a contract basis; domiciliaries; and state veterans' homes.

There are currently 123 NHCUs, up from 99 in 1985 (Yoshikawa, 1990a). Although service-connected veterans (i.e., those with a disability incurred during service or associated with military service) take first priority in receiving placement, each NHCU has the authority to determine its own admissions, so veteran status is only one of several factors that is taken into account. Occupational therapists are not routinely employed by NHCUs, but may be consulted for individual cases depending on the staffing of each facility's occupational therapy department.

Community nursing home contacts are offered as an alternative to NHCUs and as a means of providing timely placement from the hospital setting. Service-connected veterans requiring nursing home placement because of a service-connected disability may be granted an indefinite contract at a community nursing home if an NHCU is not feasible for them. Other veterans may be provided a 6-month contract to enhance the placement process, pending availability of resources, if they can demonstrate that they are not enrolled in a state Medicaid program. The 6-month period allows ample time for application for Medicaid (if eligible). Veterans placed in contract nursing homes are followed, at least monthly, by a VA staff social worker and continue to be eligible for VA medical care. Currently, 163 VA medical centers have community nursing home contract programs. A contracted nursing home must meet the same standards for skilled nursing facilities as those of Medicare and Medicaid.

Domiciliaries, or Soldiers Homes, were designed to provide comprehensive health care services in an institutional setting for those veterans who do not require acute or skilled nursing care and are independent in mobility and daily living skills. Clinical interventions are intended to provide veterans with optimal opportunity to maximize independence and community interaction. In domiciliary care programs, occupational therapy is provided both on a group and individual basis as part of an interdisciplinary approach (Holsinger, 1990). In 1989, the VA operated 27 domiciliaries (7,400 beds) with an 87% occupancy rate (Keenan, 1989; Yoshikawa, 1990a).

State veterans' homes may be either nursing homes or domiciliaries. They are established by the state and funded in part (up to 65%) through grant programs by the VA for per diem care reimbursement and new construction programs. There are currently 56 state veterans' nursing homes (4 new state veterans' homes opened in the last year) and 44 state veterans' domiciliaries (Yoshikawa, 1990a).

**Noninstitutional Extended-Care Programs**

Noninstitutional extended-care programs designed to enable veterans to continue residing in the community include hospital-based home care, VA (and contracted) community day health care programs, community residential care, and respite programs. These programs provide alternatives to institutionalization and are being used increasingly with the growth in numbers of elderly veterans. The extended-care service provides information or consultation regarding VA and community options for all aspects of long-term care.

The Hospital-Based Home Care Program (HBHC) is a supportive interdisciplinary program for the discharged patient and his or her family. Medical, nursing, social, dietary, and rehabilitation staff members may go to patients' homes to provide supervision and training for family members who are responsible for personal care of the patient. The HBHC was piloted in 1970; by 1983 there were 30 programs, and the number has now more than doubled to 73 (Yoshikawa, 1990a). Unfortunately, as a result of staffing shortages and cutbacks, home care pro-
grams sometimes lack one or more members of the interdisciplinary team. In such cases, the HBHC must prioritize its caseload: It may direct its care to the geriatric population or it may reserve its time for the specialty unit at its facility.

Many VA occupational therapy departments incorporate functional home evaluations into their functional evaluation and retraining programs. The HBHC programs may have a therapist on staff to provide home evaluations as well as continuity of care, but a patient's primary therapist will usually perform the initial home evaluation to evaluate the physical environment and to observe any disabilities or deficits in activities of daily living that may affect the veteran's function in his or her home environment. The Geriatric Evaluation and Management Unit (GEMU) at the Brockton/West Roxbury Department of Veterans Affairs Medical Center has made the home visit an interdisciplinary process as well as a teaching experience for medical residents, fellows, and student interns who have demonstrated an interest in geriatric care.

The Adult Day Health Care Program is a medically oriented day program providing rehabilitative, social, and recreational activities during standard working hours. It provides comprehensive care during the day as well as providing respite for caregivers, often enabling veterans to maintain their homes for longer periods of time. Funding for these programs is similar to that for the community nursing homes, in that it is often done on a contract basis (E. Kane, personal communication, September 1990). In 1983 there were only 5 programs, but today there are 15 in VA facilities plus 92 community contract programs (Yoshikawa, 1990a).

The Respite Program provides a temporary institutionalized setting for veterans for up to 30 days a year, usually provided in 1-week intervals up to four times a year. This program has been very successful in giving caregivers a period of relief from the emotional and physical stress of total patient care and in helping to prevent premature nursing home placement. In 1983, there were only 12 programs; there are now 118 (Yoshikawa, 1990a).

The Community Residential Care Program is a foster care program that provides room, board, limited personal care, and supervision to veterans in private residences or VA-supervised rest homes. The program was originally designed to serve the needs of deinstitutionalized psychiatric patients, but has evolved to accommodate the aging veteran who exhibits socially acceptable behavior and is able to perform activities of daily living with minimal or no assistance. Necessary transportation (e.g., to recreational programs, such as senior community centers, or to doctors' appointments) is arranged by the manager or by the VA social worker who monitors these veterans regularly. Although the home is inspected by the VA, it is chosen and paid for by the veteran.

Occupational therapists will occasionally perform home evaluations at a prospective foster home to evaluate the physical layout as part of a comprehensive rehabilitation program. The evaluation not only enables the therapist to suggest changes that may enhance the veteran's function but also provides an opportunity to simulate the environmental setup so that the veteran can practice and master specific skills that will be needed in the individual foster home. Currently, 127 Community Residential Care Programs are operated by VA medical centers (VA, Office of Academic Affairs, 1990).

Geriatric Research Education and Clinical Centers

The VA's concern for the aging veteran population is not new. In the early 1970s, VA staff members were busy researching demographics, projecting needs, and developing Geriatric Research Education and Clinical Centers (GRECCs). In 1975, the Commission on Extended Care and the first GRECC were established in recognition of the long-term health care needs of aging veterans. Just 5 years later, the Veterans Administration Health-Care Amendments of 1980 (Public Law 96-330) expanded the Commission on Extended Care to include geriatrics. The Commission on Extended Care and Geriatrics is divided into two services: the Extended Care Service and the Geriatrics and Grants Management Service. The Extended Care Service develops and coordinates policies and plans for VHS&RA for institutional and noninstitutional extended-care programs. The Geriatrics and Grants Management Service is responsible for initiating or collaborating on the development of clinical, educational, and research programs and activities in geriatrics, gerontology, and extended care, and for monitoring and managing the State Veterans Home Program, dementia and Alzheimer disease units and programs, GEMUs, and GRECCs (Yoshikawa, 1989). Today, through educational programs and medical and health services research, the VA medical centers "lead the country in geriatric research, training and education" (Taylor, 1984, p. 71).

The mission of the GRECC was to attract outstanding professionals to teach and to conduct research on aging in the context of a clinical model program that the GRECC itself developed. There are now 12 GRECCs acting as model centers of clinical care, training health care personnel and trainees with an interest in geriatrics and performing research on health care problems relevant to the aging veteran (Office of Geriatrics and Extended Care, 1985; Yoshikawa, 1989).

The GRECCs are well known for their excellence in clinical research. Nonphysician research is supported for their nonphysician faculty, through the allocation of time if not through direct funding. Two occupational therapists are directly affiliated with the GRECCs. One, at the Minneapolis GRECC, is currently performing research on functional evaluation of persons with dementia. The other occupational therapist (the author), at the Brockton/
West Roxbury GRECC, is beginning to initiate functionally oriented research topics. Some occupational therapy departments are engaged in research activities; training seminars are occasionally provided by Regional Education Medical Centers to help encourage clinicians to incorporate research into clinical practice. However, specific time allocation for research purposes is left to the discretion of individual departments.

The GRECCs are excellent resources for geriatric clinical medicine for all disciplines. Most GRECCs are actively involved in clinical fellowship and residency programs and to a lesser extent in graduate and internship programs for nurses, social workers, occupational therapists, and physical therapists. The clinical component supplements the ongoing research and educational activities of the host facility. Educational opportunities include conferences, meetings, and informal educational discussions specifically geared toward disseminating new and important information about geriatrics to VA health care providers. The author, the occupational therapist at the Brockton/West Roxbury GRECC, has ongoing responsibilities within the VA to educate, on both local and national levels, the diverse members of the medical profession concerned with the aging veteran. Topics include the role of the occupational therapist in the evaluation, training, and management of the geriatric patient as well as the therapist's function on an interdisciplinary team. The educational programs supplement other existing VA educational resources, such as Regional Medical Education Centers and Cooperative Health Manpower Education Programs. GRECCs conduct in excess of 4,000 educational activities and training programs annually and produce approximately 500 publications on aging each year in the form of books, journals, or abstracts (May-Hughes, 1985).

The GRECCs serve the geriatric veteran directly in GEMUs and Geriatric Outpatient Clinics and, less directly but very efficiently, through the Geriatric Consult Service. In the United States, there are currently 93 GEMUs operating 4 to 20 specialty beds each; 3 years ago, there were only 70 (Yoshikawa, 1990a). The GEMUs provide thorough interdisciplinary evaluations and management plans for their patients. They also provide an exciting educational climate for all disciplines, demonstrating ideal evaluation, treatment, and management of the geriatric patient. Each staff member representing a professional discipline on the team has opportunities to share his or her skills and knowledge with the other members, providing an ongoing understanding of what each discipline can offer in geriatric care. Thus, a vital knowledge base is provided to residents, fellows, and interns who later in their careers will enter settings that are not necessarily oriented toward an interdisciplinary approach or focused on geriatric issues. Unfortunately, in most GEMUs, therapists are used only on a consultant basis through the rehabilitation medicine service; thus, the full potential of interdisciplinary clinical education and treatment is lost. The GEMU is an area in which representation of occupational therapists is critical for the comprehensive treatment of geriatric patients. It may be that their impact will not be fully recognized until occupational therapy departments fill vacant positions and are able to provide comprehensive services to GEMUs.

Veterans’ Demographics

The United States has 27 million veterans, characterized by clusters in population formed during major defensive or offensive mobilizations. Although there is a continuing flow of veterans into the VA system during peacetime, it is minimal compared to the influx in wartime. The 14 million World War II and Korean War veterans will provide the next cluster of geriatric patients into the VA system (VA, 1989; Yoshikawa, 1989). Currently, 6% of these are over the age of 75 years. Nineteen percent were over 75 years of age by the year 2000, and 24% will be over the age of 75 years by 2010 (Yoshikawa, 1990a).

Only about 15% of eligible veterans use the VA health care system, the majority of whom have service-connected disabilities, insufficient medical insurance, or low income (Hollingsworth & Bondy, 1990). In a recent report (VA, 1989), half of all VA hospital users cited free care as their primary reason. The declining availability and rising costs of nonveteran health care resources can be expected to have a direct impact on the use of VA resources. With cutbacks in Medicare and Medicaid coverage and increased awareness of veteran eligibility, it is anticipated that more veterans will seek out the VA’s free medical assistance, either as a primary health care system or as a supplemental system to compensate for deficiencies in their primary health insurance.

The aging veteran population differs from the rest of the nation’s aging population in that it is mostly male. Only 4.4% of the veteran population is female; this figure, however, represents 1.2 million women. The number of enlisted military personnel is decreasing, but the number of women in the military continues to increase. The average age of female veterans is 51 years, and 30% of them are over 65 years. To ensure advocacy for female veterans, the Women Veterans’ Chartered Federal Advisory Committee was established by congressional statute in 1986 (VA, 1989).

Eligibility

In the past, conditions of eligibility for VA services were lax and many veterans felt entitled to any and all necessary care. In 1986, however, eligibility guidelines were changed to maintain fiscal viability. Automatic eligibility for veterans 65 years of age and older was discontinued; all non-service-connected veterans regardless of age are now required to pass a financial means test to qualify for
VA medical care (Keenan, 1989). Currently, the VA must provide hospitalization and may provide nursing home care for all service-connected veterans, former prisoners of war, veterans receiving VA pensions, and veterans eligible for Medicaid. The VA must furnish outpatient care without limitation to veterans with 50% or more service-connected disabilities or for a veteran’s service-connected disability. Benefits for other veterans, however, are continually changing. Even as you read this article, budgetary constraints may affect the actual benefits available for these veterans, because benefits are only “obligated within the limits of the VA facilities” (VA, 1991, p. 41).

The Role of Occupational Therapy

The role of occupational therapy in the care of the aging veteran is varied, but the clinical skills required are no different from those needed by any other occupational therapist caring for any aging person. The unique nature of caring for older veterans comes in understanding eligibility guidelines and use of specific VA programs.

Occupational therapists specialize in the evaluation, training, and management of functional living skills. They have been trained in task analysis to observe behavior and to interpret cognitive function from task performance. Occupational therapists’ knowledge of adaptive devices, their focus on treatment of the patient as an individual, and their use of a holistic model make them uniquely qualified to practice as geriatric specialists. The need for occupational therapy has never been more critical because of the magnitude of the demands of the aging veteran population.

In the VA itself, occupational therapy interests are served by the Rehabilitation Planning Specialist for Occupational Therapy and a voluntary eight-member VA Occupational Therapy Advisory Board. Both provide input to the Board of Rehabilitation Medicine Service in the areas of management, clinical practice, quality assurance, clinical education, staff development, public relations, and research in regard to occupational therapy.

The VA, by virtue of its aging population, provides opportunities for occupational therapists to work with aging veterans in every specialty area. However, opportunities to specialize in geriatrics are encouraged and supported. Geriatrics is one of the few areas of specialization that the VA recognizes for student scholarships. Many of the continuing education courses sponsored by the VA—such as Cooperative Health Manpower Education Programs, Regional Medical Education Centers, and GRECCs—have focused on geriatric rehabilitation and related geriatric issues. The VA not only sponsors these courses but also provides funds for room and board for participants to attend many of the programs. The VA encourages and supports interdepartmental and interfacility educational programs to provide for an increased understanding of each other’s role in the evaluation and management of geriatric veterans and to enhance communication between departments and facilities for more effective and efficient use of resources.

Many occupational therapists in the VA already act as geriatric specialists and take for granted the uniqueness of their skills. However, it is important to designate oneself as a geriatric specialist. The acknowledgment that one is a specialist can bring occupational therapy theories and models alive in the context of geriatric treatment. Therapists are less likely to apply these models in practice if they have not identified their geriatric population as unique. Attention needs to be focused on defining normative changes of aging (as opposed to changes that may be a result of life-style); addressing psychological issues unique to the aging population; and reviewing and performing research on the evaluation of therapeutic techniques for a geriatric population. The understanding of the normative physiological, neurological, and psychological changes of aging provides a base from which to build individualized treatment programs, the type of program that has made occupational therapists essential in geriatric health care. The VA is a firm supporter of staff training in geriatric issues in rehabilitation. Of the 799 courses sponsored by one Regional Medical Education Center in 1989, 330 were directly related to geriatric rehabilitation (VHS&R. 1989).

Each medical center controls its own rehabilitation medicine service. Occupational therapy is one of three primary rehabilitation therapies that fall under its direction. However, occupational therapists may hold clinical positions in other departments. In centers with an ample number of therapists, opportunities to specialize are available and encouraged. Specialization may be determined by service to specified units, such as rehabilitation or neurology, or more specifically by service in particular programs, such as cardiac care or hand therapy. Interestingly, most rehabilitation medicine services do not consider geriatrics a specialty, possibly because so many of the veteran patients in all areas of specialization are over 65 years of age. There are, however, a few designated geriatric rehabilitation units that have proved successful. There are also 93 GEMUs, of which 87 use therapists from the rehabilitation medicine service. The therapists providing therapy to the GEMUs may or may not consider themselves specialists in geriatrics. This may be, in part, because of the need for these same therapists to provide therapy to several other services because of staff shortages.

Veterans benefit from the unique flexibility of occupational therapists to develop programs, schedule treatments, and plan discharge. In general, the VA does not seek third-party reimbursement for individual therapy sessions or for equipment issued during inpatient admissions. Consequently, therapists may provide customized therapy sessions of the length appropriate for each patient without having to concern themselves directly with
cost or reimbursement. There is the luxury of time for ample communication between interdisciplinary team members and time to initiate and incorporate new programs. However, the lack of accountability for reimburse­ment makes occupational therapy departments vulnerable to cutbacks during fiscal crises, regardless of the positive results so appreciated by the veterans.

In most centers, adaptive equipment and prosthetic devices are available in a timely manner. Almost all hospitalized veterans are eligible for prosthetic equipment. Veterans benefit from the cooperative relationship between the occupational therapy department and the prosthetics department, which creates an efficient and effective means of allocating appropriate equipment. An interdisciplinary approach is encouraged in VA medical centers and has been very effective in preventing the issue of unnecessary or inappropriate equipment and, of equal importance, in ensuring that veterans receive the equipment they require. Training can often be provided with the very adaptive aids and equipment with which the patient will be discharged. In addition to the benefits to the veteran, there is a certain excitement for the occupational therapist in knowing that the equipment he or she has determined to be necessary to maximize the patient’s independence can be provided to the patient free of charge.

Occupational therapists are encouraged to keep abreast of the latest information and skills related to their discipline. This is done through VA tuition support programs, which are administered by the individual medical centers. Tuition support funds have paid more than $350,000 to occupational therapists and physical therapists, enabling them to attend more than 1,000 continuing education and academic courses in 1989 (A. Feliciano, personal communication, September 1990).

National shortages of occupational therapists and physical therapists have triggered various congressionally mandated and agency-initiated recruitment and retention efforts. The turnover rate for occupational therapists rose from 23% in 1986 to 25.8% in 1987 to 32.7% in 1988. The vacancy rate also rose disturbingly from 9.2% to 13.8% to 19% in the same years (Evans, 1988; B. Evans, personal communication, September 1990). Because the high attrition rate compounds the problem of increasing the number of practicing therapists in the VA system, some positive steps are being taken to attract both occupational therapists and physical therapists. In 1988, the VA provided more than $1 million in health professional scholarship funds, which is equivalent to full educational reimbursement for 47 physical therapy students. Thirty-four physical therapists have already been placed in VA medical center facilities, and 40 more are expected to be placed this summer. The VA extended the health professional scholarship program in 1990 to include occupational therapists. Eligible therapists include those in an accredited master’s program, and those working toward an advanced master’s in designated specialties (including geriatrics) needed by the VA. Thirty-nine occupational therapy students were awarded a total of almost $1 million in scholarships for fiscal year 1991 to provide for tuition and fees, reasonable educational expenses, and a monthly stipend.

In the 1991 fiscal year, the VA expanded the stipend program. Each of the 12 GRECCs received funding to support an occupational therapy student (at the baccalaureate, master’s, or doctoral level) for his or her clinical fieldwork or research program in geriatrics. The GRECC works in conjunction with the rehabilitation medicine service to ensure support from the occupational therapy department (A. Feliciano, personal communication, September 1990). In 1988, the VA provided clinical affiliation training to 23% of all graduating occupational therapy students in the nation and to 19% of all graduating physical therapy students. In addition, 12 medical centers funded interdisciplinary team training in geriatrics for occupational therapy students (VA, 1989). However, fewer than 5% of these students are hired by their hosting facility. Fifty-two percent of occupational therapists decline VA employment because of salary (Personnel Service Central Office, 1986). The VA, therefore, initiated salary increases in addition to its tuition support programs. Special salary rates have been established at more than 100 VA medical centers, providing salaries that are more competitive locally. On May 20, 1988, President Reagan signed the Veterans Benefits and Services Act of 1988 (Public Law 100–322), putting occupational therapy under the Hybrid Title 38 wage scale. This gave personnel managers the authority, in the individual medical centers, to hire and pay professional occupational therapists and physical therapists salaries commensurate with those paid by competing employers. On December 4, 1989, Secretary Derwinski of the
VA signed Circular 00-89-38, which allowed for the actual conversion of occupational therapists from the Title 5 wage scale to the Title 38 wage scale. This congressionally mandated change provided these professionals with opportunities for advancement that were not previously available. Professional advancement can now be formally recognized and financially rewarded. Financial rewards can be provided not only for increased responsibilities, such as management of a specialty unit, but also for advanced educational degrees or publication in professional journals. The retention and recruitment effects of Title 38 are now being studied. The VA’s Rehabilitation Planning Specialist for Occupational Therapy is working diligently on standards for certified occupational therapy assistants and physical therapy assistants so that they may receive salaries commensurate with their 2-year professional education. Certified occupational therapy assistants and physical therapy assistants are currently paid the same rate as nurses’ aides, who receive on-the-job training. In a 1989 survey of VA medical center occupational therapy departments, only 40 facilities employed certified occupational therapy assistants (Gobern, Douglas, & Treijs, 1989).

Directions for Long-Term Care

The variety of VA programs for aging veterans, when used in conjunction with non-VA resources, is unique in its potential to provide a complete range of services to meet the needs of aging veterans. In the past, lack of staffing and funding prevented this potential from being completely realized. However, as of fiscal year 1991, although budget constraints have been evidenced in many areas of government, geriatric programming has been recognized as a priority. The National Institute on Aging’s budget has been increased by 35%, and funding for three new GRECCs for fiscal year 1991 has been approved. There has been an increase of $5 million in health services research, focusing especially on aging. Plans to increase the number of GEMUs have been implemented, including budget allocations for additional staff positions and training programs. Plans have also been implemented for converting 500 VA acute care hospital beds to nursing home beds this fiscal year, with a 5- to 7-year goal of converting a total of 5,000 beds (Yoshikawa, 1990b).

As in all federal and state agencies, budgets are tight, and concern for continued and improved quality of extended-care programs is real. Fortunately, the VA has acknowledged the importance of geriatric programs and the importance of occupational therapists in the care of aging veterans. The conversion of occupational therapy to Title 38, thereby providing opportunities for competitive salaries and financial incentives for professional development, is a breakthrough that has the potential for rebuilding occupational therapy departments that have been understaffed for years. However, the fiscal insecurity of individual medical centers puts the rehabilitation medicine service at risk of not being able to provide professional occupational therapy services to eligible veterans. Individual medical centers have reduced the number of positions within the occupational therapy department as attrition occurs. This places those departments at risk of being unable to provide the quality and quantity of services the veterans deserve even when the remaining positions are filled. It is hoped that the continued support from the VA’s central office in Washington, DC, will protect the integrity of the medical centers’ occupational therapy departments. The wages, benefits, and educational programs should help to lure bright, competent, and enthusiastic therapists who are ready to take on the challenge of the complex disabilities of aging veterans.

The number of occupational therapy positions available has increased from 758 (614 filled) in 1988 to 764 (624 filled) in 1989, with the turnover rate declining from the all-time high of 32.7% to 22.4% (Evans, 1988; B. Evans, personal communication, September 1990). A significant number of occupational therapy positions are still left unfilled, however. The future for occupational therapists in the VA system presents both incentives and exciting opportunities, making the prospect of a geriatric specialty for occupational therapists in the VA a growing reality.

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