REPORT

GOVERNOR'S BLUE RIBBON TASK FORCE ON VETERANS HOMES

September 29, 2000

ALEXANDER KAPITANSKI, Veterans of Foreign Wars of the U.S. life member , makes final touches on a Liberty Bell replica at the Chula Vista Veterans Home dedication, May 13, 2000.

CALIFORNIA HAS HAD A LARGE STATE VETERANS HOME IN YOUNTVILLE, near Napa, since the 1880s. Originally operated by the Grand Army of the Republic, it was turned over to the state toward the end of the nineteenth century.

Governor's Message

September 29, 2000

Dear Task Force Members:

I would like to extend my deepest appreciation for your contributions to the Blue Ribbon Task Force on Veterans Homes and your dedication to enhancing the quality of life for California's veterans. As a veteran, I understand the debt of gratitude we owe the men and women who have given so much to our state and nation. As governor, I am committed to ensuring that our veterans are given access to the best and most comprehensive services available.

Through your efforts we have begun the important task of enhancing the health, safety and dignity of the Veterans Home of California residents. I know there is much more work to be done, but this report by the Governor's Blue Ribbon Task Force on Veterans Homes represents a significant milestone in our plan to ensure that California is serving its veterans, just as they served us. I am proud of what we have accomplished together and I am confident that with your continued assistance we can provide an enhanced, safe and secure living environment in California's state veterans homes, with every resident veteran treated with the utmost respect and dignity. Thank you again for being a part of this important task.

Warm regards,

GRAY DAVIS

Table of Contents

Governor's Message 1

Table of Contents 2

Executive Summary 3

Introduction & Background 16

Chapter 1: Quality of Care 20

Chapter 2: Quality of Life 24

Chapter 3: Alzheimer's & Dementia 26

Chapter 4: Expanding the Vision 28

Chapter 5: Conclusions & Recommendations 31

Appendix A: VHC Levels of Health Care ..40

Appendix B: Acknowledgements 41

COVER PHOTOS (Clockwise): Medal of Honor recipient Mitchell Paige and his wife Marilyn Paige, opening day, VHC-Chula Vista; architect's rendering, VHC-Chula Vista; VHC-Yountville resident Homer Fisher, 101.

BLUE RIBBON TASK FORCE CO-CHAIR L. Jerry Hansen (right) meets Veterans Home of California (VHC) -Yountville Administrator Marcella McCormack (left). Auditor/Investigator Frank Loop (center) talks with Veronica Russo, RN.

VHC-BARSTOW RESIDENT, the late Dorothy Kohlars, 104, accepts honorary membership in The Retired Officers Association. ★

Executive Summary

Background

Governor Gray Davis formed the Blue Ribbon Task Force on December 1, 1999, charging the group with "reviewing and making recommendations on ways to improve the quality of health care provided in California's veterans homes." The governor, a Vietnam veteran, said, "As a public servant, I believe that when Californians leave the armed services, California should not leave them. It is our duty to provide our courageous veterans with first rate health care, and to ensure they are afforded the opportunity to succeed."

The task force will report to the governor on the condition of California's veterans homes. After its initial review of California's veterans homes, the task force will make recommendations to the governor on ways to improve the quality of health care and management in the homes. "I am very pleased that the members of this panel have agreed to examine this very important issue," said Davis. "I have the utmost confidence in these individuals to address the needs of our veterans."

Membership

Each of the governor's appointees selected to the panel is a veteran or a leader in the long-term health care arena. Their comments to veterans home residents follow:

• Dr. JoAnn **Damron-Rodriguez**, Ph.D.:

"I'm at the Veterans Administration at West Los Angeles, the Greater Los Angeles Area. I'm the associate director of the Geriatric Research, Educational and Clinical Center. I'm a gerontologist and interested in services for older people. I'm also at UCLA, the School of Public Policy and Social Research."

• Co-Chair L. Jerry **Hansen**, retired Army colonel, California inspector general for veterans affairs:

"I'm retired Army, 30 years, and a Vietnam veteran. Previously, inspector general for the California Military Department as well as with the prison system. I'm very honored to be working now with veterans."

• Dr. William **Jagust**, M.D., University of California-Davis:

"I'm the chair of neurology at the University of California-Davis and I also run the Alzheimer's Disease Research Center."

• Co-Chair Dan **McCorquodale**, former California state senator:

"I was a sergeant in the Marine Corps. I consider sergeant in the Marine Corps for four years, about the equivalent of being in the Army for 20 years!"

• Capt. John McGinty, Medal of Honor recipient, U.S. Marine Corps (Ret.), military outreach specialist, VA Regional Office-San Diego:

"I'm from the U.S. Department of Veterans Affairs in San Diego. I'm with the Veterans Benefits Administration."

• Col. Mitchell Paige, Medal of Honor recipient, U.S. Marine Corps (Ret.):

"I enlisted in 1936 as a private. Made lots of money, $20.80 a month. Been around a bit in World War II and Korea; my son and I both fought in Vietnam."

• Leon Panetta, former White House chief of staff:

"In my twenties, I was a lieutenant in the U.S. Army. I served as chief legislative aide to the minority whip of the U.S. Senate, and then as director of the U.S. Office for Civil Rights. I later spent a year as executive assistant to the mayor of New York City, and returned home to the Monterey Bay area, where I ran successfully for Congress. My 16 years in the House included four years as chairman of the Budget Committee. In 1993, President Clinton asked me to serve as director of the Office of Management and Budget, and the following year appointed me White House chief of staff. In addition to my work administering, developing and promoting the Panetta Institute, I serve there as principal classroom professor."

• Dr. Jon Pynoos, Ph.D., gerontologist, University of Southern California:

"I am a professor at the other university in Los Angeles, where Fernando used to be, the University of Southern California, at the Andrus Gerontology Center."

• Dr. Fernando Torres-Gil, Ph.D., former U.S. deputy health and human services secretary for aging:

"I'm at the University of California-Los Angeles as well as faculty and director of the UCLA Center for Policy and Research on Aging."

State Veterans Homes

What is a state veterans home? According to the VA, the term 'state home' means a home established by a state for veterans disabled by age, disease, or otherwise, who, by reason of such disability, are incapable of earning a living. A state veterans home is also, according to the California Department of Veterans Affairs' (CDVA) web site, a facility where veterans can come and find a therapeutic community dedicated to providing the required support to allow and encourage members to live quality lives at the highest levels possible. The VA promotes the care and treatment of veterans in state veterans homes as one means to attain the goal of developing and maintaining the highest possible quality of patient care with an appropriate scope to meet the eligible veteran's health care needs. Federal grants for the construction of state homes are authorized by Title 38 United States Code (USC), § 8131-8137, for up to 65 percent of the estimated cost of construction or renovation. Construction must meet federal guidelines to qualify. Federal daily per diem payments for each resident are also authorized, up to half the cost of veterans care in such homes, by Title 38 USC, § 17411743. The fiscal year (FY)

2000 maximum payments are $21.43 per resident per day in domiciliary care, $50.55 per day for skilled nursing or hospital care, up to the 50 percent cap. In addition to federal per diem payments, the homes receive payments for reimbursements authorized under Medicare or Medicaid (called Medi-Cal in California).

The states decide how to meet the gap between federal reimbursements and total cost per resident. Virtually all require some contributions from the residents. The Veteran Homes of California (VHC) requires a contribution of 55 percent of income for domiciliary residents, to a maximum of $1,200 per month. The percentage is fixed in the state Military and Veterans Code (§ 1012.3). Most residents share a room with another resident. Bathrooms are usually located between, and shared by the residents of, two rooms.

In older homes like VHC-Yountville, bathrooms may be centrally located in each hallway in the residential care buildings. Individual contributions for residential care facility for the elderly (RCFE) residents are set at 65 percent of income and for skilled nursing facility (SNF) residents at 70 percent. In addition to federal and individual contributions to home expenses, the state general fund subsidizes the existing two homes to the extent of approximately $33 million per year. Policies among the states regarding the extent of state subsidies vary greatly. The VA encourages state participation in funding because they feel that greater state subsidies result in improved health care, both because of the additional funding itself and because of the greater state oversight that accompanies greater state funding. Some states provide no subsidies from their general funds, requiring residents to pay the differences between federal subsidies and total costs. Residents unable to pay are accommodated to the extent that state Medicaid funding allows. In most states, residents eligible for SNF care are covered by Medicaid if they have spent down their resources to a specified level. Some states cover RCFE care under Medicaid as well. California authorizes Medi-Cal only for SNF level of care, although sources in the state Department of Social Services (DSS) report that policy is currently under review.

California has had a large state veterans home in Yountville, near Napa, since the 1880s. Originally operated by the Grand Army of the Republic, it was turned over to the state toward the end of the nineteenth century.

Home to approximately 1,200 residents, VHC-Yountville provides five levels of care:

1. Unlicensed residential, called the domiciliary, offering 732 beds of independent living;
2. RCFE for 101 beds, licensed by DSS;
3. Intermediate care facility (ICF);
4. SNF (ICF + SNF = 405 beds; and
5. Holderman Hospital, an acute care hospital with 26 beds.

The ICF, SNF and acute care hospital are licensed and certified to federal standards by the state Department of Health Services (DHS) as the agent for the federal Health Care Financing Administration (HCFA).

In the mid-1990s, the state legislature authorized four new 400-bed facilities in Southern California to accommodate a similar number of veterans as VHC-Yountville currently offers in Northern California.

The first of these facilities opened in Barstow in 1996. VHC-Barstow offers three levels of care:

1. Domiciliary (220 beds),
2. Intermediate care (60 beds), and
3. Skilled nursing (120 beds).

The next facility, VHC-Chula Vista, opened in May 2000. Future facilities are planned for Lancaster and Saticoy (Ventura County).

On Dec. 1, 1999, Gov. Gray Davis announced the formation of the Blue Ribbon Task Force (BRTF), charged with reviewing and making recommendations on ways to improve the quality of health care provided at California's veterans homes. Davis had proposed creating the task force in his 1999-2000 budget recommendations to improve the operation of state programs for veterans.

Meetings

The task force began its sessions receiving briefings at the existing state veterans homes in

Barstow and Yountville. Subsequent meetings were held at the VA Health care System of Greater Los Angeles, the new veterans home in Chula Vista and CDVA in Sacramento. Tours of each campus were also part of the process. Briefings and discussion topics included:

1. Quality of care issues;

2. Quality of life issues;

3. External audit findings and recommendations from the past several years;

4. Self-assessments by the homes;

5. A review of budget change proposals submitted by CDVA;

6. Best practices suggested by various professional organizations;

7. Input from residents and veterans organizations; and

8. Other management challenges.

BRTF 2000 MEETINGS

1. VHC-Barstow	=	January 12-13
2. VHC-Yountville	=	February 15
3. USDVA-West L.A.	=	March 17
4. VHC-Chula Vista	=	May 8
5. CDVA-Sacramento	=	June 27
6. Panetta Institute-Seaside	=	August 11

Other Activities

To broaden its inputs and ensure full understanding of the challenges confronting the homes in "Be[ing] All ... [They] ... Can Be," members of the task force met with various outside agencies with regulatory responsibilities in the health care field. These agencies included the VA state veterans home program manager; VA medical centers (VAMC); VA Domiciliary-White City, Oregon; DHS licensing and certification agencies responsible for verifying home compliance with HCFA guidelines and promulgating best practices for SNF; DSS community care licensing personnel responsible for licensing and certification of RCFEs; and county ombudsmen, trained by DHS, who work for the state Department of Aging.

Recent Governor's Initiatives

The task force (TF) reviewed and feels deserved credit is due to CDVA and the Davis Administration for the many initiatives in the veterans home arena which have been implemented recently or are in the process of being implemented. The 2000-01 Governor's Budget proposed an additional $24 million to fund the governor's initiatives, departmental budget change proposals and capital outlay projects relating to the homes. This funding was included in the Budget Act of 2000.

The Blue Ribbon TF strongly supports the following initiatives:

1. Creating a separate position of administrator for each SNF and requiring that the administrator be certified as a nursing home administrator. Previously, the administrator of each home doubled as the SNF administrator and was not required to be certified as a nursing home administrator.

2. Funding recruiting and retention bonuses for licensed staff. The 2000-01 Governor's Budget proposed an additional $4.5 million in recruiting and retention initiatives for the two existing homes. This funding was included in the Budget Act of 2000. The initiatives provide a monthly bonus for licensed nursing staff and other incentives such as assistance in making a down payment on a home (for Barstow). Physical therapy, psychology, psychiatry, and social work need to be included in the staffing pattern. Gerontology and geriatric education should be written into the job descriptions.

3. Creating a separate position of deputy secretary for veterans homes and a quality assurance team at the department level to provide greater oversight to the homes overall and to enhance quality assurance programs.

4. Providing additional positions and funding for staff and training, primarily at the Barstow home. The 2000-01 Governor's Budget proposed and the Budget Act of 2000 includes funding for 21 new positions, primarily health care providers such as doctors and nurses, to address health care issues raised by DHS and to ensure continuous quality care for veterans. Increased training, both at the home and off-site, is needed to ensure that staff has the proper long-term care (LTC) and gerontology skills.

5. Ensuring a full-time chief medical officer (CMO) at all homes, preferably with long-term care experience; requiring the director of nursing (DON) to have a minimum of a bachelor's degree in nursing and previous DON experience in a LTC environment; and increasing the DON's salary as necessary to ensure interest from a highly-qualified pool of applicants.

Findings

The task force found three key areas impacting quality of care:

1. Staffing, including supervision, training and turnover of clerical and medical staff. Within the area of staffing, the task force focused on:

a. Qualifications of administrators and other key personnel,

b. Staff qualifications, training, and turnover,

c. Recruiting and retention incentives,

d. Work load, and

e. Physical setting and the location of the homes;

2. Alzheimer's/dementia issues;

3. System problems concerning the automated system for medical records and related documentation deficiencies.

In the dementia area, the task force considered both the numbers of veterans with dementia who must currently be turned away due to the lack of approved staffing and facilities for dementia, as well as the challenge of meeting the needs of current residents who develop various stages of dementia after they are admitted as residents of the home.

The task force also considered additional initiatives which the department should consider in ensuring that veterans receive first-rate health care and an enhanced quality of life.

Conclusions

1. Pursuant to the California Department of Veterans Affairs mission, the department should continue to provide the state's aged or disabled veterans with rehabilitative, residential and medical care and services in a homelike environment at the Veterans Home of California. This should include independent living (domiciliary), assisted living (residential care facility for the elderly/RCFE) and skilled nursing care.

2. Although the California Business and Professional Code, section 3905, requires administrators of skilled nursing facilities to be licensed by the state, administrators of state veterans homes have not been subjected to that requirement in the past. They should be.

3. Although quality of life has not been a serious problem in recent surveys of the homes, there is room for improvement in some areas, such as creating a more homelike environment, increasing privacy and combating boredom.

4. The department needs to periodically assess special needs of veterans in areas such as Alzheimer's/dementia. The assessment should include the level of care and locations with the greatest need. For example: VHC-Yountville already has a building which could be used as an Alzheimer's/dementia facility at the assisted living (RCFE) level with minor modifications. The care could be provided, as a pilot project, there sooner and at less expense than building a new facility elsewhere.

5. In order to better serve veterans home

residents, CDVA must know more about the demographics of veterans overall and those served by the department -- how many there are, where they live and their social and economic characteristics. An objective needs assessment is needed before deciding locations and configurations of future homes. The intent is to put future homes in the areas of greatest need.

6. The homes currently do not appear to reflect the diversity (ethnic, racial and gender) of the overall veterans population. Minorities who may feel disenfranchised by past practices of discrimination and segregation may not have been reached by prior efforts in the outreach and marketing areas.

7. The task force agrees with the Governor's Aging with Dignity Initiatives in the FY 2000-2001 budget. The initiatives support devices which allow families to stay together longer in their own homes. However, once a veteran is admitted to a state veterans home, VHC should allow elderly or disabled residents to stay as long as the home is able to provide the essential quality of care.

8. The long-term care provisions of the Veterans Millennium Health Care Act encourages the expansion of the scope of the state veterans home program to provide a complete continuum of care, from independent living through assisted living and skilled nursing.

Recommendations

The task force acknowledges that even with the funds provided in the Budget Act of 2000 there are resource constraints within state government. With that in mind, the task force believes the following ('Phase I') priority initiatives should be implemented as soon as possible to ensure quality of care and full federal reimbursements. Some recommendations are already in the process of being implemented.

PHASE I

1. Computerized Patient Records System: Develop an Alternative to Meditech

Conduct an expedited study to review alternatives and recommend the best option regarding the current Meditech computer system. The existing system is slow, tedious, lacking a LTC module and, consequently, detrimental to quality care. Medical staff is spending an inordinate amount of time in data entry and retrieval, time better spent with patients. Possible upgrades -- such as a portable bedside ordering and evaluation capability for doctors -- should also be considered.

Note: One computer system which should be given serious consideration is the VISTA Computerized Patient Record System (CPRS), used at many VA facilities, including the VA domiciliary at White City, Oregon. Since upgrades to the system are nearly complete, the system will soon be owned by the VA and should be available to CDVA at virtually no cost. The system is fast, user-friendly and offers an electronic interface with other VA records and medical centers.

2 . Creating New Positions

A. Creating a separate position of administrator for each SNF and requiring the administrator to be certified as a nursing home administrator.

Note: Funding was proposed for this in the 2000-01 Governor's Budget, included in the Budget Act of 2000, and was implemented as of September 2000.

B. The Governor's Blue Ribbon Task Force on Veterans Homes acknowledges that CDVA has created a separate position of deputy secretary for veterans homes and a quality assurance team at department level to provide greater oversight to the homes overall and enhancing quality assurance programs. The deputy should have long-term care management experience.

Note: The deputy position was proposed in the 2000-01 Governor's Budget and was included in the Budget Act of 2000.

C. Providing additional positions and funding for staff and training, primarily at the Barstow home. The governor's budget adds 21 new positions, primarily health care providers such as doctors and nurses, to address health care issues

raised by DHS and to ensure continuous quality of care for veterans. Increased training, both at the home and off-site, is needed to ensure that staff has the proper long-term care and gerontology skills.

D. Ensuring Full Time CMO

Ensuring a full-time chief medical officer at all homes with LTC experience. Requiring the director of nursing (DON) to have previous DON experience in a LTC environment; increasing the DON's salary as necessary to remain competitive with other LTC facilities.

E. Adding an Assistant Director of Nursing/Nurse Practitioner

Any SNF, with more than 100 beds, is large enough to justify adding an additional supervisory position for assistant director of nursing. A single DON is stretched too thin in a large facility with 24 hour per day operations seven days a week. Another position which should be considered is a geriatric nurse practitioner.

F. Establishing Registries/Retired Annuitant Lists

1) The homes should consider establishing their own nurse registry so that they can control whom they are employing and ensure that all have long-term care training.

2) The department, in cooperation with state Department of Personnel Administration, should establish a list of retired state health care professionals who would be eligible to serve as volunteers or retired annuitants at the homes.

G. Recruiting and Retention (R & R) Incentives

The 2000-01 Governor's Budget proposed an additional $4.5 million in recruiting and retention initiatives for the two existing homes*. The initiatives would provide a monthly bonus for licensed nursing staff and other incentives such as a relocation allowance and assistance in making a down payment on a home. Further incentives in the educational area would also be desirable.

*This funding was included in the Budget Act of 2000.

3. Meeting the Need for Sufficient Quantities of Qualified Staff

Nursing-Type Initiatives

In order to meet the need for adequate numbers of qualified licensed staff in a competitive shortage field, the department must continue to be innovative in incentives to attract "the best." The governor's assistance in the budget act will help significantly. Other possible examples of innovative initiatives follow.

1) Establish a cooperative educational program for nurses, such as the previous 20/20 Program (work 20 hours, attend school 20 hours) at VHC or the Career Development Sponsorship Program at Napa State Hospital. Such a program would help to recruit and retain nursing staff at all facilities. Participation in the program imbues loyalty in the staff and reduces staff turnover. Several graduates of the program at Yountville testified that they continue working at the home to this day because of the opportunities they received through the program. Geriatric education should be a part of the qualifications and training. Nurse training programs with local colleges can help meet the needs for certified nursing assistants (CNAs).

2) Another possibility for nursing staff is an educational bonus, or similar incentive, for RNs who possess a bachelors or masters degree. Consultants indicated that, compared with comparable private facilities, there are very few RNs at the homes with degrees. An inducement to encourage continued education would enhance quality of care and ensure a pool of candidates for supervisory positions. Incentives should also be considered for additional training and qualifications in gerontology.

3) Day care assistance for staff should be

considered. The homes should consider providing such care or, at least, attempt to coordinate day care within the vicinity of the home, such as the Ginger Bread House at VHC-Yountville.

4) The 2000-01 Governor's Budget proposed funding for housing and relocation assistance for VHC-Barstow. This funding was included in the Budget Act of 2000. Providing or subsidizing rental apartments for staff, a recruiting and retention incentive, could also be considered, especially in remote or high-cost areas.

5) The department should consider resources available through existing programs such as Welfare-to-Work, Cal Works, and the VA Work Study Program as potential sources for funding to encourage local residents to enter Certified Nursing Assistant (CNA) or RNA programs.

Non-Nursing-Type Initiatives

In addition to incentives for licensed nursing staff, the department should continue to seek incentives that would attract quality staff across the board and improve conditions for residents. Possible examples follow.

1) Conduct a space study at Yountville to determine the optimal use for vacant and underutilized facilities such as wings B and E in consideration of existing and future veterans' needs.

2) A mentoring and sponsorship program should be initiated for newly assigned staff. The objective is to facilitate all areas associated with the transition to the new job, including technical areas and practical areas such as ensuring the new employee can work out day care and transportation arrangements. The military's sponsorship program works well and is a good model. The best programs usually involve volunteer sponsors with a good attitude and a heart for people.

3) Similarly, systems for billing, accounting and pay must be automated, efficient, timely and responsive. CDVA has the capability to do a needs assessment in-house and should do its own analysis before contracting studies with outside agencies.

4) The task force received several comments questioning the adequacy of security at the homes. The department should consider whether, in addition to a roving security guard, additional security (i.e., a fence) is needed at the homes, especially at VHC Chula Vista, due to its proximity to a densely populated area.

5) The state homes should make use of veterans who served in the health-care profession and are discharged in California. They could be employed as retired annuitants, on a registry list, or as VA work study members. Veterans service organizations and county veterans services offices could assist in locating such individuals.

4. Solutions for Fiscal Accountability and Full Reimbursements

The California Department of Veterans Affairs needs to ensure that it is recouping all allowable reimbursements and ensuring efficient personnel, billing and accounting systems.

A) Since many of the recommendations require additional funding, both onetime and recurring, the department must ensure it is doing everything possible to maximize the level of reimbursements from federal and other sources in all areas - e.g., Medicare, Medi-Cal, medications. Hiring a consultant to assist in creating a more efficient process for recouping reimbursements may be needed/desirable. Additional sharing agreements should be possible with the VA in areas such as ophthalmology, pharmacy, dental, and audiology.

B) The department should also review the level of contributions by members, especially those requiring the highest levels of care. Comparisons should be made with other states to ensure that California veterans are not providing reasonable, but not a disproportionate share of their costs.

C) The personnel system must be able to fill vacancies expeditiously. Homes cannot afford to lose qualified applicants due to a hiring process which is too slow or inefficient. Similarly, systems for billing and accounting must be automated, efficient, timely and responsive.

D) The department should consider additional ways to inform veterans of ways that they can donate time or resources to the homes.

PHASE II

In the collective assessment of the Blue Ribbon Task Force members, additional improvements, while not as urgent or as time sensitive as the Phase I recommendations above, are important for the Veterans Homes of California to fulfill the governor's vision for "world class" veterans homes. Some are achievable with very little additional investment. The task force recognizes that the first priority currently is and must be to bring each home into "substantial compliance" with all state and federal standards. Once that has been achieved, attention should shift to the remaining recommendations. The task force hopes that all recommendations will be considered for existing homes within the next few years and incorporated into planning for future homes. The following list, while not exhaustive, suggests examples of additional improvements that can be made.

1. Alzheimer's/Dementia Care Initiatives

The Veterans Home of California, especially new campuses of the home, should have a dedicated unit and a support staff (i.e., aides) capable of caring for residents who develop Alzheimer's/dementia. The presence of Alzheimer's/dementia patients at the homes is a present reality and the need for appropriate care is growing. A suggested priority list to phase in such a capability over time follows:

Priority No. 1: Fund the staffing and physical plant improvements needed to properly care for Alzheimer's/dementia patients residing at existing state veterans homes, beginning with a pilot project at Yountville, which already has enhanced levels of care and a building which can be modified at the assisted living (RCFE) level.

Priority No. 2: Establish a pilot project for a buddy system for Alzheimer's/dementia patients already residing at VHC.

Priority No. 3: Admit eligible veterans from off-campus suffering from these diseases directly into the Alzheimer's/dementia unit, as space permits.

Priority No. 4: Consider a new state facility dedicated exclusively to Alzheimer's/ dementia patients, perhaps co-located with a VA geriatric facility -such as the centers located in Long Beach or West Los Angeles (the West L.A. VA Medical Center has several buildings ready for CDVA to move on) -- or based at the existing state veterans home in Barstow or Chula Vista or Yountville. A preliminary study should validate the need, the required size, the urgency (time frame), and the estimated cost of such a facility.

2. Providing Care for Local Veterans

In addition to accommodating Alzheimer's/ dementia patients at the veterans homes, the department should study additional ways to meet the needs of veterans in the community. The focus should be to extend the length of time that veterans are able to live independently. This should be a joint effort with local, state and federal agencies, using available community resources to the extent possible. The task force commends the Governor's Aging with Dignity Initiative which provides needed services toward this objective.

3. Providing Vocational Rehabilitation and Training

A. The homes can serve as a support facility for veterans living in the community.

B. Initiate a pilot project to expand the

mission of a state veterans home to fund staff and provide facilities to provide vocational rehabilitation and training. With such training, some domiciliary residents may be able to return to the work force. Others will enjoy enhanced quality of life. The department should consider the programs at the VA Domiciliary-White City, Oregon, as a model. The program operates like a small company and uses minimal space, staff (two full-time) and funding. An extremely cost-effective program, Veterans Industries is essentially self-supporting by competing for contracts to provide products made by veterans. Adding such a program to VHC-Barstow could fill existing domiciliary vacancies by attracting more younger veterans needing such rehabilitation.

4. Create a More Homelike Environment and More Quality of Life Programs

A. The site visits and discussions with residents and staff indicate that existing facilities provide insufficient privacy for residents. While some residents prefer to share rooms, many do not. Even those who share rooms complain about the lack of privacy provided in the way rooms are configured and laid out. Such problems contribute to resident conflicts and frustration. They are further compounded by the sharing of bathrooms among residents of several rooms. Efforts should be made to alleviate these problems through interior changes in existing homes; new homes should be built with different configurations that include more single rooms; different designs for shared rooms; and more private bathrooms. In addition, policies and design should encourage residents to personalize their rooms.

B. The homes must have/need funding for holistic programs, drawing from the nationally recognized Eden Alternative™, to address quality of life issues. The initiative should include funding for a pilot project to address measures to combat boredom, loneliness and feelings of helplessness. Current laws require the campuses to instill a homelike environment and treat residents with dignity and respect. This would formalize a program to improve and measure achievement of those goals. Meeting personal needs such as assistance with taxes and bills or providing areas to pursue personal hobbies, would also be desirable. VHC-Yountville already has space for such activities.

C. An interested veteran provided a suggestion to add a title on the sign at the entrance to each facility reading "Home of Heroes." This and other programs, such as adding a biographical sketch for each resident desiring such recognition on his or her door, would enhance respect for the residents by staff and other residents, while improving self-esteem for the residents. Many residents have distinguished and heroic pasts, not evident or well known. Management should caution staff in addressing residents by a nickname or term of endearment, unless the resident requests to be addressed in that manner.

D. Residents mentioned the vast untapped reservoir of talent available in the resident population. Administrators should maximize the use of resident volunteers to tap those resources on behalf of the home, ensure residents continue to feel needed, and be afforded the opportunity to serve the surrounding community. Some are already employed in the Member Helper Program which could be expanded in a way that remains in compliance with the law and Federal Labor Standards Act (FLSA) requirements.

5. Establishing Special Programs for Residents

The department should use available community, state and federal resources to ensure viable programs for patients with special needs, including (as a minimum) substance abuse programs, psychiatric and other mental health needs such as posttraumatic stress disorder. If a campus does not have an effective program for each special need area, applicants should be directed to the homes having the appropriate programs or enroll residents in existing programs in the community, or through the USDVA. Other programs which should be considered include adult day care, home

health care and hospice.

6. Special Needs

A. Physical therapy is extremely important to the residents' well being and should be a high priority in the budget for space, equipment and staff. A therapeutic swimming pool at VHC-Barstow and VHC-Chula Vista would be highly desirable.

B. Each campus should ensure minority veterans are included adequately in their outreach efforts, and should assess the needs of minority veterans currently residing at VHC.

C. There should be an active veterans speaking program in the community where veterans give as well as receive. As an example, veterans could present a personal living history lesson of their military service to students, K through 12. This is already being done at VHC-Yountville through the Redwood Middle School Program. "Such programs are ongoing at VA medical centers -- as well they should be. Until a person starts talking, he cannot start healing."

Future Homes

Background

Gov. Gray Davis Establishes New Commission on Veterans Homes

The report of the Blue Ribbon Task Force on Veterans Homes provides a logical transition to the new commission.

The charter of the new Governor's Commission on Veterans Homes is to establish findings and make recommendations to the governor and the Legislature on the establishment of veterans homes in California.

According to the Military and Veterans Code, the findings and recommendations may include, but need not be limited to, the following matters:

1. Possible sites of one or more state veterans homes.

2. Selection of a site specifically for the treatment of veterans who suffer from Alzheimer's disease or other diseases causing dementia. Preference should be given to a site with access to an existing medical teaching or research facility.

3. The scope and level of health care, residential care and recreational facilities and other services and amenities to be provided at each home.

4. The number of sites to be established and the resident population to be served at each site, including a description of the type, size, and projected population of each of the residential components of the home, including, but not limited to, assisted living beds, skilled nursing care beds, intermediate care beds, domiciliary care, independent living facilities, and day care facilities.

5. Estimates of design and planning costs, land acquisition costs, capital construction costs, and annual operating costs of each home that would be associated with various modes of construction.

6. Financing options for the development and construction of a home on one or more sites that shall include, but not be limited to, financial assistance available through the VA State Home Grants Program.

7. The management of each home by state or private administration.

Recommendations

The task force recommends that the department as well as the Governor's Commission on Future Veterans Homes ensure consideration of the following factors in site selection and home design, which are not listed in order of priority:

1. Availability of nurses in the area around

the site and local salary levels of such nurses. Some areas have many nurses, but even more LTC facilities vying for the available pool.

2. Proximity to families.

3. Proximity to a VA medical center (MC) within reasonable commuting distance (not more than one hour away). The VA recommendation adopted by some other states of co-locating with a VAMC should be seriously considered.

4. Proximity to other medical centers, such as a university health center offering geriatric care.

5. Proximity of local colleges able to offer nursing courses.

6. Veterans population: An objective needs assessment prior to determining sites for future homes that includes veterans demographics data to ensure that areas with the greatest veterans density receive first consideration.

7. Availability of desirable, affordable housing in the area for staff.

8. There are still privacy issues to be resolved in the individual rooms at the homes. Therefore, CDVA should seriously evaluate the existing platforms and not copy the current model before building additional campuses. The department should learn from past mistakes and require the architect to submit innovative and nontraditional plans for future facilities.

9. Facility designs should consider:

1) More single rooms and individual bathrooms

2) Privacy enhancements and personalization

3) Facilities for married couples

4) Apartments for nurses and other staff

5) Visitor lodging and parking

6) Expanded recreational and warehouse facilities

7) Additional programs such as vocational rehabilitation training and adult day care

10. Greater networking and training with professional groups like the California Association of Health Facilities (CAHF), Quality Care Health Foundation (QCHF), Department of Health Services (DHS), and others. DHS conducts quarterly training sessions where they discuss common issues and bring in administrators and staff members to do brainstorming and discuss best practices.

11. Take greater advantage of the VA's consultation abilities and make sure the homes are using them year-round to improve services, rather than waiting for an annual inspection.

12. Recent historical books and motion pictures and the fund-raising drive for a national veterans memorial in Washington, D.C. have created a greater public awareness of the sacrifices of military service during World War II. The department should take advantage of this patriotic climate and encourage individual and corporate involvement for contributions and funding. ★

TASK FORCE SOUTH (left to right): Dr. Jon Pynoos; Steven J. Dakota, special assistant; Senator Dan McCorquodale, co-chair; Veronica Russo, R.N.; Col. Mitchell Paige; Capt. John McGinty; and Dr. JoAnn Damron-Rodriguez depart the Veterans Home of California-Chula Vista following adjournment of the Blue Ribbon Task Force meeting on May 8, 2000.

4 MEMBERS OF THE BLUE RIBBON TASK FORCE (left to right): Co-Chair L. Jerry Hansen; Dr. JoAnn Damron-Rodriguez, Ph.D.; Former White House Chief of Staff Leon Panetta; and Senator Dan McCorquodale, co-chair, take a break during the final task force meeting on Aug. 11, 2000 at the Leon & Sylvia Panetta Institute for Public Policy in Seaside, Calif.

3 MEMBERS OF THE PEARL HARBOR SURVIVORS ASSOCIATION, San Diego Chapter No. 3, dine at the VIP luncheon following the dedication ceremony at the Veterans Home of California-Chula Vista on May 13, 2000. All three veterans have completed applications for residency at the campus. The gentleman on the far left is Duffy Clemons.

Introduction & Background

Introduction

Governor Davis formed the Blue Ribbon Task Force on December 1, 1999, charging the group with "reviewing and making recommendations on ways to improve the quality of health care provided in California's veterans homes." The governor commented, "As ... a Vietnam veteran and ... public servant, I believe that when Californians leave the armed services, California should not leave them. It is our duty to provide our courageous veterans with first rate health care, and to ensure they are afforded the opportunity to succeed."

> **"The governor ... wants to ensure that the Veterans Homes of California are world-class, second-to-none."**
> **Jerry Hansen, co-chair**

The Members

Task force members included:

1. Dr. JoAnn Damron-Rodriguez, Ph.D., gerontologist, University of California-Los Angeles, VA Greater Los Angeles Healthcare System:

"I recently visited Yountville for the first time and enjoyed the beautiful place and the dedication that the people there have to serving the residents."

2. Co-chair and Vietnam veteran Col. L. Jerry Hansen, U.S. Army (Ret.), California inspector general for veterans affairs:

"The governor established the Blue Ribbon Task Force, not primarily because there were problems, but also because he wants to ensure that the Veterans Homes of California are world-class, second-to-none. As the Department of Finance and other agencies look at budgets and budget proposals, they want to ensure resources are focused in the right direction and include the right initiatives, the right projects. The task force will consider the various alternatives to ensure we retain the best that's already there and incorporate any additional changes needed to ensure that we are, in fact, a world class veterans home -- a network of veterans homes. Recently, in addition to the creation of the Blue Ribbon Task Force, the governor created my position as the inspector general, as well as the new deputy secretary for veterans homes. All of these initiatives are indications of the support at the top for the veterans homes. And we're all part of the solution, but veterans home residents are also valuable resources and that's why we are meeting at VHC-Barstow, Yountville and Chula Vista to get inputs that might help us in our task. "

3. Dr. William **Jagust**, M.D., University of California-Davis:

"I've been to Yountville a couple of times actually, but it's really always a pleasure to go back there."

4. Co-chair and former California state Senator Dan **McCorquodale**, a former Marine:

"I was very pleased to see that the governor would take the interest that he has taken in veterans -- to be supportive of the continuation of building the additional homes, to look at what's happening, to recognize that over a period of time, facilities will deteriorate some, that the times change, that you have to deal with keeping facilities up-to-date, being able to ensure that they are licensed, that they meet licensing standards, that they meet the health and safety standards. And really, the state is providing through Yountville and in Barstow and soon in Chula Vista, homes for about 1,500 people. So these are the veterans' homes. The state is, to some extent, the landlord and the landlord has a responsibility to ensure that the tenants have safe facilities, that veterans have the opportunity to exercise the capacities that they want to exercise, that veterans take part in the events and activities that they want to take part in, and that they are as productive and as active and as involved in their life as they want to be. And to ensure that they do that in a safe and healthy setting. So that's our job and our goal -- to bring together and to focus attention on all the issues that veterans live with every day -- and to ensure that we inform the governor and get the attention of the Legislature, the administration, and others in dealing with the issues affecting veterans home residents."

5. Medal of Honor recipient and Vietnam veteran Capt. **John McGinty**, U.S. Marine Corps (Ret.), military outreach specialist, VA Regional Office-San Diego:

"I'm glad to be a member of the task force. And I might also say that my mother told me the same thing that Mitch Paige's mother told him, 'Trust in God. Don't try to figure out everything by yourself and God will show you the way.' And when I got to Parris Island, I got to meet God who was my drill instructor."

6. Medal of Honor recipient and retired Marine Col. Mitchell **Paige**, a veteran of three wars, World War II, Korea and Vietnam:

"This is truly a special occasion for me as it is for all on this panel, I'm sure, because we must do everything in our power to assist the veteran. We have to stick together and help one another. You veterans, I honor each and everyone of you. I know that you've experienced all sorts of things, but I know somewhere in your life that God showed you the way and helped you through. Thank you for allowing me to be part of this panel because we're going to do everything in our power to do whatever is necessary to make things better for you. And we just trust in the Lord that we can do that for you."

7. Former White House Chief of Staff and former U.S. Representative Leon **Panetta**, director of the Panetta Institute, Seaside, Calif.:

"As a congressman, I authored numerous successful measures that established Medicare and Medicaid reimbursement of hospice care for the terminally ill and other measures on a variety of health issues. I served as a first lieutenant in the U.S. Army from 1964 to 1966, and received the Army Commendation Medal."

8. Dr. Jon Pynoos, Ph.D., gerontologist, University of Southern California:

"Yountville is a landmark facility. And I must say, coming to the campus, the facility is so beautiful and the grounds are so lovely and the spirit of the staff and the residents that I have met along the way are heartwarming. I agree with everyone else on the panel that we're to do our best to make things even better at all the campuses of the Veterans Home of California, including Barstow and China Vista, and also to make the new facilities, the new places, the new homes that are being built, even better by learning what has transpired and taking the lessons from and applying them to other places. I'm really privileged to be on this commission."

9. Former Deputy Secretary for Aging, Health and Human Services, Dr. Fernando Torres-Gil, Ph.D.:

"It's my great pleasure and honor to meet with the residents to do my small part to improve conditions at the Veterans Home of California and for all veterans. I'm honored especially to be with Medal of Honor recipients Mitch Paige and John McGinty and the number of veterans and heroes that I've met during my visit to the homes."

Background

The task force began its sessions receiving briefings and tours at the existing state veterans homes in Barstow, Yountville and Chula Vista. Briefings and discussion topics included:

1. Quality of care issues,
2. Quality of life issues,
3. External audit findings and recommendations from the past several years,
4. Self assessments by the homes,
5. A review of budget change proposals submitted by the VA.

To broaden its inputs and ensure full understanding of the challenges confronting the homes in "Be[ing] All...[They]...Can Be," members of the task force met with various outside agencies with regulatory responsibilities in the health care field. These agencies included:

1. VA medical centers (VAMC), the state veterans home program manager, and the VA Domiciliary-White City, Oregon;
2. State Department of Health Services (DHS) licensing and certification agencies responsible for verifying home compliance with federal Health Care Financing Administration (HCFA) guidelines and for promulgating best practices for skilled nursing facilities (SNF);
3. State Department of Social Services (DSS) community care licensing staff with responsibility for licensing and certification of residential care facilities for the elderly (RCFE); and
4. County ombudsmen who service both SNFs and RCFEs under the staff supervision of the state ombudsman in the Department of Aging.

Findings

What is a State Veterans Home?

1. According to CDVA's web site, this is a question that is often asked by those who have little or no experience with the Veterans Homes of California. The answer is both simple and complex. According to the VA, the term 'state home' means a home established by a state for veterans disabled by age, disease, or otherwise, who, by reason of such disability, are incapable of earning a living. A state home may provide nursing home care, domiciliary care or hospital care in combination with another level of care. The simple answer is, a state veterans home is a facility where veterans can come and find a therapeutic community dedicated to providing the required support to allow and encourage members to live quality lives at the highest levels possible. From this simple descriptive base, the operative description becomes much more complex.

2. Home members are veterans of military service ranging from World War I to the Vietnam War, and sometimes their spouses. The most obvious common characteristic relates to their

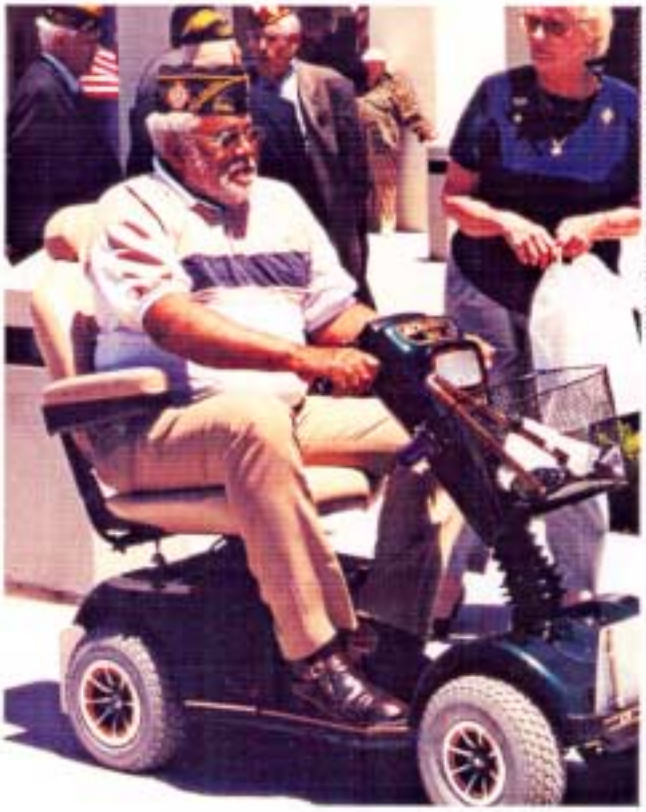
military service. For each service period represented, the experience of entering the military represented for many the first introduction to people from different social, economic and geographic backgrounds, and the first opportunity to experience real responsibility. From the rigors of basic training to wherever their careers may have taken them, they shared a code, a language, a prospective, and a commonality of purpose which was service to their nation. As a reward for that service, a grateful state of California has established a system dedicated to assuring that veterans, who have sacrificed so much, are provided care and support as the need develops.

3. The veterans homes are considered therapeutic communities in their entirety. The therapies may range from a simple "good morning" to involved medical procedures. The caregivers may be members of the food service, maintenance, security, medical, or nursing staffs, or a host of volunteers who are intimately involved in providing service to members on a daily basis. In each case the care is tailored for the needs of the individual. And because of the extraordinary relationships that exist in this rare situation, the caregiver often experiences as much benefit as the recipient of the care.

4. Residents may become as actively involved in the affairs of the homes as they desire by volunteering their time in activities such as the resident-managed Allied Council, writing for campus newsletters, or concerning themselves with issues and pursuits of a more personal and private nature -- reading, painting, music or a large variety of other activities. As home member Bill Bayless so eloquently phrased it, "Come here to find peace or stand up one more time, ...each to his dream." Choices are a critical aspect of one's life, wherever home may be. And the homes seek to provide those choices. As in any community, opinions may differ on what the best approach may be to resolving an issue or starting a new program or activity. At the homes, you can always count on an active debate as solutions are sought. This is healthy for the community.

5. Many residents develop strong bonds of camaraderie. The degree to which members provide care and concern for each other is truly remarkable. There are instances where those facing certain functional limitations form mutually beneficial relationships, where together they overcome their individual challenges - "I'll help you with your brace and you can help me read my mail." This kind of sharing goes on all the time, and is so common as to be taken for granted. One only has to reflect on the reasons for coming to the homes to realize just how remarkable these communities are. It is a common experience for veterans to come to the Homes in failing health, and sometimes in despair, and find they thrive on the many positive aspects of life at one of the facilities.

6. And when life as we know it has ended, it is then that the real depth of caring is most poignantly revealed by the dignified and often tearful responses to Taps being played for fallen comrades. Concurrently, there is also a sense of celebration in remembrance of a life well-lived and made better by the opportunity to have been a part of this extraordinary experience. ★



PUBLIC AFFAIRS OFFICE, VHC-CHULA VISTA

TOM DORSEY, state chairman of the Veterans of Foreign Wars of the U.S. blood drive, traverses the Chula Vista campus on May 13, 2000.

Chapter 1: Quality of Care

Background

The task force found three key areas impacting quality of care:

1. Staffing, including supervision, training, and turnover of administrative and medical staff. Within the area of staffing, the task force focused on:

a. Qualifications of administrators and other key personnel,

b. Staff qualifications, training, and turnover;

c. Recruiting and retention incentives,

d. Work load, and

e. Physical setting and the location of the homes.

2. Alzheimer's/dementia issues, and,

3. System problems, including the automated system for medical records and related documentation deficiencies.

In the dementia area, the task force considered both the numbers of veterans with dementia who must currently be turned away due to the lack of approved staffing and facilities for dementia, as well as the challenge of meeting the needs of current residents who develop various stages of dementia after they are admitted as residents of the home. The task force also considered additional initiatives which the department could consider in ensuring that veterans not only receive first-rate health care, but quality of life issues important to ensuring veterans achieve their full potential.

Problems

1. Alzheimer's Disease and Dementia Care

Oversight agencies have raised concerns about the ability of both homes to care for Alzheimer's and dementia residents. Although the admissions policies currently preclude admission of veterans with dementia, a number of residents develop dementia symptoms after admission. CDVA has requested additional funding support to make staff and facility changes necessary to accommodate residents with dementia. An independent study commissioned by the department in 1997 concluded that necessary changes to existing facilities would require initial funding of $6.4 million and, at least, an additional $296,400 per year to provide the increased level of care.

2. Other Problems at the Veterans Home of California

State and federal oversight agencies -- DHS, DSS, the Bureau of State Audits (BSA) and the VA -- have cited both the Barstow and Yountville campuses for a number of compliance issues in recent years related to management problems and difficulties in hiring sufficient quantities of qualified health care professionals.

DHS has cited both homes for problems related to quality of care. In the five years of its existence, Barstow failed to pass its initial annual certification survey four times. Some of the citations raised serious quality of care concerns.

Findings

1. <u>Staffing</u>

a. <u>Qualifications of Administrators and Other Key Personnel</u>

Although the California Business and Professional Code, § 3905, requires adminis-

trators of SNFs to be licensed by the state, administrators of state veterans homes, in the past, have not been subjected to that requirement.

The reasons are twofold:

1) Because VHC-Yountville has an acute care hospital as well as a SNF, the license of the hospital administrator covered the SNF as well, and

2) Because CDVA relied upon Title 22 California Code of Regulations, section 72007, which seems to allow an exception for state facilities where the administrator is a state civil servant.

CDVA has recently decided to hire a separate licensed administrator for the skilled nursing facility (SNF) and the governor approved funding for the position in the FY 2000-2001 budget.

In addition, the home administrators have agreed to undergo the licensing process by working under the tutelage of a licensed administrator for six months until they are licensed themselves. This double initiative will mean that all homes will eventually have both an overall home administrator and a SNF administrator, licensed by the state. They will also have a certified administrator for their RCFE.

b. Staff Qualifications

In addition to the minimum qualifications for job classifications -- e.g. a registered nurse (RN) license for RN positions -- other desirable educational and experiential qualifications which promote quality of care are in short supply. For instance, virtually no RNs possess a bachelor's or master's degree. Very few incoming nurses or doctors have long-term care (LTC) or gerontology experience. Incentives are lacking to encourage busy professionals to continue their education on their own beyond the minimum number of hours required for continued licensing.

1) Training

Although each home has at least one nurse trainer, more are needed. Barstow has had only one and this trainer has been overloaded attempting to schedule and conduct training for nurses on all shifts. The governor's budget this year recognized the need for more. Nurses report being asked to teach classes in subjects in which they are weak themselves. Each nurse is required to receive 30 hours over a two year period in order to renew their license; it is their responsibility to arrange that training on their own. Many do it through correspondence courses. There are many excellent training opportunities available through professional organizations focused on LTC, but some staff members report they have given up requesting the training because their request either doesn't make it into the budget or it is the first thing cut when the inevitable belt-tightening occurs later in the year.

2) Turnover

Attracting and retaining the quality and quantity of health care professionals needed for large veterans homes is a continuing management challenge. The problem is shared by both existing veterans homes. The town of Barstow does not have a sufficient labor pool of nurses so the home must recruit from as far as San Bernardino (80 miles); even the two nurse registries used are located more than 20 miles away. Many medical staff simply do not want to live in the high desert or their spouses cannot find suitable employment. Although there are more nurses in the Yountville area, there are four other major facilities in the area drawing upon the same labor pool. The pay and incentives tend to be higher at the other facilities and the private facilities are able to leapfrog ahead whenever the home succeeds in gaining approval for an incentive. The challenges exist nationwide due to an overall nursing shortage. State facilities are particularly challenged when competing with generous salaries and benefit packages at private facilities.

c. Recruiting and Retention

Although CDVA has requested funding for recruiting and retention incentives in the past, approval through the budget process has been illusive until this year. A previous cooperative education program called 20/20 was an excellent incentive to attract and retain staff who wanted to progress in their nursing education to the next higher level and beyond. A number of the RNs currently at Yountville are products of that pro-

gram. They report that they would not be there today if it had not been for that program, which allowed them to become licensed as RNs and instilled a loyalty toward the home because of what they had received. Between 1985 and 1991, when fund-raising was eliminated, 26 employees successfully completed the 20/20 Program. Twelve of those employees currently are still employed at VHC-Yountville. The new governor's budget for FY 2000/2001 recognized the need and provides assistance with moving expenses and down payments on homes as well as a bonus of $400 or more per month.

d. Work Load

Federal Health Care Financing Administration (HCFA) guidelines provide a ratio of licensed staff hours of care per patient to meet a minimum standard for numbers of nursing staff. The numbers for skilled nursing are 3.2 hours per day for residents of a skilled nursing facility (SNF), 1.1 hours per day for residents of an intermediate care facility (ICF) and 0.7 for residents of a special treatment center. DHS surveys frequently report insufficient numbers of nursing staff even if the facility exceeds the numerical ratio prescribed by HCFA. The rationale is that the numbers provide a minimum for a standard facility, but the number may be too low for a specific facility. Variables such as staff training levels, efficiency, and numbers of residents needing more intensive care may dictate a higher minimum for a given facility. Some facilities may opt for more certified nursing assistants and fewer licensed vocational nurses or RNs, while other facilities may have more patients requiring the services of licensed staff. For instance, if the facility has a number of residents with "g-tubes," they should be attended by licensed staff. When a facility operates with vacancies in nursing staff or nurses out for illness, vacations or other reasons, the facility must either fill in with permanent staff on overtime or hire temporary staff, typically from a nurse registry. Using more nurses from a registry to fill in the gaps puts a greater work load on permanent staff since the registry nurses may not know the residents, may not be allowed to make computer entries in medical records, and may be inexperienced in LTC or gerontology. The physical layout of the facility may also affect the minimum staffing levels.

e. Physical Setting

An objective needs assessment is needed before home site selection to ensure that veterans demographics, available skilled labor pool and acute care hospitals in close proximity will support the size and location of the planned facility. Homes should be located in the areas with the greatest need due to density of eligible veterans.

2. Alzheimer's/Dementia

In the dementia area, the task force considered both the numbers of veterans with dementia who must currently be turned away due to the lack of approved staffing and facilities for dementia, as well as the challenge of meeting the needs of current residents who develop various stages of dementia after they are admitted as residents of the home.

3. Automation and Documentation

The task force reviewed the overall system within the homes for the delivery of medical care. The review considered the effectiveness and efficiency of the current computer system as well as the entire process for documenting health care.

The current computer system in use by the homes is a commercial program used in many acute care hospitals. While the system may be effective in other environments, it has become a burden to the homes. Although the system is reasonably effective at capturing reimbursable expenses, it does not work well for the medical staff who use it for data entry and retrieval. The system is not user-friendly; it is a disk operating system or DOS-based rather than Windows-based, featuring dumb terminals (with no mouse) that must be used to access a centralized computer server in Yountville; it lacks a LTC module; and it requires the user to scroll through numerous pages of material to get to the screen needed by the operator. Users report that the system is slow and subject to numerous delays in data entry and

retrieval.

When the system was purchased, CDVA staff members were expecting a turnkey, user-friendly system, which would meet their needs without significant modification, training, or maintenance needs. VHC-Barstow and VHC-Yountville "went live" in 1996 and 1998, respectively. However, neither home had adequate training packages and integration is not complete.

The department has begun to research alternatives to the current computerized system. Alternatives fall into one of two categories:

A. Upgrades to the current system, which may include additional modules either integrated into the system or operating independently; and/or

B. Replacement systems.

Replacement components or systems fall into two categories:

A. Those commercially available and

B. Those available within other government agencies, such as the VA. ★

VETERANS HOME OF CALIFORNIA-BARSTOW SKILLED NURSING offers a range of medical care that provides continuity in the lives of residents and assures a comprehensive health care program in an atmosphere of dignity and respect, according the VHC-Barstow home page.

Chapter 2: Quality of Life

Background

Current laws (42 CFR 483.15 et al) require surveyors of LTC facilities to assess quality of life. The objectives of the assessment are:

1. To determine if the facility protects and promotes residents' rights,
2. To assess the impact of overall facility environment (schedules, interactions with staff, policies, etc.) with the quality of residents' lives,
3. To determine if the facility is assisting the residents in achieving their highest possible level of well-being, and
4. To ensure the facility provides equal quality of care for all residents.

Findings

1. Combating Loneliness and Boredom

VHC-Yountville has attempted a pilot project, patterned after the Eden Alternative™ philosophy, to address quality of life issues. The program specifically addresses measures to combat boredom, loneliness and feelings of helplessness. The project incorporates animals and plants into the residents' daily lives, to give them an opportunity to care and to nurture. Pets, children, gardening and a homelike environment are all important ingredients in bringing a feeling of independence to residents in LTC facilities. Funding to increase the scope of the initiative has been limited.

"The project brings a homelike environment to a LTC facility," said Karen Zanetell, coordinator of volunteer services at VHC-Yountville. "From my perspective, it allows us to bring in children, families, the community, pets, beautification, wall coverings, plants, and so forth. It makes the environment much more homelike, realistic and warm. It's a fabulous program."

2. Teamwork

Commenting about teamwork, Zanetell said, "We do work in teams. We had a performance improvement team for the Quality of Life Program. At that time, it was the fall of 1999, there was a team composed of home members and staff. It was a conceptual part of the project. Since then, we have a couple of targeted areas, 1C and 1D, for the project. They are the first places where the staff and home members got together and intensively planned what they wanted to have in the environment. They have a beautiful courtyard with flowers, vegetable gardens, and planter boxes, accessible for wheelchair people. They have a cat and birds and fish, so they have lots of animals We're excited about focusing on well-being and positive health habits. The whole wellness concept is a paradigm shift at the home. It's really exciting to be a part of the changing way we're doing things."

3. VHC-Barstow's Create-a-Smile Pet Therapy Program

Animals have gotten into the act at VHC-Barstow. The Create-a-Smile Pet Therapy Program has been a psychologically important part of the patient care plan. Buddy, a Bichon Frise, has been the home's social therapy dog. Every Tuesday morning, he visited patients wearing a little blue jacket and photo identification badge. A German shepherd named Molly visited on Sundays. These specially trained animals administered unconditional love to everyone they encountered. Animal assisted therapy is proven to help reduce blood pressure, stress and anxiety. It aids in the treatment of depression, stimulates

motivation, memory and attention span and enhances speech and social skills, self-esteem and confidence. Alzheimer patients respond exceptionally well to animal assisted therapy.

4. VHC-Yountville's Plant Therapy Program

At VHC-Yountville, gardens in raised flower beds have been a popular addition to the campus. They're the right height for residents in wheelchairs, and the brightly colored flowers and the herbs are great therapy for the residents.

As reported on *California Heartland*, broadcast by Sacramento PBS affiliate KVIE-6 on June 29, 2000, Cpl. Walter Kirby served as a medical specialist in the U.S. Army from Nov. 3, 1961 to March 5, 1965 and has lived at VHC-Yountville since 1982. To stay active, Kirby developed a love of gardening.

"This is my third garden here on the grounds," commented Kirby who said, "This is the largest garden on the grounds."

His garden adds a nice touch to the landscape of the veterans facility. Along with the beautiful flowers, Kirby grows carrots, lettuce, tomatoes and pumpkins. His love for gardens has inspired others at the home to take an interest as well. New plots have been built, encouraging other residents to exercise their green thumbs, even those with special needs.

"Our home members are really involved in coming out here and watering and tending to the garden," said Vickie Allen, supervisor of Therapeutic Activities at VHC-Yountville.

Kirby is pleased that his gardening is inspiring others, but he has no plans to slow down.

"Well, Walter is a phenomenon. And he's working seven days a week," said Larry Latman, chair of the Allied Council at VHC-Yountville.

"[It] keeps you busy. You're out in the weather and the sun. And I find it keeps me healthy. I enjoy it," said Kirby. ★

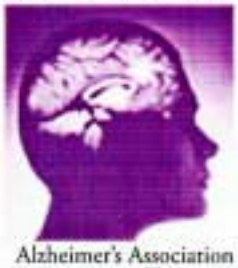
PHOTO PROVIDED BY RETIREMENT HOUSING FOUNDATION

PET THERAPY is an activity enthusiastically received by residents. Frances Gier (left) and June Jewett (right) respond to Spunky (the dog).

Chapter 3: Alzheimer's & Dementia

Background

"Imagine your brain as a house filled with lights. Now imagine someone turning off the lights one by one. That's what Alzheimer's disease does," according to "The New Science of Alzheimer's (Racing against time -- and one another -- researchers close in on the aging brain's most heartbreaking disorder)," published in the July 26, 2000 issue of *Time* magazine. Author J. Madeleine Nash goes on to say that Alzheimer's "turns off the lights so that the flow of ideas, emotions and memories from one room to the next slows and eventually ceases. And sadly -- as anyone who has ever watched a parent, a sibling, a spouse succumb to the spreading darkness knows - there is no way to stop the lights from turning off, no way to switch them back on once they've grown dim."


Alzheimer's Association

Findings

CDVA commissioned a study regarding Alzheimer's disease and related dementia in 1998. The scope of the study included the magnitude of the challenge for the population of veterans in the target age groups, the adequacy of the current program in view of the current admission restrictions regarding dementia and the likely impact of broadening the admission criteria to admit more veterans with diagnosed dementia.

Statistics indicate that the average age of residents is currently 79; at that age, roughly 20 percent of the population has dementia of some severity. Estimates at the homes support those statistics. Despite admissions restrictions, residents develop dementia after admission with rates similar to national averages.

Higher levels of cognitive impairment - those with Global Deterioration Scales (GDS) of 4-7., as defined by B. Reisberg et al (1982) in *The American Journal of Psychiatry*, 139 - need assistance with most activities of ADL such as grooming, hygiene, dressing and eating; they need special care skilled nursing units or traditional skilled nursing units.

In a July 26, 1999 evaluation of the RCFE at VHC-Yountville, the state Department of Social Services (DSS) cited deficiencies in the following area:

- Care of clients with dementia

DSS concluded that, because some current residents had cognitive and behavioral deficits associated with dementia, the facility must comply with Title 22 California Code of Regulations (CCR), § 87724, regarding physical plant, staffing and plan of operations documentation. These requirements include:

1. Fenced yards,
2. Exit alarms,
3. Additional staff training and
4. Approved individual care plans for each resident with dementia.

DSS also commented that the 100-plus bed RCFE requires a full-time, qualified administrator who is not responsible for the domiciliary as well as the RCFE. The department has taken steps toward approval and funding of a separate position for the RCFE administrator.

The department would prefer to

provide a complete continuum of care for residents with dementia in recognition of the need existing among current applicants for the homes as well as the deterioration of cognitive ability among current residents. The 1998 study commissioned by the department supported a complete continuum of care, but funding was placed in abeyance while awaiting Blue Ribbon Task Force recommendations.

The Montague-DeRose study attempted to quantify the initial cost of modifying facilities to accommodate a full continuum of care for dementia patients, but they acknowledged the need for a more detailed staffing realignment and cost impact study to assess future costs associated with implementing a best practice dementia care model for each home.

A key cost factor will be the establishment of a threshold of cognitive impairment which applicants or residents must meet in order to remain at the homes. Although the ideal situation is to allow all cases, exceptions may continue to be necessary. Actually, some wanderers can be cared for with controlled perimeters, i.e., fenced yards, automatic door locks, etc. However, some of the most challenging dementia cases are those that exhibit agitated, aggressive, angry and abusive behaviors toward other residents and staff. In such cases, the veteran may be too great a challenge for him or her to remain at home and the department should coordinate with other service agencies to ensure a satisfactory solution.

Nationwide, 37 of 48 state veterans homes (77 percent) responding to an informal 1996 poll reported that they accepted Alzheimer's and dementia patients and had programs for their treatment. ★

THE SPECIAL CARE POD at VHC-Barstow provides residents with 24-hour full-time skilled nursing care on an extended basis. Residents receive rehabilitation, nursing, pharmaceutical and dietary services and can participate in activity programs. The three patient wings at the Barstow campus are accessible through connecting corridors.

Chapter 4: Expanding the Vision

Introduction

The U.S. Department of Veterans Affairs (USDVA), which subsidizes state veterans homes through construction grants and daily per diem payments, defines a state veterans home as a home approved by USDVA which a state established primarily for veterans disabled by age, disease, or otherwise who by reason of such disability are incapable of earning a living. A state veterans home may provide domiciliary (independent living) care, residential care for the elderly (RCFE) (assisted living), nursing home care, home health care, and/or hospital care. Hospital care may only be provided when the State home also provides domiciliary and/or nursing home care.

Background

Other alternatives which can extend the time veterans can live independently include adult day care programs, home health care and hospice care. VHC-Yountville currently provides all levels of care, including hospital but not adult day care or home health care. They have studied the feasibility of adding home health care and concluded it was not a cost-effective alternative in their situation. VHC-Barstow currently offers only domiciliary and skilled nursing care. They expect to offer an RCFE assisted living option soon. VHC-Chula Vista will offer domiciliary and skilled nursing initially, expanding to RCFE as well. None of the homes currently have plans to offer adult day care or home health care. Another option within the scope of the domiciliary concept is to include vocational rehabilitation programs. Federal models for such programs are found at the White City, OR VA Domiciliary, where the age of residents due to such programs is much lower (49 years) than at current state veterans homes in California (79 years); and the West Los Angeles veterans center. Additional study is needed to determine the desirability of expanding the role of VHC-Barstow to include vocational rehabilitation options. Since the domiciliary there has never reached capacity and the home is not that close to veterans in the Los Angeles basin in need of such programs, Barstow may be able to fill that need in coordination with existing federal VA facilities.

Nationwide, 10 of 46 state veterans homes (22 percent) responding to an informal 1996 poll reported having formal vocational rehabilitation support programs.

Findings

1. Changes Over Time

According to the VA report "The Changing Veteran Population: 1990 - 2020," published in March 2000 (by the Assistant Secretary for Planning and Analysis, Office of the DAS for Program and Data Analyses), since the last Census in 1990, the estimated total veteran population in the U.S. and Puerto Rico declined 9 percent, from 27.3 million in 1990 to 24.4 million in 2000. By 2010, the total veteran population in the U.S. and Puerto Rico is expected to decline to 20.1 million. By 2020, it is projected to decline to 16.2 million. Between 2000 and 2020, the year-to-year rate of decline in the total veteran population is projected to be, on average, nearly 7 percent.

The decline in the total veteran population between 1990 and 2020 masks differences among component age and period of service groups. For example:

A. There is a projected decline in the

veteran population "under 45", primarily as a consequence of the down-sizing of active duty forces.

B. Veterans age "45-64" declined steadily from 1990 on.

C. The number of veterans age "65 or over" is projected to increase from 7.2 million in 1990 to a peak of 9.3 million in 2000.

D. Most veterans age "65 or over" in 2000 will be World War II veterans, but they will be superceded by age "65 or over" Vietnam era veterans.

More specifically, a second peak of close to 9 million veterans age "65 or over" will occur about 2013, as Vietnam era veterans age.

Between 2010 and 2020, all the age groups shown are projected to decline. However, the proportion of veterans "65 or over" is projected to increase, from 43% in 2010 to 51 % in 2020. This is because the Vietnam era cohort, who will make up much of this age group in 2020, far outnumbers later cohorts.

Dramatic changes are projected for the "oldest old" veterans, age "85 or over". Their number is projected to increase more than eightfold, from 154,000 in 1990 to 1.3 million in 2010. By 2020, however, the number of veterans "85 or over" is projected to decline to 1.2 million, reflecting high mortality among the World War II cohort, who will make up most of this age group in 2010, and the smaller size of later cohorts who will move into this age group by 2020.

2. State Veterans Population

The total number of veterans in each state is projected to decline between 1990 and 2020.

California, the largest state, is projected to have the largest absolute decline of 1,278,700 veterans (from 2,970,100 in 1990 to 1,691,400 in 2020).

3. State Veterans Population Age "65 or Over"

Between 1990 and 2020, a decline in the *total veteran population* for each state masks a different trend from that projected for *aged veterans.* While the total number of veterans in each state is projected to decline, the number of veterans "65 or over" is projected to increase in more than 40 states. Although not in the top five, California is among the states with the largest percent increase (22.4%) in the number of veterans "65 or over," from 747,869 in 1990 to 915,523 in 2020.

4. State Veterans Population Age "85 or Over"

Between 1990 and 2020, the number of veterans "85 or over" is projected to increase even more dramatically than veterans "65 or over" for each state, with multi-fold increases in the "85 or over" population. For example:

1. Among the states with more than a tenfold increase are Alaska, Nevada, South Carolina, North Carolina, Delaware, Hawaii, and Georgia.

2. Among the states with a fivefold increase or less are South Dakota, New York, Iowa, Oregon, Kansas, and the District of Columbia.

3. Among the states projected to have more than 55,000 veterans "85 or over" in 2020 are: California (130,500); Florida (94,500); Texas (73,900); New York (68,500); Pennsylvania (67,500); and Ohio (55,600).

5. Major Study Says Longevity Is Up, But So Is Chronic Disease

America's seniors are living longer, healthier and wealthier lives, but also suffer form chronic health conditions and depression, and women especially face economic stress as they age, according to the Aug. 10, 2000 *Sacramento Bee* story "A snapshot of older Americans."

Quoting the page A15 story by Jennifer Sergent, Scripps Howard News Service: "Those are the findings of a federal study billed as the first comprehensive assessment of what life is like for Americans 65 and over. The report, called "Older Americans 2000" and put together over a year by a consortium of 10 federal agencies, was released Aug. 10, 2000.

"I can't emphasize enough the value of having all this information in one document," said Jeanette Takamura, assistant secretary for aging at the Department of Health and Human Services. "It describes the longevity revolution and the

challenge we are given, since we have not seen any other generation live quite as long or in such great numbers."

The 128-page report describes, in 31 categories, how seniors are faring:

1. The 65-and-over population has increased ten-fold since 1900, and will more than double by 2030. Also increasing are the proportions of ethnic minorities, such as African Americans, Latinos and Asians.

2. Older Americans living in poverty have dropped substantially, from 35 percent in 1959 to 11 percent in 1998. More than two-thirds reported medium to high incomes, up from just half in 1974. The poverty rate remains higher among women and minorities.

3. Life expectancy is up nearly 30 years from 1900, from 48 to 74 years for men, form 51 to 79 for women.

4. Reports of chronic disease such as arthritis are up slightly among people age 70 and older, compared to just 10 years before. Memory impairment and depression increased with age.

5. Reliance on home-care services has increased, and while fewer people are using nursing homes, those who do tend to be sicker and less able to get around on their own.

Legislation such as the Older Americans Act addresses new aspects of the aging population, such as the increased need to support family caregivers. The act, which the Senate is expected to consider in September 2000, offers a $3,000 tax credit to people caring for their elderly friends and family members.

"We need to ensure that these caregivers receive adequate support," Takamura said.

Caregivers often must quit their jobs or switch to part-time, which means they put themselves at increased economic risk when they eventually retire, she said.

The report also highlights a problem that it says is not yet being addressed and will only get worse: the health and economic disparities between white seniors and their minority counterparts. Only 8.2 percent of whites 65 and older lived in poverty in 1998, compared to 26.4 percent of African Americans, 21 percent of Latinos and 16 percent of Asians. Minorities have higher rates of some ailments such as diabetes.

Many more whites are vaccinated against common ailments such as the flu and pneumococcal disease.

These disparities will place greater demand on health care as the proportions of minorities grow, as expected, in the next 50 years.

Governor Davis recognized future needs and the desirability of assisting seniors to live independently with their families as long as possible. The governor's aging with dignity initiative provides funding for essential services to assist famlies with elderly members to stay together as long as possibe. ★

VHC-BARSTOW

VHC-CHULA VISTA

VHC-YOUNTVILLE

Chapter 5: Conclusions & Recommendations

Conclusions

1. Pursuant to the California Department of Veterans Affairs mission, the department should continue to provide the state's aged or disabled veterans with rehabilitative, residential and medical care and services in a homelike environment at the Veterans Home of California. This should include independent living (domiciliary), assisted living (residential care facility for the elderly/ RCFE) and skilled nursing care.

2. Although the California Business and Professional Code, section 3905, requires administrators of skilled nursing facilities to be licensed by the state, administrators of state veterans homes have not been subjected to that requirement in the past. They should be.

3. Although quality of life has not been a serious problem in recent surveys of the homes, there is room for improvement in some areas, such as creating a more homelike environment, increasing privacy and combating boredom.

4. The department needs to periodically assess special needs of veterans in areas such as Alzheimer's/dementia. The assessment should include the level of care and locations with the greatest need. For example: VHC-Yountville already has a building which could be used as an Alzheimer's/dementia facility at the assisted living (RCFE) level with minor modifications. The care could be provided, as a pilot project, there sooner and at less expense than building a new facility elsewhere.

5. In order to better serve veterans home residents, CDVA must know more about the demographics of veterans overall and those served by the department -- how many there are, where they live and their social and economic characteristics. An objective needs assessment is needed before deciding locations and configurations of future homes. The intent is to put future homes in the areas of greatest need.

6. The homes currently do not appear to reflect the diversity (ethnic, racial and gender) of the overall veterans population. Minorities who may feel disenfranchised by past practices of discrimination and segregation may not have been reached by prior efforts in the outreach and marketing areas.

7. The task force agrees with the Governor's Aging with Dignity Initiatives in the FY 2000-2001 budget. The initiatives support devices which allow families to stay together longer in their own homes. However, once a veteran is admitted to a state veterans home, VHC should allow elderly or disabled residents to stay as long as the home is able to provide the essential quality of care.

8. The long-term care provisions of the Veterans Millennium Health Care Act encourages the expansion of the scope of the state veterans home program to provide a complete continuum of care, from independent living through assisted living and skilled nursing.

Recommendations

The task force acknowledges that even with the funds provided in the Budget Act of 2000 there are resource constraints within state government. With that in mind, the task force believes

the following ('Phase I') priority initiatives should be implemented as soon as possible to ensure quality of care and full federal reimbursements. Some recommendations are already in the process of being implemented.

PHASE I

1. Computerized Patient Records System: Develop an Alternative to Meditech

Conduct an expedited study to review alternatives and recommend the best option regarding the current Meditech computer system. The existing system is slow, tedious, lacking a LTC module and, consequently, detrimental to quality care. Medical staff is spending an inordinate amount of time in data entry and retrieval, time better spent with patients. Possible upgrades -- such as a portable bedside ordering and evaluation capability for doctors -- should also be considered.

Note: One computer system which should be given serious consideration is the VISTA Computerized Patient Record System (CPRS), used at many VA facilities, including the VA domiciliary at White City, Oregon. Since upgrades to the system are nearly complete, the system will soon be owned by the VA and should be available to CDVA at virtually no cost. The system is fast, user-friendly and offers an electronic interface with other VA records and medical centers.

2 . Creating New Positions

A. Creating a separate position of administrator for each SNF and requiring the administrator to be certified as a nursing home administrator.

Note: Funding was proposed for this in the 2000-01 Governor's Budget, included in the Budget Act of 2000, and was implemented as of September 2000.

B. The Governor's Blue Ribbon Task Force on Veterans Homes acknowledges that CDVA has created a separate position of deputy secretary for veterans homes and a quality assurance team at department level to provide greater oversight to the homes overall and enhancing quality assurance programs. The deputy should have long-term care management experience.

Note: The deputy position was proposed in the 2000-01 Governor's Budget and was included in the Budget Act of 2000.

C. Providing additional positions and funding for staff and training, primarily at the Barstow home. The governor's budget adds 21 new positions, primarily health care providers such as doctors and nurses, to address health care issues raised by DHS and to ensure continuous quality of care for veterans. Increased training, both at the home and off-site, is needed to ensure that staff has the proper long-term care and gerontology skills.

D. Ensuring Full Time CMO

Ensuring a full-time chief medical officer at all homes with LTC experience. Requiring the director of nursing (DON) to have previous DON experience in a LTC environment; increasing the DON's salary as necessary to remain competitive with other LTC facilities.

E. Adding an Assistant Director of Nursing/Nurse Practitioner

Any SNF, with more than 100 beds, is large enough to justify adding an additional supervisory position for assistant director of nursing. A single DON is stretched too thin in a large facility with 24 hour per day operations seven days a week. Another position which should be considered is a geriatric nurse practitioner.

F. Establishing Registries/Retired Annuitant Lists

1) The homes should consider establishing their own nurse registry so that they can control whom they are employing and ensure that all have long-term care training.

2) The department, in cooperation with state Department of Personnel Administration, should establish a list of retired state health care professionals who would be eligible to serve as volunteers or retired annuitants at the homes.

G. Recruiting and Retention (R & R)

Incentives

The 2000-01 Governor's Budget proposed an additional $4.5 million in recruiting and retention initiatives for the two existing homes*. The initiatives would provide a monthly bonus for licensed nursing staff and other incentives such as a relocation allowance and assistance in making a down payment on a home. Further incentives in the educational area would also be desirable.

*This funding was included in the Budget Act of 2000.

3. Meeting the Need for Sufficient Quantities of Qualified Staff

Nursing-Type Initiatives

In order to meet the need for adequate numbers of qualified licensed staff in a competitive shortage field, the department must continue to be innovative in incentives to attract "the best." The governor's assistance in the budget act will help significantly. Other possible examples of innovative initiatives follow.

1) Establish a cooperative educational program for nurses, such as the previous 20/20 Program (work 20 hours, attend school 20 hours) at VHC or the Career Development Sponsorship Program at Napa State Hospital. Such a program would help to recruit and retain nursing staff at all facilities. Participation in the program imbues loyalty in the staff and reduces staff turnover. Several graduates of the program at Yountville testified that they continue working at the home to this day because of the opportunities they received through the program. Geriatric education should be a part of the qualifications and training. Nurse training programs with local colleges can help meet the needs for certified nursing assistants (CNAs).

2) Another possibility for nursing staff is an educational bonus, or similar incentive, for RNs who possess a bachelors or masters degree. Consultants indicated that, compared with comparable private facilities, there are very few RNs at the homes with degrees. An inducement to encourage continued education would enhance quality of care and ensure a pool of candidates for supervisory positions. Incentives should also be considered for additional training and qualifications in gerontology.

3) Day care assistance for staff should be considered. The homes should consider providing such care or, at least, attempt to coordinate day care within the vicinity of the home, such as the Ginger Bread House at VHC-Yountville.

4) The 2000-01 Governor's Budget proposed funding for housing and relocation assistance for VHC-Barstow. This funding was included in the Budget Act of 2000. Providing or subsidizing rental apartments for staff, a recruiting and retention incentive, could also be considered, especially in remote or high-cost areas.

5) The department should consider resources available through existing programs such as Welfare-to-Work, Cal Works, and the VA Work Study Program as potential sources for funding to encourage local residents to enter Certified Nursing Assistant (CNA) or RNA programs.

Non-Nursing-Type Initiatives

In addition to incentives for licensed nursing staff, the department should continue to seek incentives that would attract quality staff across the board and improve conditions for residents. Possible examples follow.

1) Conduct a space study at Yountville to determine the optimal use for vacant and underutilized facilities such as wings B and E in consideration of existing and future veterans' needs.

2) A mentoring and sponsorship program should be initiated for newly assigned staff. The objective is to facilitate all areas associated with the transition to the new job, including technical areas and practical areas such as ensuring the new

employee can work out day care and transportation arrangements. The military's sponsorship program works well and is a good model. The best programs usually involve volunteer sponsors with a good attitude and a heart for people.

3) Similarly, systems for billing, accounting and pay must be automated, efficient, timely and responsive. CDVA has the capability to do a needs assessment in-house and should do its own analysis before contracting studies with outside agencies.

4) The task force received several comments questioning the adequacy of security at the homes. The department should consider whether, in addition to a roving security guard, additional security (i.e., a fence) is needed at the homes, especially at VHC Chula Vista, due to its proximity to a densely populated area.

5) The state homes should make use of veterans who served in the health-care profession and are discharged in California. They could be employed as retired annuitants, on a registry list, or as VA work study members. Veterans service organizations and county veterans services offices could assist in locating such individuals.

4. Solutions for Fiscal Accountability and Full Reimbursements

The California Department of Veterans Affairs needs to ensure that it is recouping all allowable reimbursements and ensuring efficient personnel, billing and accounting systems.

A) Since many of the recommendations require additional funding, both onetime and recurring, the department must ensure it is doing everything possible to maximize the level of reimbursements from federal and other sources in all areas - e.g., Medicare, Medi-Cal, medications. Hiring a consultant to assist in creating a more efficient process for recouping reimbursements may be needed/desirable. Additional sharing agreements should be possible with the VA in areas such as ophthalmology, pharmacy, dental, and audiology.

B) The department should also review the level of contributions by members, especially those requiring the highest levels of care. Comparisons should be made with other states to ensure that California veterans are not providing reasonable, but not a disproportionate share of their costs.

C) The personnel system must be able to fill vacancies expeditiously. Homes cannot afford to lose qualified applicants due to a hiring process which is too slow or inefficient. Similarly, systems for billing and accounting must be automated, efficient, timely and responsive.

D) The department should consider additional ways to inform veterans of ways that they can donate time or resources to the homes.

PHASE II

In the collective assessment of the Blue Ribbon Task Force members, additional improvements, while not as urgent or as time sensitive as the Phase I recommendations above, are important for the Veterans Homes of California to fulfill the governor's vision for "world class" veterans homes. Some are achievable with very little additional investment. The task force recognizes that the first priority currently is and must be to bring each home into "substantial compliance" with all state and federal standards. Once that has been achieved, attention should shift to the remaining recommendations. The task force hopes that all recommendations will be considered for existing homes within the next few years and incorporated into planning for future homes. The following list, while not exhaustive, suggests examples of additional improvements that can be made.

1. Alzheimer's/Dementia Care Initiatives

The Veterans Home of California, especially new campuses of the home, should have a dedicated unit and a support staff (i.e., aides) capable of caring for residents who develop Alzheimer's/dementia. The presence of Alzheimer's/dementia patients at the homes is a

present reality and the need for appropriate care is growing. A suggested priority list to phase in such a capability over time follows:

Priority No. 1: Fund the staffing and physical plant improvements needed to properly care for Alzheimer's/dementia patients residing at existing state veterans homes, beginning with a pilot project at Yountville, which already has enhanced levels of care and a building which can be modified at the assisted living (RCFE) level.

Priority No. 2: Establish a pilot project for a buddy system for Alzheimer's/dementia patients already residing at VHC.

Priority No. 3: Admit eligible veterans from off-campus suffering from these diseases directly into the Alzheimer's/dementia unit, as space permits.

Priority No. 4: Consider a new state facility dedicated exclusively to Alzheimer's/ dementia patients, perhaps co-located with a VA geriatric facility -such as the centers located in Long Beach or West Los Angeles (the West L.A. VA Medical Center has several buildings ready for CDVA to move on) -- or based at the existing state veterans home in Barstow or Chula Vista or Yountville. A preliminary study should validate the need, the required size, the urgency (time frame), and the estimated cost of such a facility.

2. Providing Care for Local Veterans

In addition to accommodating Alzheimer's/ dementia patients at the veterans homes, the department should study additional ways to meet the needs of veterans in the community. The focus should be to extend the length of time that veterans are able to live independently. This should be a joint effort with local, state and federal agencies, using available community resources to the extent possible. The task force commends the Governor's Aging with Dignity Initiative which provides needed services toward this objective.

3. Providing Vocational Rehabilitation and Training

A. The homes can serve as a support facility for veterans living in the community.

B. Initiate a pilot project to expand the mission of a state veterans home to fund staff and provide facilities to provide vocational rehabilitation and training. With such training, some domiciliary residents may be able to return to the work force. Others will enjoy enhanced quality of life. The department should consider the programs at the VA Domiciliary-White City, Oregon, as a model. The program operates like a small company and uses minimal space, staff (two full-time) and funding. An extremely cost-effective program, Veterans Industries is essentially self-supporting by competing for contracts to provide products made by veterans. Adding such a program to VHC-Barstow could fill existing domiciliary vacancies by attracting more younger veterans needing such rehabilitation.

4. Create a More Homelike Environment and More Quality of Life Programs

A. The site visits and discussions with residents and staff indicate that existing facilities provide insufficient privacy for residents. While some residents prefer to share rooms, many do not. Even those who share rooms complain about the lack of privacy provided in the way rooms are configured and laid out. Such problems contribute to resident conflicts and frustration. They are further compounded by the sharing of bathrooms among residents of several rooms. Efforts should be made to alleviate these problems through interior changes in existing homes; new homes should be built with different configurations that include more single rooms; different designs for shared rooms; and more private bathrooms. In addition, policies and design should encourage residents to personalize their rooms.

B. The homes must have/need funding for holistic programs, drawing from the nationally

recognized Eden Alternative™, to address quality of life issues. The initiative should include funding for a pilot project to address measures to combat boredom, loneliness and feelings of helplessness. Current laws require the campuses to instill a homelike environment and treat residents with dignity and respect. This would formalize a program to improve and measure achievement of those goals. Meeting personal needs such as assistance with taxes and bills or providing areas to pursue personal hobbies, would also be desirable. VHC-Yountville already has space for such activities.

C. An interested veteran provided a suggestion to add a title on the sign at the entrance to each facility reading "Home of Heroes." This and other programs, such as adding a biographical sketch for each resident desiring such recognition on his or her door, would enhance respect for the residents by staff and other residents, while improving self-esteem for the residents. Many residents have distinguished and heroic pasts, not evident or well known. Management should caution staff in addressing residents by a nickname or term of endearment, unless the resident requests to be addressed in that manner.

D. Residents mentioned the vast untapped reservoir of talent available in the resident population. Administrators should maximize the use of resident volunteers to tap those resources on behalf of the home, ensure residents continue to feel needed, and be afforded the opportunity to serve the surrounding community. Some are already employed in the Member Helper Program which could be expanded in a way that remains in compliance with the law and Federal Labor Standards Act (FLSA) requirements.

5. Establishing Special Programs for Residents

The department should use available community, state and federal resources to ensure viable programs for patients with special needs, including (as a minimum) substance abuse programs, psychiatric and other mental health needs such as posttraumatic stress disorder. If a campus does not have an effective program for each special need area, applicants should be directed to the homes having the appropriate programs or enroll residents in existing programs in the community, or through the USDVA. Other programs which should be considered include adult day care, home health care and hospice.

6. Special Needs

A. Physical therapy is extremely important to the residents' well being and should be a high priority in the budget for space, equipment and staff. A therapeutic swimming pool at VHC-Barstow and VHC-Chula Vista would be highly desirable.

B. Each campus should ensure minority veterans are included adequately in their outreach efforts, and should assess the needs of minority veterans currently residing at VHC.

C. There should be an active veterans speaking program in the community where veterans give as well as receive. As an example, veterans could present a personal living history lesson of their military service to students, K through 12. This is already being done at VHC-Yountville through the Redwood Middle School Program. "Such programs are ongoing at VA medical centers -- as well they should be. Until a person starts talking, he cannot start healing."

Future Homes

Background

Gov. Gray Davis Establishes New Commission on Veterans Homes

The report of the Blue Ribbon Task Force on Veterans Homes provides a logical transition to the new commission.

The charter of the new Governor's Commission on Veterans Homes is to establish findings

and make recommendations to the governor and the Legislature on the establishment of veterans homes in California.

According to the Military and Veterans Code, the findings and recommendations may include, but need not be limited to, the following matters:

1. Possible sites of one or more state veterans homes.

2. Selection of a site specifically for the treatment of veterans who suffer from Alzheimer's disease or other diseases causing dementia. Preference should be given to a site with access to an existing medical teaching or research facility.

3. The scope and level of health care, residential care and recreational facilities and other services and amenities to be provided at each home.

4. The number of sites to be established and the resident population to be served at each site, including a description of the type, size, and projected population of each of the residential components of the home, including, but not limited to, assisted living beds, skilled nursing care beds, intermediate care beds, domiciliary care, independent living facilities, and day care facilities.

5. Estimates of design and planning costs, land acquisition costs, capital construction costs, and annual operating costs of each home that would be associated with various modes of construction.

6. Financing options for the development and construction of a home on one or more sites that shall include, but not be limited to, financial assistance available through the VA State Home Grants Program.

7. The management of each home by state or private administration.

Recommendations

The task force recommends that the department as well as the Governor's Commission on Future Veterans Homes ensure consideration of the following factors in site selection and home design, which are not listed in order of priority:

1. Availability of nurses in the area around the site and local salary levels of such nurses. Some areas have many nurses, but even more LTC facilities vying for the available pool.

2. Proximity to families.

3. Proximity to a VA medical center (MC) within reasonable commuting distance (not more than one hour away). The VA recommendation adopted by some other states of co-locating with a VAMC should be seriously considered.

4. Proximity to other medical centers, such as a university health center offering geriatric care.

5. Proximity of local colleges able to offer nursing courses.

6. Veterans population: An objective needs assessment prior to determining sites for future homes that includes veterans demographics data to ensure that areas with the greatest veterans density receive first consideration.

7. Availability of desirable, affordable housing in the area for staff.

8. There are still privacy issues to be resolved in the individual rooms at the homes. Therefore, CDVA should seriously evaluate the existing platforms and not copy the current model before building additional campuses. The department should learn from past mistakes and require the architect to submit innovative and nontraditional plans for future facilities.

9. Facility designs should consider:

1) More single rooms and individual bathrooms

2) Privacy enhancements and

personalization

3) Facilities for married couples

4) Apartments for nurses and other staff

5) Visitor lodging and parking

6) Expanded recreational and warehouse facilities

7) Additional programs such as vocational rehabilitation training and adult day care

10. Greater networking and training with professional groups like the California Association of Health Facilities (CAHF), Quality Care Health Foundation (QCHF), Department of Health Services (DHS), and others. DHS conducts quarterly training sessions where they discuss common issues and bring in administrators and staff members to do brainstorming and discuss best practices.

11. Take greater advantage of the VA's consultation abilities and make sure the homes are using them year-round to improve services, rather than waiting for an annual inspection.

12. Recent historical books and motion pictures and the fund-raising drive for a national veterans memorial in Washington, D.C. have created a greater public awareness of the sacrifices of military service during World War II. The department should take advantage of this patriotic climate and encourage individual and corporate involvement for contributions and funding. ★

COURTESY VAN chauffeurs a VHC-Barstow resident (in wheelchair) to the main entrance of the campus. Barstow's main building incorporates the health care and administrative support services. All buildings are single story.

VHC-Barstow

VHC-Chula Vista

VHC-Yountville

Appendix A: Levels of Health Care

Provided by
Veterans Home of California (VHC)

Direct admissions are made on a space available basis. Please check with the individual facility for current status of vacancies.

	VETERANS HOME OF CALIFORNIA BARSTOW	Veterans Home of California CHULA VISTA	
	VHC-Barstow	VHC-Chula Vista	VHC-Yountville
Residential Care -- Domiciliary	Yes	Yes	Yes
Residential Care -- Licensed	Yes	Yes	Yes
Intermediate Care	Yes	Yes	Yes
Skilled Nursing Care	Yes	Yes	Yes
Acute/Intensive Care	No	No	Yes
Alzheimer's/Dementia Program (at RCFE or Dom.)	No	No	No
Drug/Alcohol and Posttraumatic Stress Disorder Program	No	No	Yes ★

Appendix B: Acknowledgements

Consultant

Veronica Russo

Registered Nurse

Consultant

Frank Loop

Auditor & Investigator

Research & Graphic Design

Steven J. Dakota, Special Assistant

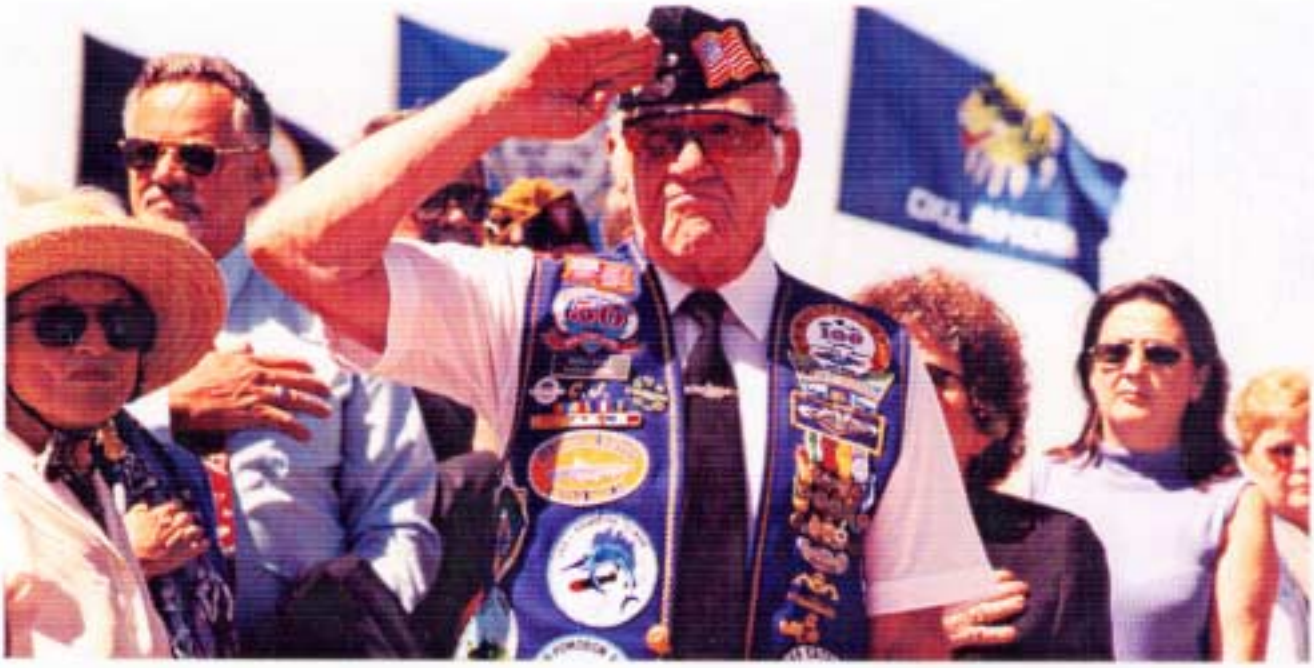
Governor's BRTF on Veterans Homes

Photo Scanning

Kenn Capps. Webmaster

Information Services Division, CDVA ★

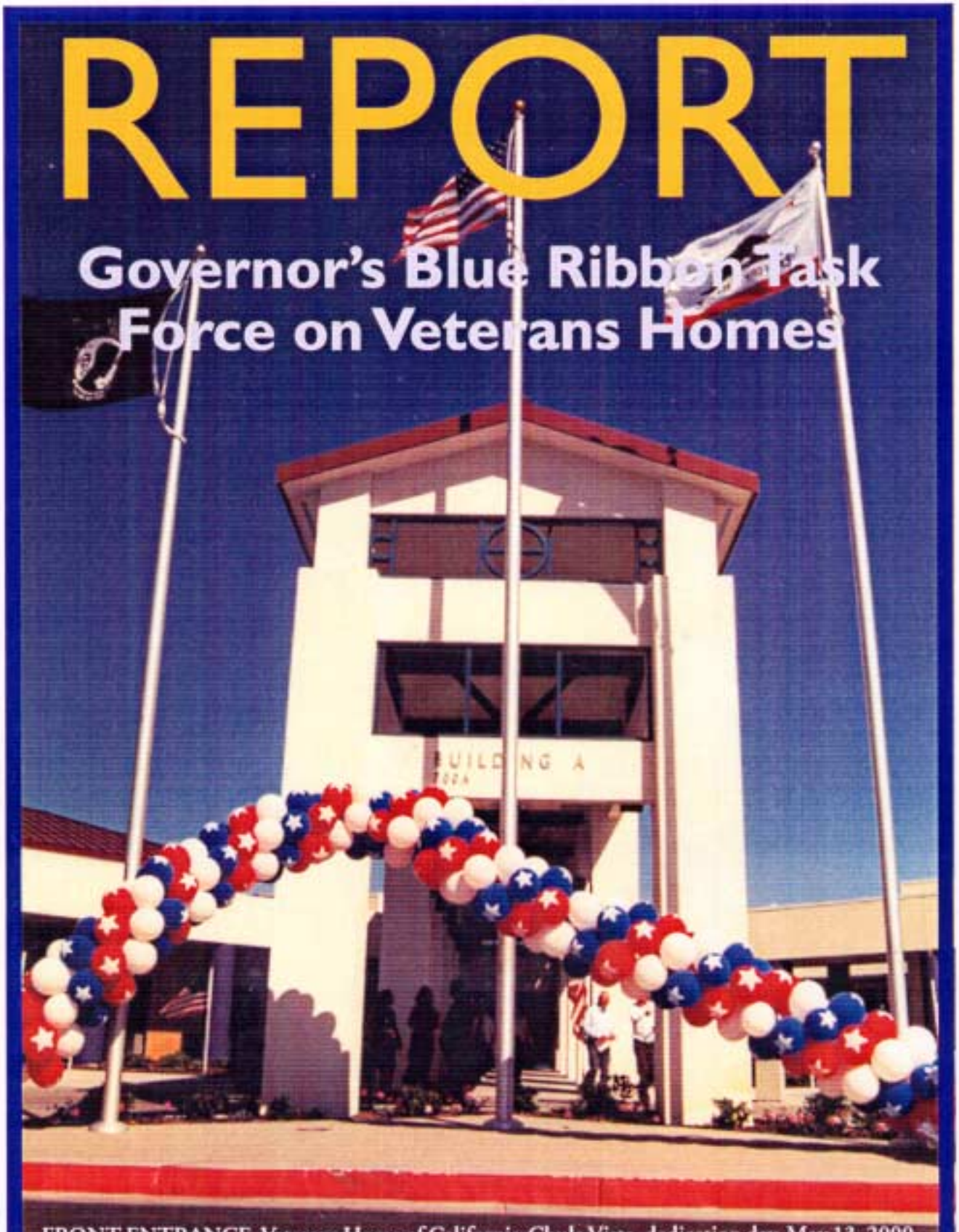
UNITED STATES NAVY SAILORS STAND DOWN on the deck of their ship. Posters waged a constant battle for the hearts and minds of the American citizenry just as military weapons engaged the enemy in World War II. Of the 1,125 members residing in April 2000 at VHC-Yountville, the majority (640) were veterans of the second world war.



C. J. GLASSFORD, WELL-KNOWN LEADER, SAN DIEGO VETERANS COMMUNITY; president, World War II U.S. Submarine Veterans Association; member, San Diego County United Veterans Council; former chairman, San Diego County Veterans Day Parade Committee; salutes during 'posting of the colors', VHC-Chula Vista dedication, May 13, 2000.

REPORT

Governor's Blue Ribbon Task Force on Veterans Homes



FRONT ENTRANCE, Veterans Home of California-Chula Vista, dedication day, May 13, 2000. Staff members designed the decorations (including the balloons) for the grand opening. Public Affairs Officer John Smith said, "It was a beautiful day and all who attended were impressed."