The Governor's Blue Ribbon Commission on the Minnesota Veterans Homes

FINAL REPORT

February 12, 1988

INTRODUCTION

On July 30, 1987, Governor Perpich temporarily transferred authority for the Minnesota Veterans Homes from the Department of Veterans Affairs to the Department of Human Services. The transfer followed a state Health Department inspection of the Minneapolis home which turned up more than 30 health and safety violations. Earlier inspections in September 1986, November 1986, March 1987 and April 1987 had also found serious health and safety violations.

Following the July 1987 inspection, the commissioner of Health notified the governor that her department was required under state law to begin disciplinary proceedings to suspend or revoke the home's license for repeated violations of Health Department rules.

In August, the governor appointed a blue-ribbon commission to study operations and governance of the homes as well as the long-term health care needs of Minnesota veterans. The governor's charge for the commission was:

> To develop a blueprint that will address the health care and related needs of disabled and elderly veterans and eligible family members into the next century.

The commission held fact-finding hearings, taking testimony from health-care experts, veterans, their families and other concerned citizens. It reviewed findings prepared by the State Planning Agency, Department of Health, Department of Human Services, Department of Finance, Department of Employee Relations, Department of Veterans Affairs and the Veterans Administration.

The commission also reviewed data collected by the Department of Administration's Management Analysis Division as part of the division's study of the homes' management and operations. The study was requested by the Minnesota Legislature.

Gordon E. Donhowe, chief executive officer of Fairview Hospitals, served as chair of the commission. Its other 23 members were representatives of Minnesota's health care, veteran, labor, retirement, academic and public policy communities.

RECOMMENDATIONS OF THE BLUE RIBBON COMMISSION

MISSION

1. It is recommended that the Minnesota Veterans Homes' mission be:

   - to provide high-quality skilled nursing and health-related care for Minnesota veterans and their spouses;

   - to educate physicians, nurses and other health-care professionals, both staff and students, in geriatric care;

   - to develop innovative methods of geriatric care, to evaluate their usefulness in a patient care setting, and to demonstrate their practicality for export to other Minnesota nursing care facilities.

   Adopting a research and teaching mission would enable the homes to attract health care experts and to apply advanced geriatric care techniques, consequently improving the homes' quality of care.

VALUES

It is recommended that the Minnesota Veterans Homes:

1. Act with honesty and integrity.

2. Encourage the independence of each resident and recognize the human dignity of each individual.

3. Provide residents with a safe and secure environment and individualized programs within which they can function at their highest level of physical, social and mental abilities.

4. Ensure each resident's informed cooperation and participation in his/her care and in decisions concerning that care. Residents should have the right to privacy, confidentiality and consent in research conducted at the homes.

5. Provide high-quality, cost-effective care.

6. Encourage innovation in service delivery, procedures and technology.

7. Integrate their health care services with those in the rest of the community so that veterans have a wide choice and continuum of high-quality services.

STRATEGIES

It is recommended that the Minnesota Veterans Homes:

1. Develop a transition plan to become a national center of excellence for chronic care. Before the Minnesota Veterans Homes can become a research and teaching institution, major management and operational improvements must be made to raise the quality of care provided to residents.

2. Affiliate with the geriatric research, education and clinical center at the VA Medical Center in Minneapolis and with the University of Minnesota. The homes' research mission should be to increase basic knowledge of the aging process and related diseases and conditions and knowledge of nursing techniques and administration.

3. Provide rehabilitative and long-term care to Minnesota veterans and their spouses.

4. Maintain a skilled nursing facility of about 346 beds (its current capacity) and a bed level in the domiciliary program consistent with safe, comfortable facilities and adequate resources for quality care.

5. Adopt a philosophy of care which ensures that residents have a safe and secure environment that maximizes their independence and provides individualized programs designed to allow them to function at the highest level of their physical, social and mental abilities.

6. Investigate the need to develop or strengthen:

    - psycho-social programming
    - mental health programs
    - chemical dependency programs
    - Alzheimer's programs
    - acute rehabilitation (physical therapy, occupational therapy, speech therapy)
    - respiratory and oxygen therapy
    - hospice care
    - short-term rehabilitation services

7. Establish reciprocal transfer agreements with VA Medical Centers and other general hospitals so that health care resources in the community are available to residents for emergency care.

8. Continue close ties with the veterans community, which provides significant financial and volunteer support to the homes.

9. Work with the VA Medical Center in Minneapolis and with other state and private agencies to develop alternative institutional and non-institutional care programs for veterans. Veterans should be afforded the least restrictive, most appropriate level of care available.

GOVERNANCE

It is recommended that the Minnesota Legislature:

1. Transfer the Minnesota Veterans Homes to an independent board of directors appointed by the governor.

   The board should have nine members knowledgeable in public policy and health care management. Three of the members should be representatives of veterans service organizations. The commissioner of Veterans Affairs should serve as an ex officio member. The chair should be elected by the board.

   The board's responsibilities should be to: a) govern the homes by establishing general policies and direction, b) hire and appraise the performance of an executive director and the homes' administrators, and c) identify and develop alternative care programs.

   The homes' current employees should be transferred to the new board with all accrued rights and benefits.

   The board should sunset in five years, at which time the legislature should determine the homes' permanent governing structure.

   The homes have had a long history of very serious management and health care problems under the governance of the Veterans Affairs Department. To ensure every opportunity for vastly improved care of veterans and their families, the homes should be released from their past and given a new beginning. The recommended governing board would provide the needed expertise and stability while protecting the homes from political interference in daily operations.

   The Department of Veterans Affairs would continue to serve as an advocate for Minnesota's veterans -- an important responsibility, but one that has proven in the past to be incompatible with the management of health care facilities.

ORGANIZATIONAL STRUCTURE

It is recommended that:

1. The Minnesota Legislature transfer legislative jurisdiction for Minnesota Veterans Homes appropriations from the State Departments Divisions to the Health and Human Services Divisions in the House Appropriations and Senate Finance Committees. The Veterans Affairs Committees should continue to have jurisdiction over policy issues.

2. The governing board operate the Minneapolis and Hastings Veterans Homes as separate institutions. Where economically beneficial, the homes would share services.

3. The governing board require that administrators of both homes be licensed nursing home administrators with experience operating large long-term health care facilities. Each administrator would report directly to the governing board's executive director. Both administrators would serve in the unclassified civil service, but with removal only for cause and with the right to a hearing.

4. Management at the homes review and update all position descriptions, carefully defining responsibilities and authorities so that accountability can be clearly determined and strengthened.

5. The Minnesota Legislature include the new agency as a member of the Interagency Board on Quality Assurance which advises the governor and legislature on long-term health care policy.

ELIGIBILITY AND ADMISSION POLICIES

It is recommended that:

1. The Minnesota Legislature restrict eligibility for admission to the homes to:

   a. veterans and
   b. a veteran's spouse, if the veteran is a resident of the home. A spouse, however, could stay at the home after a veteran has died or been discharged.

   Parents would no longer be eligible for admission.

2. The Minnesota Legislature and the governing board require all people seeking admission to the Minnesota Veterans Homes to go through the state's pre-admission screening process to see if institutional care is appropriate. The Minnesota Veterans Homes would admit only those residents needing such care.

3. The governing board establish administrative rules which set clear admission priorities, such as:

   a. service-connected disabilities
   b. POWs
   c. wartime veterans
   d. length of wartime service
   e. financial need (income and asset level)
   f. age
   g. extended residence in the state
   h. particular medical conditions/needs

4. Management at the homes establish a strong admissions review process. Admission decisions should be based solely on an applicant's health care needs and on the homes' ability to provide quality care to that individual.

QUALITY ISSUES

It is recommended that:

1. Management at the homes meet all applicable state and Veterans Administration requirements pertaining to the operation of Minnesota state nursing and boarding care facilities.

2. Management at the homes establish a written ongoing quality assurance process designed to objectively and systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care, and resolve identified problems.

3. The Minnesota Department of Health continue its unannounced regulatory inspections and the Veterans Administration continue its annual inspections of the homes.

4. Management at the homes ensure that deficiencies cited by external reviews are corrected in a timely manner.

5. Management at the homes establish and/or strengthen the following committees to assist them and the medical director in assuring quality of care:

    - Utilization Review
    - Infection Control
    - Quality Assurance
    - Pharmacy
    - Patient Care
    - Ethics
    - Residents Council
    - Family Council

    These committees would meet regularly and conduct business in accordance with Joint Commission on Accreditation of Health Organizations standards. Committee membership would include outside physicians to assure that the committees were not solely self-policing.

6. Management at the homes continue on-site ombudsman or patient advocacy services half-time at the homes.

OPERATIONS

It is recommended that:

1. The governing board establish permanent administrative rules to define admission, discharge, fee, resident conduct and other policies necessary for administration and operation of the homes.

2. Management at the homes clearly define the role of the medical director (see Appendix A).

3. Management at the homes use the established Minnesota case-mix system to determine levels of care and staffing needs.

4. The Minnesota Legislature transfer the homes' budget from the Direct Appropriated Special Revenue Fund to the General Fund.

5. The Minnesota Legislature approve the Department of Human Services' supplemental budget request for 84 positions ($3.9 million) and capital improvements ($425,000).

6. Management at the homes make maximum use of federal VA funds such as aid and attendance and pensions to increase resident contributions and thereby reduce state financial support of the homes.

7. The governing board investigate the long-term feasibility and economic benefit of medical assistance certification for the homes' nursing care program.

8. Management at the homes set the homes' rates in the same manner as other state nursing homes.

9. Management at the homes implement an effective utilization management program to monitor over- and under-utilization of resources and to ensure high-quality care and the judicious use of the homes' resources.

DOMICILIARY PROGRAM

It is recommended that the governing board:

1. Restrict the domiciliary program to veterans needing assistance with medical and social services.

2. Investigate whether to scale down the size of the domiciliary program and transfer residents to alternative VA and community programs. The board should develop a long-term plan for the domiciliary program for submission to the governor and legislature by January 1, 1989. The board should consider the results of the VA engineering study on the condition of the homes' domiciliary care buildings and the impact of the:

   - stricter admission criteria to the homes,
   - increased use of alternative care programs,
   - increased capacity at the VA Medical Center in St. Cloud.

   Before implementing any plan which reduces the size of the domiciliary program, the board should ensure that alternative programs are available and discharge planning for residents is adequate.

SUPPLEMENTAL PROGRAMS

It is recommended that the governing board:

1. Develop innovative alternative care programs in consultation with the Veterans Administration, Altcare and other organizations. These programs should be phased in and should supplement the mission of the homes. Implementation would depend on the availability of federal, state and private funds. The board should consider such supplemental programs as:

   An Alzheimer's Care Network encompassing adult day health care, inpatient and outpatient care, home care, caregiver support groups and other alternative programs. The network should provide a wide variety of health services to assure a continuous system of care as patients' needs change. Case managers could coordinate the care plans.

   Small-group supportive living programs which address the care needs of major target groups, such as the frail elderly, chemically dependent and mentally ill. These programs would encourage self-sufficiency and mutual support, and could include volunteer participation by veterans organizations.

   Community-based residential boarding care programs to supplement the homes' domiciliary program. This might require changes in Veterans Administration and state funding policies, program rules and regulations.

   State-initiated and directed pilot programs in long-term care which focus on the individual patient's disability and/or diagnosis. Using a mutually-agreed-upon funding mechanism, veterans could participate in alternative programs through the state, community or VA Medical Centers.

2. Postpone construction of additional veterans nursing homes until the legislative moratorium on nursing beds is lifted and the state has developed a post-moratorium plan for long-term care. The board should develop alternative care programs before constructing additional nursing facilities. After the moratorium, the board should use strict criteria in deciding whether to build additional nursing care facilities. Any additional homes should be built near VA Medical Centers and in areas with shortages of nursing care beds.

ISSUES FOR DISCUSSION

The following is a list of issues discussed by the commission.

HOME OPERATIONS

* Should the mission of the homes be clarified or amended? If yes, what should the mission of the homes be? Should there be separate and distinct missions for the nursing care and domiciliary units?

* Are the groups of veterans being served by state's homes consistent with the current mission? A clarified or amended mission?

* How should the homes be connected to state government?

* Should control of the Veterans Homes return to the Department of Veterans Affairs or stay with the Department of Human Services?

* What, if any, additional steps are needed to assure the recruitment and retention of capable management and staff for the homes?

* What are the actual staffing needs of the homes? Should the legislature approve the additional positions requested by the Department of Human Services?

* Should the freeze on admissions be lifted?

VETERANS SERVICES

* What groups needing nursing home or domiciliary care are not served by the federal Veterans Administration?

* Which of these groups should be served at a state veterans home?

* Should the state adopt the VA's strategic goal of gradually evolving from an institution-based system to a multi-faceted delivery system?

LONG-TERM CARE ISSUES

* How will planning for the long-term care of elderly veterans fit into the state's efforts to cope with the long-term needs of all elderly Minnesotans?

* What are the unique needs of veterans that justify the maintenance of a separate long-term care system for veterans?

* Would the addition of veterans nursing home beds affect community nursing home occupancy rates?

* Is an increase in veterans home beds counter to the intent of the moratorium?

* If the commission recommends additional veterans nursing home beds:

  Whom should the new facilities serve?

  Where should they be located?

  Should buildings be newly constructed, purchased, converted from existing state facilities, or leased?

  Should the new facilities be managed by the Department of Veterans Affairs, the Department of Human Services, private contractors, or others?

* Should the Minnesota Veterans Homes participate in the state's pre-admission screening and alternative care grants programs?

* How would pre-admission screening and the development of veterans' in-home and community care options affect long-term care for veterans?

* Do any of the approaches used in other states merit consideration for Minnesota's veterans homes?

* What other health care issues (such as the overwhelming cost of AIDS) could affect long-term care planning for veterans?

CARE FINANCING

* Is the state appropriation for veterans being distributed fairly among veterans with similar needs?

* Should the state seek Medical Assistance certification for nursing care beds at the Minneapolis Veterans Home?

* Should the budget for the Veterans Homes stay in the Direct Appropriated Special Revenue fund?

* Should the homes contract for more services?

* Should the rates at the Minnesota Veterans Homes be set on a prospective basis?

* Which legislative committee should have oversight of the Veterans Homes -- State Departments or Health and Human Services?

Summary of Findings: HOME OPERATIONS

Following is a summary of the commission's findings. Details can be found in the Department of Administration's Study of the Minnesota Veterans Homes, February 1988. Copies of materials presented to the commission are available for inspection at the Department of Administration offices.

History of the Homes

* The Minnesota Veterans Home is 100 years old. It was established by the legislature in 1887 as a home for honorably discharged veterans and their spouses and mothers.

* Top management people and structures have often changed. There have been four different administrators and three acting administrators in the past seven years. In 1972, the chief operating officer was changed from a commandant to a health care administrator. A major jurisdictional shift occurred in 1975 when the responsibility for the home was moved from a board of trustees to the Minnesota Department of Veterans Affairs.

* Nursing beds are gradually replacing domiciliary (boarding care) beds in the Minneapolis facility.

  For the first 89 years, the Minnesota Veterans Home in Minneapolis was the State Soldiers' Home, a boarding care facility.

  The nursing facilities were built in 1972 and 1980.

  Currently, the Minneapolis home is licensed for 346 nursing care beds and 194 boarding care beds.

  The Hastings home became a veterans facility in 1978 and is licensed for 200 boarding care beds.

* Older buildings are in use on each campus. Veterans Affairs requested $7,449,000 from the legislature for 12 major capital improvement projects for the 1988-89 biennium. The department was granted $2,500,000 for four projects.

  Minneapolis: Four buildings are 94 to 98 years old. One houses 18 to 25 residents. Another is leased to a chemical dependency treatment program. The others are a maintenance shop and the administration building. Building 6 (81 years old) houses 109 residents. Building 9 (51 years old) houses 65 residents. Building 15 (29 years old) is used for activities/auditorium. The nursing facilities are 7 and 15 years old and house 232 and 83 residents, respectively. Three buildings are closed and ready for demolition.

Hastings: Building 23 has 155 beds and is 71 years old. Its addition is 36 years old. Building 25 is 68 years old and has 45 beds.

Licensure and Inspection History

* The Minnesota Department of Health Office of Survey and Compliance routinely inspects nursing homes and boarding care homes. It has Veterans Home records dating back to 1945. Veterans Affairs has been the licensee since 1975. Health Department records show that 119 correction orders and 21 fine assessments have been issued as a result of inspections between 1981 and 1987.

  Thirty-five correction orders were issued in July 1987. The Health Department survey team conducted an annual inspection of the Minnesota Veterans Home in Minneapolis July 14-17, 1987, and issued 35 correction orders on July 28, 1987. Only one correction order is issued for a violation of a given regulation regardless of the number of incidents observed during the inspection. For example, one correction order issued for violation of a system of safe and proper administration of medicines describes five different instances of improper administration.

  Twenty-five of the correction orders involved indirect care. Many of these addressed unsanitary conditions in the dietary area, including decomposed fowl, spoiled fruit, cockroaches, and rodent and pigeon droppings found in food storage areas; unsanitary food-handling techniques; an accumulation of dirt, dust, grease and dried-on food in the food services area; and the transport of perishable foods in an unrefrigerated truck. Housekeeping practices were found to be inadequate, as evidenced by dirty patient rooms, lounges and carpeting. Numerous physical plant problems were noted, such as the absence of screens on some outside openings to prevent the entrance of flies and an unsatisfactory alarm system in the building housing Alzheimer's patients.

  Ten correction orders involved direct care problems. These included medications and records left unattended, medication errors, lack of follow-up charting on identified medical problems, poor nursing techniques used for gastrostomy feedings, wound treatments and catheterizations, and failure to notify a physician in an instance of projectile vomiting.

The annual inspection conducted by the Veterans Administration in September 1986 revealed problems in the areas of indirect and direct care.

Indirect care: Food processing and distribution did not meet sanitation and safety requirements of federal, state and local authorities, and overcrowding in the kitchen and lack of employee hours placed sanitation at risk. There was an insufficient number of trained personnel to maintain a safe, clean and orderly environment. The VA recommended adding three housekeeping staff. General maintenance and upkeep were unsatisfactory as evidenced by numerous violations of OSHA standards and the National Fire Code and only partial compliance with the Life Safety Code applicable to nursing homes.

Direct care: The VA cited ineffective or non-existent committees on quality assurance review, utilization review and pharmacy. Access to drugs was not controlled. No regular review of infection was carried out. Standards were only partially met for ongoing staff development for all levels of nursing and for 24-hour nursing services sufficient to meet the total nursing care needs of all patients. The VA recommended hiring additional staff in the psychiatry, social services and activities areas to facilitate/improve work therapy programs, quarterly treatment and discharge planning/goals for domiciliary residents, goal-directed activities programs, group treatments and psychiatric consultation services.

Budget and Staffing Resources

* Veterans Affairs' biennial budget and staffing requests for the homes have not been fully funded by the governor and legislature.

In Fiscal Years 1982-83, the department requested 42.5 permanent and 13 seasonal positions and received 28.

In Fiscal Years 1984-85, there was an exception: Veterans Affairs requested 47.5 positions and received 53, as a result of opening the new nursing care Building 16.

In Fiscal Years 1986-87, the department requested full funding of 14 positions held vacant due to underfunding, and requested additional funds for 11 new positions. It was granted seven positions.

In Fiscal Years 1988-89, the department requested 74 positions due to increased occupancy rates and collection efforts. The governor recommended granting 32 positions based on the balance of special revenue. The Minnesota Department of Human Services and the Health Department reviewed the request and recommended granting 10 more positions, bringing the total positions received to 42.

* Staff shortages have been aggravated by reductions in the availability and use of resident workers.

  The number of residents in domiciliary care at Minneapolis has declined from 330 to 146 since 1980.

  The Minneapolis home was fined by the Health Department in August 1985 for excessive use of resident workers in positions which would otherwise be filled by staff employees.

  The number of hours of resident work at the Minneapolis campus declined from 148,000 in Fiscal Year 1984 to 64,000 in Fiscal Year 1987.

* Occupancy rates have increased without comparable increases in staff levels.

* The homes and the issue of long-term care for veterans have been subjects of many previous studies. The Management Analysis Division study and the work of the blue-ribbon commission will add to the number of studies conducted in Minnesota since 1980 (in addition to routine health licensing inspections).

  Some of these previous studies were routine (e.g., the 1984 and 1985 legislative audits).

  Others were responses to a perception that there were serious problems at the homes (e.g., the 1980 Management Analysis Division study and the 1987 report by Health Commissioner Mary Madonna Ashton).

<u>Veterans Home Process</u>

* The mission of the homes is to " . . . assure a 'maximum quality of life' for eligible veterans and their spouses residing in the State of Minnesota . . . , ensure that each resident has a structured environment and an individualized program . . . to function at their highest level of physical, social and mental abilities, solicit participation from each resident in structuring his/her care and encourage the independence of each resident . . . rendered in a professional and considerate manner providing for the comfort and recognizing the human dignity of each individual."

* Candidates for admission must demonstrate medical justification.

  Veterans are eligible if they were discharged honorably or discharged for bad conduct or dishonorably if it was due to drug dependency or abuse. They must also have entered the armed forces from Minnesota or be a state resident. They must have served in a war for more than one day or have peacetime duty of 181 consecutive days.

Spouses and parents of veterans are also eligible, but non-veterans may not exceed 10 percent of the home's population.

* To be admitted, candidates must meet eligibility requirements, complete formal applications and be screened by the Veterans Home admissions committee which recommends acceptance or denial.

  The admissions committee is not currently active due to a moratorium on admissions ordered by the Commissioner of Veterans Affairs in March 1987. At various times, the committee has included the director of social services (or designee), the director of nurses, the director of indirect services, the physician, the assistant group supervisor from Hastings, a member of clinical services and a social service worker from the floor on which the candidate would be placed.

  Some admissions have been approved or accelerated due to political pressures.

* The average age of individuals on the waiting list for nursing care is 73 years. The highest age is 97 years. Eighty percent are over 65.

  There are currently 180 people on the list and it continues to grow. There is a slow turnover in the home and few requests to withdraw from the list.

  Administrative rules have not been promulgated to address a formal priority system for admissions.

* Nursing home care includes long-term care (primarily custodial), terminal care and certain types of treatment.

  Types of care not provided include acute rehabilitation (physical, occupational and speech therapy), oxygen dependence, intravenous feeding and medication, and care of combative residents or those who resist care.

  Critical program development issues include oxygen therapy, patient teaching, mental health component, extended care, short-term rehabilitation, AIDS and Alzheimer's programming and chemical dependency issues.

* Boarding home care primarily includes room and board services.

* There are three types of discharges: 1) planned discharges made to lower levels of care or independent living; 2) higher level care discharges made for chemical dependency, mental illness and other inpatient treatment or follow-up of a lengthy nature; and 3) other discharges, such as for the abuse of alcohol or non-prescription drugs, acts of violence and intimidation of peers, refusal to address defined health care needs, or nonpayment of fees.

The 1986 discharge records for the Minneapolis home follow: death 46.2 percent, transfer to the VA Medical Center 17.2 percent, transfer to other hospital 4.1 percent, independent living 27.6 percent, other level of care 3.4 percent, other .7 percent, transfer to Hastings .7 percent.

* Rules were developed and published for public comment by Veterans Affairs. They were withdrawn by Human Services and are being revised. Involuntary discharges are prohibited by court order until the rules are adopted.

Veterans Home Demographics

* Occupancy: Minneapolis has 461 residents (315 nursing care residents and 146 boarding care residents). Hastings has 173 boarding care residents.

* Case mix: In Minneapolis, 70.7 percent of the residents (domiciliary and nursing care) require a low level of care (classes A-C), 8 percent require a medium level of care (classes D-F), and 21.3 percent require a high level of care (classes G-K).

  In Hastings, all residents require a low level of care (classes A and B).

  Those diagnosed with mental impairments, including chemical dependency diagnoses, include 60.7 percent of the residents in Minneapolis and 91.7 percent in Hastings.

  Case-mix index figures at various state facilities:

Minneapolis nursing and domiciliary	1.63
Minneapolis nursing only	1.99
Hastings domiciliary	1.02
Ah-Gwah-Ching	1.95
Oak Terrace	2.34

* Period of service: 80.3 percent of the residents were involved in World War I, World War II or the Korean War, 11.2 percent served in Vietnam, 6.3 percent served during peacetime and 2.2 percent are not veterans.

* Gender: 95.3 percent of residents are male. By comparison, the Ah-Gwah-Ching Nursing Home has 57.4 percent male residents and Oak Terrace has 34.9 percent.

* Age: 81.6 percent of those in Minneapolis nursing care beds are over 65. In Minneapolis boarding care, 32.9 percent are over 65. In Hastings, 29.5 percent are over 65. A total of 56.2 percent of the residents in both homes are over 65.

* Marital status: 20.6 percent of the residents are married, 16.5 percent are widowed, and 62.9 percent are single, divorced, separated or their status is unknown.

* Prior residence: 63.8 percent of the residents are from the Twin Cities seven-county metropolitan area.

  Prior to admission to nursing care, residents lived in their own home (24.3 percent), a community nursing home (27.2 percent), a hospital (2.1 percent), domiciliary care at the Veterans Home (7 percent), the VA Medical Center (34.1 percent), or in other states (.4 percent). Prior residence is unknown for 4.9 percent.

Human Services Management Changes: A Representative List

* The Department of Human Services' objective has been to make no radical changes in the mission or range of services, but to address basic resident needs in order to achieve and maintain compliance with Health Department and VA regulations.

* Personnel, purchasing and financial operations now report directly to the administrator instead of to the financial management director.

* Nursing services have been restructured. The non-nursing supervisory system is being abolished. Human Services is considering contracting with a nursing management firm to evaluate the nursing program and assist in the transition to new management.

* The search for a new permanent administrator is in process.

* A new assistant administrator of care-related services and a new director of nurses have been hired. A quality assurance coordinator was also hired.

* Staff shortages have been identified and documented through comparisons with other state nursing homes, observation of daily operation, completion of the case-mix assessments, and independent consultant reviews.

  Fifty-eight new positions were requested and granted by the Legislative Advisory Commission. An additional 26 positions have been requested for 1988. The 58 new positions will be divided as follows: 9.5 RNs, 13.5 LPNs, 32 human services technicians, one social worker and 2.6 maintenance positions.

  If the 26 additional positions are approved, the total 84 new positions will be allocated as follows: nursing 59, housekeeping 8, dietary 4, maintenance 4, social services 4, recreation therapy 3, and staff development 2.

  Aggressive hiring is in process to fill existing vacancies as well as the 58 new positions. Some hiring issues include the nursing shortage, the recent resignation of the personnel director at the home, and the scarcity of candidates for part-time human services technician positions.

The new positions assure ongoing compliance in care levels with Health Department and VA regulations. The new nursing staff will bring the nursing hours per patient per day to the state average of 2.5. The new positions do not allow for major changes in the scope of services, programs or mission.

* Human Services plans to lift the current moratorium on admissions because adequate staff have been hired. A few individuals have been admitted to the domiciliary in Minneapolis and management plans to open up admissions to the nursing care unit in February 1988. Lifting the moratorium will help reduce a projected shortfall of $600,000 by the end of Fiscal Year 1987-88.

SOURCES

Minnesota Statutes 1987, Chapter 198.

Representative history chart of the Minnesota Veterans Home presented to the commission by Management Analysis Division staff on September 14, 1987.

"Summary of Biennial Budget Change Requests" memo from the Department of Veterans Affairs.

Minnesota Department of Health licensure records, "Report on the Minnesota Veterans Home in Minneapolis" by the commissioner of the Minnesota Department of Health (August 1987).

September 1986 VA Inspection Report.

Telephone call with William C. Kelley, Department of Finance, December 11, 1987.

Department of Veterans Affairs Fiscal Years 1985-87 Biennial Budget Request.

"Notice of Assessment for Noncompliance with Correction Orders" from the Minnesota Department of Health dated August 30, 1985.

Telephone call with Tom Barrett of the Department of Veterans Affairs, December 10, 1987.

1987 Legislative Advisory Commission request by the Department of Human Services; "Rationale and Documentation: Resource Request, Minnesota Veterans Homes" dated October 5, 1987.

"Summaries of Relevant Reports" presented to the commission on September 14, 1987.

Minnesota Veterans Home mission statement.

Presentation to the commission by Department of Human Services officials on October 26, 1987.

"Minnesota Department of Health Quality Assurance and Review Program" materials dated September 14, 1987.

Department of Human Services (Pam Parker) memo to Gus Donhowe regarding the status of new positions as of November 23, 1987.

Department of Administration's Study of the Minnesota Veterans Homes, February 1988.

VETERANS SERVICES

Background

* Minnesota's veterans are eligible for all services and benefits available to the general population. Veterans and dependents of veterans are also eligible to receive additional benefits and services not available to others.

* The federal government, through its Veterans Administration, spends about $27 billion annually and employs 202,000 people to carry out its programs of benefits and services to veterans nationwide.

* The VA's hospital and medical care services constitute the largest health care system in the free world. More than 90 percent of the VA's employees work in the area of medical care.

Non-medical benefits and services available to veterans

* The federal VA provides compensation and pension programs for eligible veterans.

  Compensation provides support for veterans disabled in the line of duty, during war or peacetime. Size of monthly payment depends on the severity of the disability.

  Pensions support wartime veterans whose disability is not traceable to service. (All veterans over age 65 and not working are considered permanently and totally disabled for pension purposes.) A pension makes up the difference between an eligible veteran's income and a minimum income threshold (currently $496/month for a single veteran). Veterans with income above this threshold do not receive pensions.

  A veteran in a nursing home, in need of regular aid and attendance of another person or permanently housebound, may be entitled to a larger pension. The VA raises the minimum income threshold to $794/month for a single veteran in this situation.

  Congress has pending legislation increasing pensions by 4.2 percent, which would be effective retroactively to December 1, 1987.

* The federal government also provides miscellaneous benefits and services to veterans:

  * educational assistance programs,
  * vocational rehabilitation services,
  * home mortgage loans,
  * burial benefits, and
  * insurance programs.

* The state, through its Department of Veterans Affairs, provides

    * assistance in obtaining federal and state benefits,
    * temporary financial assistance,
    * educational assistance programs,
    * guardianship of the estates of incompetent veterans,
    * assistance with Agent Orange issues, and
    * advocacy regarding veterans preference statutes.

* County veterans service officers, under the general supervision of the commissioner of Veterans Affairs, provide information, referral and advocacy services at a local level. There are 116 veterans service officers in the 87 counties.

Medical benefits and services available to veterans

* The VA provides a broad range of medical services:

    Hospital care is available in 172 medical centers around the country, including facilities in Minneapolis, St. Cloud, Fargo and Sioux Falls. Hospital care is provided to any veteran with a service-connected disability or who receives a pension or who has an annual income below $15,000 (if no dependents) or who meets one of several other eligibility criteria. Veterans without service-connected disabilities and with higher income levels may receive care on a space-available or co-payment basis.

    Nursing home care is available at VA expense for veterans with a service-connected disability, whose need for care relates to that disability, and who are discharged through the VA system.

    If the need for nursing home care does not relate to a service-connected disability, nursing home care at VA expense is generally limited to a six-month period. Eligibility is again conditioned on discharge through the VA system.

    Nursing home care can be provided in VA facilities or in private nursing homes contracted through the VA.

    The VA provides domiciliary care to veterans who meet specified medical care admissions standards.

    Outpatient medical treatment, which may include home health services, is available. For veterans with non-service-connected disabilities who are discharged through the VA system, the VA pays for up to 60 days of home health services. For veterans with service-

connected disabilities or those receiving aid and attendance or those who are housebound, the VA will pay for home health services indefinitely (conditioned on medical determinations of need and discharge through the VA system).

Additional inpatient/outpatient medical services provided by the VA include day hospital, day treatment, adult day health care, travel reimbursement, free medical/dental treatment, treatment related to Agent Orange or nuclear radiation exposure, chemical dependency treatment, post-traumatic stress syndrome treatment, prosthetic devices, blind aids, and readjustment counseling. There are specific eligibility requirements for the various services.

* The VA provides (or plans to provide) the following direct care which is potentially available to Minnesota's veterans:

    * 130 nursing care beds at St. Cloud,
    * 50 nursing care beds at Fargo,
    * 75 nursing care beds at Sioux Falls,
    * 120-bed nursing care unit being developed at Minneapolis,
    * 80-bed domiciliary unit being developed at St. Cloud.

* At any one time, an average of 308 Minnesota veterans are residing in nursing homes through the VA's contract nursing home care program. The Minneapolis VA Medical Center contracted with 127 nursing care facilities in the state for such services during Fiscal Year 1987.

* The state's contribution to health care services available exclusively to veterans and their dependents is the operation of the two Minnesota Veterans Homes. The VA provides financial and other support to Minnesota's two homes:

    Per diem payments on behalf of eligible residents in Fiscal Year 1987 provided approximately $1,914,000 for nursing care ($17.05 per person per day, expected to increase to $20.35 in 1988) and $960,000 for domiciliary care ($7.30 per person per day, expected to increase to $9.20). The VA does not provide per diem to the state for holding a bed while a resident is hospitalized.

    Approximately $5,900,000 in medical care (roughly 1,200 inpatient visits and 9,000 outpatient visits) was provided to residents of the homes by the Minneapolis and St. Cloud medical centers during Fiscal Year 1987. The VA also contracts with the Minneapolis home to provide physician services.

Federal law authorizes a 65 percent participation rate in the construction or acquisition of new facilities. The VA has contributed $8 million toward state construction. It is subject to a 20-year recapture provision. (The VA may participate in the cost of construction for up to four beds per 1,000 veterans in the state.)

The VA also shares educational and training resources and conducts periodic inspections to monitor compliance with federal standards.

* The VA's major strategic goals focus on the gradual evolution of the VA system from a totally institutional setting to a diverse multi-faceted delivery system.

SOURCES

"Minnesota Department of Human Services Presentation to the Governor's Blue Ribbon Commission on the Minnesota Veterans Home," October 26, 1987.

Federal Benefits for Veterans and Dependents, Veterans Administration, January 1987.

Telephone confirmation from Karen Weidner, senior health systems planner, Veterans Administration, December 4, 1987, and December 11, 1987.

Presentations by VA officials at the commission meeting of October 26, 1987.

Minnesota Guidebook to State Agency Services 1984-85, State of Minnesota, 1984.

Jeff Olson, deputy commissioner of the Department of Veterans Affairs, presentation to the commission on October 26, 1987.

"Nursing Home Referral Through the Veterans Administration," handout provided by VA officials at the November 9, 1987, meeting.

Thomas P. Mullon, director of the Minneapolis VA Medical Center, presentation to the commission on October 26, 1987.

Demographics of the Elderly in Minnesota

* Minnesota's elderly population (persons 65 and older) is growing rapidly, and will continue to grow for the next 25 to 35 years.

* The veterans population is aging. Elderly veterans will comprise an increasing percent of all veterans into the next century.

* Veterans now comprise 17 percent of Minnesota's elderly population, and will be nearly 23 percent of all elderly persons by the year 2000. After that, elderly veterans will make up a smaller portion of the expanding total elderly population, as the baby boom group ages.

Institutional Long-term Care in Minnesota

* Minnesota has 44,999 licensed nursing home beds and 4,734 licensed boarding care beds.

* Average statewide occupancy of nursing homes was 93.5 percent in 1986.

* In 1982, Minnesota had 85 beds per thousand elderly, compared with a national average of 55.

* Minneapolis and Hastings veterans homes have a combined capacity for 346 nursing care beds and 394 domiciliary care beds.

* Although veterans make up 17 percent of the total elderly population, a 1982 Veterans Affairs study determined that veterans represent only 7.3 percent of private nursing home residents. This is primarily because most veterans are male and thus more likely to have a living spouse to provide informal care. The majority of community nursing home residents are female.

* A moratorium on nursing home beds was put in place in 1983 and extended in 1985. The moratorium was put in place to control the rapid growth of nursing homes in Minnesota and to place an emphasis on alternatives to institutionalization for the elderly.

* Several communities have expressed interest in constructing veterans nursing homes or in using existing facilities as veterans homes.

  In a presentation to the commission, Silver Bay proposed construction of a 44-bed domiciliary unit and the conversion of an elementary school building into an 89-bed veterans nursing home.

* The Department of Veterans Affairs expressed support to the commission for the development of a network of unused facilities around the state as veterans nursing homes. Veterans Affairs' proposed approach would allow options such as leasing existing facilities (or wings or floors of facilities), converting existing state facilities, contracting for management and staffing, and/or expanding existing homes.

* Good Neighbor, Incorporated, is a private health care provider which contracts with the VA in 24 of its 27 Minnesota nursing homes. It has proposed a joint project with Veterans Affairs to provide a range of services to veterans, including contracted management of veterans homes. In a presentation to the commission, Good Neighbor reported success in its management of a previously troubled facility in International Falls, including financial turnaround, improved quality of care and retention of staff.

Alternatives to Nursing Homes: At-home and Community Care

* In addition to the moratorium on nursing home beds, in 1982 the state developed the Pre-admission Screening and Alternative Care Grants programs to provide alternative care services for elderly persons at risk of nursing home placement.

* All persons seeking admission to Medical Assistance-certified nursing homes must be screened by a pre-admission screening team. Alternative Care Grant funds are available for eligible applicants who choose to remain at home.

* In 1987, 24 percent of persons seeking nursing home placement were deferred from institutionalization and placed in the community with home care services.

* Alternative care services cost an average of $375 per month, compared with an average nursing home cost of $1,620 per month. Human Services estimates that the state saved $14.5 million through the Pre-Admission Screening and Alternative Care Grants programs in Fiscal Year 1987.

* Veterans seeking admission to the Minnesota Veterans Home are <u>not</u> routinely screened to determine appropriate placement or eligibility for Alternative Care Grant funds.

* Community care emphasizes the importance of remaining at home and independent for as long as possible. Alternatives to institutionalization are growing more popular and more options are steadily being developed.

* One alternative presented to the commission is **ALTCARE**, a partnership between the Wilder Foundation and General Mills. It advocates fundamental reforms in long-term care for the elderly with the goal of a more integrated system and a broad range of non-institutional options. **ALTCARE** affiliates with service providers that wish to experiment with new approaches consistent with **ALTCARE**'s goals.

Alternatives from Other States

* Thirty-five states currently have state veterans homes.

* Veterans homes in other states are managed by various state departments: veterans affairs, health, human services or public safety. Homes may or may not have governing boards or advisory committees.

* Some states have relatively strict eligibility requirements involving income and assets, age, wartime service or other criteria.

* Medical Assistance payments are not a significant revenue source for most veterans homes.

* Service contracts at veterans homes in other states range from laundry to the administration and staffing of the entire home. These contracts may be with the VA, other state agencies or the private sector.

* A few states use their veterans homes as centers for geriatric research and as training centers for medical students.

SOURCES

Trend Reports: Long-Term Care for the Elderly, Minnesota State Planning Agency, November 1987.

Veterans population projections from the Veterans Administration, September 29, 1987.

Minnesota Population Projections, 1980-2010, State Demography Unit, Minnesota Department of Energy, Planning and Development, 1983.

Minnesota Department of Health, Health Resources Division.

Minnesota Department of Human Services, Long-term Care Management Division.

"Nursing Homes, Mental Care Facilities, and Health Care Expenditures," State and Metropolitan Area Data Book, 1986, U.S. Department of Commerce, Bureau of the Census.

Presentation to the commission by the State Planning Agency, November 23, 1987.

Veterans' Long-term Health Care Study, Minnesota Department of Veterans Affairs, January 1982.

Long-term Care for the Elderly, Minnesota Department of Human Services and the Center for Health Services Research, School of Public Health of the University of Minnesota, 1986.

Minnesota Statutes 1983, Section 144A.071.

Letters to governor from various Minnesota communities.

Presentation to the commission by contingent from Silver Bay, November 23, 1987.

Presentation to the commission by Jeff Olson, deputy commissioner of the Department of Veterans Affairs, November 23, 1987.

Proposal of Good Neighbor, Inc. (executive summary provided to the commission), presented to the commission by Merle Sampson, director of administration, Good Neighbor, Inc., November 23, 1987.

The ALTCARE Perspective, ALTCARE, November 1987, presented to the commission by Verne Johnson, president of ALTCARE, November 23, 1987.

Department of Veterans Affairs Budget

* The state appropriated $7.6 million from the general fund to the Department of Veterans Affairs in Fiscal Year 1988. Of that amount, 80 percent went to support the Veterans Homes and 20 percent went to support veterans benefits and services.

Minnesota Veterans Home Rates

* The Minnesota Veterans Homes set their rates retrospectively.

* Prior to January 1, 1988, the per diem for a nursing care resident at the Minneapolis Veterans Home was $54.38; for domiciliary care the per diem was $26.53 in Minneapolis and $28.98 in Hastings.

* As of January 1, 1988, the rates were increased to reflect the cost of the additional 42 staff approved by the legislature in 1987. Because these staff were added in the middle of the rate-setting period, the full cost of these positions will not be reflected in the rate. The nursing care per diem is $59.00 and the domiciliary rates are $30.11 in Minneapolis and $30.56 in Hastings.

* Setting rates prospectively, taking into account the full cost of the 42 additional staff approved by the legislature and the 58 staff approved by the Legislative Advisory Commission, the nursing care per diem would be $77.80 and the domiciliary per diem would be $36.84.

* Setting rates prospectively, taking into account both the cost of additional staff and capital costs (property acquisition, debt service), the nursing care per diem would be $85.49. This number gives an apples-to-apples comparison between the Minneapolis Veterans Home and other long-term care facilities. The per diem for Oak Terrace is $90.81; the per diem for Ah-Gwah-Ching is $96.30.

* The state share of the above-mentioned prospective per diem of $85.49 can be roughly estimated at $23.93 (see calculation No. 1 below).

Veterans in Community Care

* There are roughly 3,071 veterans in community long-term care (see calculation No. 2 below)

* Approximately 1,722 veterans in community long-term care receive Medical Assistance (see calculation No. 3 below).

Benefits at State Veterans Home as Opposed to Receiving Me Assistance

* The personal needs allowance is $85/month at the Veterans Home as opposed to $40/month for those receiving Medical Assistance.

* After deducting the personal needs allowance, 100 percent of the income remaining to a Medical Assistance recipient is applied toward the cost of care. At the Minnesota Veterans Home, 95 percent of a resident's remaining income is applied toward the cost of care.

* The Department of Veterans Affairs issued a rule for Veterans Home residents (subsequently withdrawn by the Department of Human Services) that would have increased the personal needs allowance to $90 and applied all remaining income (as opposed to the current 95 percent) to the cost of care.

* Medical Assistance and the Minnesota Veterans Home treat assets differently. The values of a life insurance policy and a $1,000 pre-paid burial policy, for instance, are not included as assets for residents of a veterans home; for Medical Assistance recipients they are considered assets. Veterans home residents must spend down their assets to $2,500, Medical Assistance recipients to $3,000.

* The community spouse of a Medical Assistance recipient must contribute to the cost of care if net monthly income exceeds $647. A community spouse of a Medical Assistance recipient must also make a one-time contribution of assets equal to one-third the amount exceeding $10,000. A community spouse of a resident in the Veterans Home is not required to make any such contribution from income or assets towards care.

* Medical Assistance recipients have 18 leave days for hospitalization and 36 leave days for therapy. Residents at the Minnesota Veterans Home have no such leave days. If they miss five consecutive days, they must repay their per diems retroactively for those missed days.

* Residents at the Minnesota Veterans Home could receive reimbursements from both the VA and from Medical Assistance. This would require conformity of Veterans Home financial criteria, such as the personal needs allowance, to that of Medical Assistance. However, the federal government is reassessing its willingness to allow dual eligibility for Medical Assistance and a full VA pension.

* If the Veterans Home became certified for Medical Assistance, the state would save roughly $1.7 million (see calculation No. 4 below).

* Many veterans feel there is a welfare stigma attached to Medical Assistance.

Direct Appropriated Special Revenue Fund

* The Veterans Homes are placed in this fund because they recover their costs, in part, through fees. Activities in the direct appropriated special revenue fund must fully recover their costs through fees. Since the Veterans Homes do not fully recover their costs, they receive a general fund supplement to the fund.

* Since admissions were frozen, estimated fees are running behind projections (roughly around $600,000).

* The Department of Finance is required by law to reduce the amount allotted for the activity, to prevent a deficit. This may result in preferential admission of those residents who can pay for their expenses in full.

CALCULATIONS

Calculation No. 1 - State Share of the Nursing Care Per Diem

The prospective rate for nursing care at the Minneapolis Veterans Home, accounting for additional staff and property costs, is $85.49, according to the Departments of Veterans Affairs and Finance.

Currently, residents pay for 57 percent of the cost of care. If per diems were increased to $85.49, some residents would not be able to pick up the full cost of the increase. This would reduce resident contributions as a percent of the total revenue stream. Assumption No. 1 - resident contributions would pay for around 50 percent of the cost of care, or $42.75 of the per diem.

The VA is expected to raise its nursing care per diem to $20.35 in 1988. Currently, the per diem is $17.05. Because of non-veteran residents and loss of per diems due to missed days, the Veterans Home does not receive maximum VA per diems. Assumption No. 2 - The Departments of Veterans Affairs and Finance estimate that average VA per diems for nursing care would be $18.81, as opposed to the maximum per diem of $20.35.

Therefore, the state would pay for $23.93 of the per diem: $85.49 minus $42.75 (resident contribution) minus $18.81 (federal contribution.)

Calculation No. 2 - Veterans in Community Care

The state has 45,000 nursing care beds. The average occupancy rate is 93.5 percent, giving a total of 42,075 residents. According to a 1982 Department of Veterans Affairs study, 7.3 percent of all private nursing care residents are veterans. Therefore, 7.3 percent of 42,075 totals 3,071 veterans in community care.

Calculation No. 3 - Veterans in Community Care Receiving Medical Assistance

The VA contracts for 400 beds in community nursing homes. Therefore, 3,071 minus 400 leaves 2,671 veterans in community care who are private-pay residents. The Department of Human Services estimates that 64.5 percent of all nursing home residents receive Medical Assistance. Assuming that veterans are a representative sample of the nursing home community means that roughly 1,722 veterans in community care receive Medical Assistance.

Calculation No. 4 - State Savings through Medical Assistance Certification of the Veterans Home

The state general fund would pick up, assuming prospective rate setting, $23.93 of a nursing care resident's per diem. If, instead, this was paid for through Medical Assistance, the federal share would be $12.68, the state share $10.05 and the county share $1.20. The state would realize a savings of $23.93 minus $10.05, or $13.88 on each per diem. Assuming an average population of 333 residents, $13.88 times 333 residents times 365 days/year works out to approximately $1.7 million. The county share of cost would be $1.20 times 333 times 365, or approximately $145,000.

SOURCE DISTRIBUTION
MINNESOTA VETERANS HOME NURSING CARE RATES

Without* Medical Assistance Certification	Source	With Medical Assistance Certification
$42.75	Resident	$42.75
$18.81	VA per diem	$18.81
$23.93	State	$10.05
--	Federal	$12.68
--	County	$ 1.20
$85.49	TOTAL	$85.49

(See the Department of Administration assessment for additional discussion of Medical Assistance issues and the financial impact of a potential change in federal policy.)

SOURCES

Presentation to the commission by the Department of Finance, November 9, 1987.

Memo from John Anderson of the Department of Human Services, presented to the commission October 26, 1987.

Presentation to the commission by the State Planning Agency, November 9, 1987.

Memo from Tom Barrett, Department of Veterans Affairs, regarding Medical Assistance certification for the Minnesota Veterans Homes, January 21, 1988.

APPENDIX A

CHARGE FOR THE GOVERNOR'S BLUE RIBBON COMMISSION

To develop a blueprint that will address the health care and related needs of disabled and elderly veterans and eligible family members into the next century.

Toward this goal the Commission will:

* Study current and past operating problems affecting the quality of care provided by the Minnesota Veterans' Homes to determine the underlying causes.

* Review the results and recommendations of the legislatively mandated study of the homes. (Minnesota Laws 1987, Chapter 404, Section 55, Subd. 2.) In light of the report of the State Health Commissioner to the Governor, dated August 27, 1987, it is assumed that this study will be expanded to cover Recommendation No. 5.

* Collect and assess data on long-term health care needs of Minnesota veterans and their families.

* Review alternative administrative and policy actions to provide improved quality health care for veterans and their families.

* Recommend to the Governor administrative and managerial changes to assure the highest quality of care at the Minnesota Veterans' Homes.

* Recommend policy alternatives to address the long-term health care needs of Minnesota veterans and their families.

Governor's Blue Ribbon Commission on the Minnesota Veterans' Home

Gordon M. Donhowe, Chair
Chief Executive Officer
Fairview Hospital and
Healthcare Services

Pamela K. Barrows
Assistant Administrator
Weiner Memorial Hospital

Peter Benner
Executive Director
AFSCME, Council 6

Don Brown (retired)
Hibbing

Elizabeth Colloton
Director of Patient
Care Services
Walker Methodist Health Center

Edward J. Dirkswager
Chief Administrative Officer
Group Health, Inc.

Kent Eklund, Ph.D.
President
Ebenezer Society

Carl Falkowski
Past National Commander
Military Order of the
Purple Heart

Iris Freeman
Executive Director
Minnesota Alliance for
Health Care Consumers

Curtis Johnson
Executive Director
Citizens League

Verne C. Johnson
President and CEO
Altcare, Inc.

W. B. Jorgens
Past Department Commander
The American Legion

Rosalie Kane, DSW
Professor
School of Public Health
Center for Health Services
Research and Policy
University of Minnesota

Dr. Joseph Keenan
Director of Program in
Geriatric Medicine
University of Minnesota

Al Loehr
Committee Administrator
Senate Committee on Local and
Urban Government

LuVerne Molburg
President
The Webster Institute

Thomas P. Mullon
Director
Veterans Administration
Medical Center
Minneapolis

Tom Nelson
Director of Support Services
Independent School District 196
Rosemount Schools

Lyle Pearson
Past National Commander
Disabled American Veterans

Senator Donna Peterson
District 61

Representative Joseph Quinn
District 50B

Harry Slacum
Vice President of Operations
Beverly Enterprises

Martin O. Weddington (retired)
St. Paul

Leonard Wilkening
President
Wilder Foundation

ROLE OF MEDICAL DIRECTOR -- MINNEAPOLIS VETERANS HOME*

The Medical Director shall participate in the formulation of policies and procedures and other professional standards so that certification and licensing standards can be met by:

A. Participating as specified in the following committees as designated by regulation and the administrator, Minnesota State Veterans Home.

1. Utilization Review Committee:

   Medical Director is a member of this committee and attends all meetings. Assists in determining levels of care, discharge planning and selection of medical evaluation studies to be done.

2. Infection Control Committee:

   Medical Director is a member of this committee, and is contacted immediately whenever an infection case is suspected and advises facility on handling of the infection and reporting to the Minnesota Department of Health.

3. Quality Assurance Committee:

   Medical Director is a member of this committee and participates in its activity to ensure the effective delivery of patient care within available resources and consistent with achievable goals.

4. Pharmacy Committee:

   Medical Director reviews pharmacy reports showing medication errors and additions or deletions from the drug formulary when these reports are prepared by the pharmacist of the Minnesota State Veterans Home.

5. Patient Care Committee:

   Medical Director reviews all patient care policies annually.

B. Assisting with the establishment of admission and discharge policies.

---

* Presentation by Thomas P. Mullon, Director, VA Medical Center in Minneapolis, January 5, 1988

C. Assisting in the development of policies and procedures which:

1. Address emergency treatment of residents,

2. Address procedures for transfer of residents to other facilities,

3. Address delivery of adequate, comprehensive services,

4. Address credentialing and privileging of practicing physicians.

D. Developing and implementing a quality assurance monitoring mechanism for medical services.

The Medical Director or his designee shall serve as consultant/ advisor for efficient and effective operation on medical matters by:

A. Assuming advisorial role to the administrator and to the safety committee as requested.

B. Providing consultation in the development and maintenance of a medical record system.

C. Participating in inservice training programs.

D. Participating in establishing and maintaining a safe and sanitary environment for residents and personnel.

E. Monitoring health status of employees and advises administration on employee health practices, including pre-employment physicians and workers' compensation areas.

F. Updating administration on current policies and program of other area health care organization.

The Medical Director or his designee shall represent the Minnesota State Veterans Home in medical matters in the community by:

A. Acting as facility's medical representative in the community.