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Office of the Commissioner

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Sen. Bruce Anderson, Minority Lead
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Rep. Jerry Newton, Chair
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100 Rev. Dr. Martin Luther King, Jr. Blvd
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Rep. Matt Bliss, Minority Lead
Veterans and Military Affairs Finance and Policy
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From: Bradley S. Lindsay, Commissioner
Minnesota Department of Veterans Affairs (MDVA)

Date: January 15, 2024

RE: Veterans Domiciliary Resident Quality of Care Working Group

Per Minnesota Session Laws - 2023, Regular Session, Chapter 38, HF No. 1937, Art. 2, Sec. 8, Subd. 1; the legislature created the Veteran Domiciliary Resident Quality of Care Working Group. Per Subd. 3 of the law, Minnesota Department of Veterans Affairs Commissioner is tasked to convene an initial meeting of the working group, provide meeting space, and administrative services. The Minnesota Department of Veterans Affairs was responsible for providing the following appointees to the working group: the Commissioner, or his designee, and two staff with expertise in veterans homes. The working group was further directed to provide information and recommendations to the legislature by January 15, 2024. The purpose of the recommendations is for the legislature to make decisions and effectuate change to ensure that the standard of care and staffing levels are sufficient for the various resident acuity levels who reside in the MDVA domiciliary.

The Minnesota Department of Veterans Affairs appreciates the time and dedication of the workgroup members in reviewing and analyzing the acuity of domiciliary residents and the current care model, including admission, care plans, and day-to-day care, and the current staffing structure and ratios. We look forward to working with the legislature and our other vital partners in the continuing effort to implement these recommendations. Some of the recommendations will require an additional investment on the part of the Legislature and we look forward to working together on that. As you will see in the report, many of the recommendations are already in process, especially those related to the

personnel concerns brought forward to the Senate during the 2023 legislative session.

Employee satisfaction and retention is key to providing Minnesota's veterans with the best care. Over the last twelve months, MDVA has undergone many leadership changes, including the position of Commissioner. I have appointed a new Deputy Commissioner of Veterans Healthcare and hired a new Administrator for the Domiciliary program, both of whom are eminently qualified and collaborative leaders. Collaborative leadership is my personal style and I look forward to effectuating agency-wide culture change related to that. Given an opportunity to reinforce that transformational change, I am confident staff will experience positive effects.

I believe it is also important to note the significant investment of $77.77M made by the Legislature in 2023 for the campus upgrade at Hastings. During my rounding and listening sessions, staff mentioned to me personally how the deteriorating condition of the facility was seen as a direct reflection of the State's commitment to them and the Veteran residents. With that in mind, we will be asking for a remodel of the Building 16 Domiciliary on the Minneapolis campus this session. Building 16 was built in the 1970's and besides being quite worn and dated, it also has significant issues with drainage, sewer systems and HVAC.

The final report and recommendations of the Veterans Domiciliary Resident Quality of Care Working Group is attached for your review. Thank you again for your time and commitment to Minnesota's veterans. I look forward to working in partnership with you.

If you have any questions concerning this report, please contact me.

Thank you.

Cc: Senate Majority Leader, Senator Kari Dziedzic
Senate Minority Leader, Senator Mark Johnson
Speaker of the House, Representative Melissa Hortman
House Minority Leader, Representative Lisa Demuth
Commissioner of Health, Dr. Brooke Cunningham

Veteran Domiciliary Resident Quality of Care Working Group

Final Report and Recommendations

January 15, 2024

Minnesota Session Law, 2023, Regular Session - Chapter 38, HF 1937, Art. 2, Sec. 8

https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/38/

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Executive Summary

The Veteran Domiciliary Resident Quality of Care Working Group (Working Group), was established in Minnesota Session Laws - 2023, Regular Session, Chapter 38, HF No. 1937, Art. 2, Sec. 8, the 'Veterans and Military Affairs Omnibus bill." This Working Group was tasked with reviewing and analyzing the acuity of domiciliary residents within the Minnesota Dept. of Veterans Affairs' Domiciliary Program, assessing the current care model, including admission, care plans, and day-to-day care, and the current staffing structure and ratios.

As specified by law, the Working Group membership was comprised of agency leadership from the Minnesota Dept. of Veterans Affairs (MDVA), the Minnesota Dept. of Health (MDH), respective agency staff with expertise in Veterans Homes, boarding care homes, domiciliary settings, assisted living, and related standards of care, medical professionals with relevant medical experience, current and former Domiciliary Program (DOMs) staff with experience caring for residents, and members of the public. Members were selected and appointed by the Governor and Legislative leadership.

Following the designation and appointments process, members of the Working Group gathered bi-weekly for regularly scheduled meetings between October and December 2023. Meetings were organized topically to evaluate the legislatively identified goals for the Working Group:

(1) staffing levels that are necessary to properly care for residents based on the residents' range of acuity;

(2) a care delivery model that focuses on appropriate and adequate care for residents;

(3) additional and ongoing training for domiciliary staff;

(4) a sufficient management structure to ensure support and provide guidance to staff; and

(5) outcomes to determine if staffing levels and care delivery are appropriate or if, based on the outcomes, adjustments are necessary.

The sections contained in this report reflect a summary of the subject matter covered throughout the course of the regularly scheduled Working Group meetings. Meeting agendas and the associated materials were organized to define the domiciliary model of care, share information regarding existing staffing and care delivery practices, increase understanding of the challenges related to defining domiciliary resident acuity level assessments, development of staffing enhanced services for this population, and foster conversation in consideration of generating recommendations in response to the legislatively identified goals.

The Appendices to this report reflect, 1. the consensus of the working group's information and recommendations to the legislature, and 2. additional working group member comments and feedback. The legislature may consider using these recommendations and associated information to guide their efforts to assist the MDVA in ensuring that the standard of care and staffing levels are sufficient for different resident acuity levels in the domiciliary program, as directed by law. The following individuals were selected and appointed to participate as members of the Working Group. This is a summary of the materials and information they reviewed.

Members

Direct Agency Appointments - Governor
Eric Meittunen MS, MBA – Minnesota Department of Veterans Affairs
Susan Winkelmann, J.D. – Minnesota Department of Health
Paula Newinski MSN/MHA Gero-BC, NE -BC – Minnesota Department of Veterans Affairs
Caroline Schauer MSN, RN, CHPN, HEC-C – Minnesota Department of Veterans Affairs
Sarah Grebenc, MSW – Minnesota Department of Health
Daphne Ponds, RN, MSN, JD – Minnesota Department of Health

Medical Professionals
Medical Doctor - Robert Meiches, MD, MBA – U.S. Department of Veterans Affairs/VISN 23
Mental Health Professional - Erwin Concepcion, Ph.D. LP, FACHE – Minnesota Department of Human Services
Nurse - Shawna Clausen, MS, RN, CNL, CRRN – Minneapolis VA Health Care System
Health Care Professional, with Expertise in Veterans' Health Care #1 - Douglas Beardsley*
Health Care Professional, with Expertise in Veterans' Health Care #2 - Stacy Tepper, LICSW – Minneapolis VA Health Care System

Past Or Current Domiciliary Staff with Experience Caring for Residents
Dr. Kari Everson, DNP, MHA, RN, LNHA, LALD, PHN, DNS-CT, QCP – LeadingAge Minnesota
Past or Current Domiciliary Staffer #2 - Rebecca Kammeyer, Administrator LNHA
Past or Current Domiciliary Staffer #3 - Elnora Hagans, RN-CNP

Public Members Who Have an Interest in Veterans Affairs
Public Member #1 - Patricia FitzGibbon
Public Member #2 – N. Dan Nelson, Colonel (Retired), US Army Reserve

Public Members Who Have an Interest in Veterans Affairs
Public Member #1 - Alvaro Giraud Jr
Public Member #2 - Trent Dilks

STAFF
Benjamin Johnson, JD (MDVA)
Nicole Peine (MDVA)

**We are sad to share that a member of our team, Mr. Doug Beardsley, has passed. We extend our condolences to his family and friends.*

Section 1. Minnesota Dept. of Veterans Affairs' (MDVA) Domiciliary Program

A Supportive Environment that Fosters a Stable, Healthy and Meaningful Life

The Domiciliary (DOMs) Program provides an independent living environment to any eligible Veterans, and/or spouses, who need assistance managing clinical, mental health, financial or social well-being.

Domiciliary Program Snapshot:

- The Domiciliary Program is licensed as a boarding care facility.
- Operated and managed by the Minnesota Veterans Homes; however, it is not a nursing home. All Residents must be independently mobile and able to manage their own daily living activities.
- Specialized programming and services for each Resident. Three Paths (Fire, Water and Earth), Sobriety, Mental Health, Recreation Therapy and Work Therapy Programs.

Service Delivery Model:

- Stable, safe housing
- Support Services provided by an interdisciplinary team that is focused on the whole person
- Opportunities to build job skills
- Successful sobriety management programming
- Structured, activity-based interventions to enhance physical, cognitive, emotional, social and leisure needs and goals
- 24/7 guidance and support by trained professionals in the areas of nursing, mental health, social work, and senior care

Facilities located in Hastings and Minneapolis – 1 Program with 2 locations

- Hastings – Census Capacity 145 – current census 108
- Minneapolis – Census Capacity 50 – current census 41

1.1 MDVA DOMs program regulatory oversight and mandates

The Minnesota Veterans Homes, including the DOMs Program located at Hastings and Minneapolis are governed by Minnesota Statutes Chapter 198, and operations are guided by Minnesota Administrative Rules Chapter 9050. As a baseline under MN Rule 9050 and 38 CFR Part 51, the facility management must provide:

- A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

• Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

• Clean bed and bath linens that are in good condition;

• Private closet space in each resident's room;

• The furnishing of a home to a veteran, including the furnishing of shelter, food, and other comforts of home, and necessary medical services means the medical services requires the State home to provide:

  • Mental health services, dental care services, podiatric care services, optometric care services, diagnostic services on written order of the resident's attending physician, pharmaceutical services, transportation to and from medical providers.

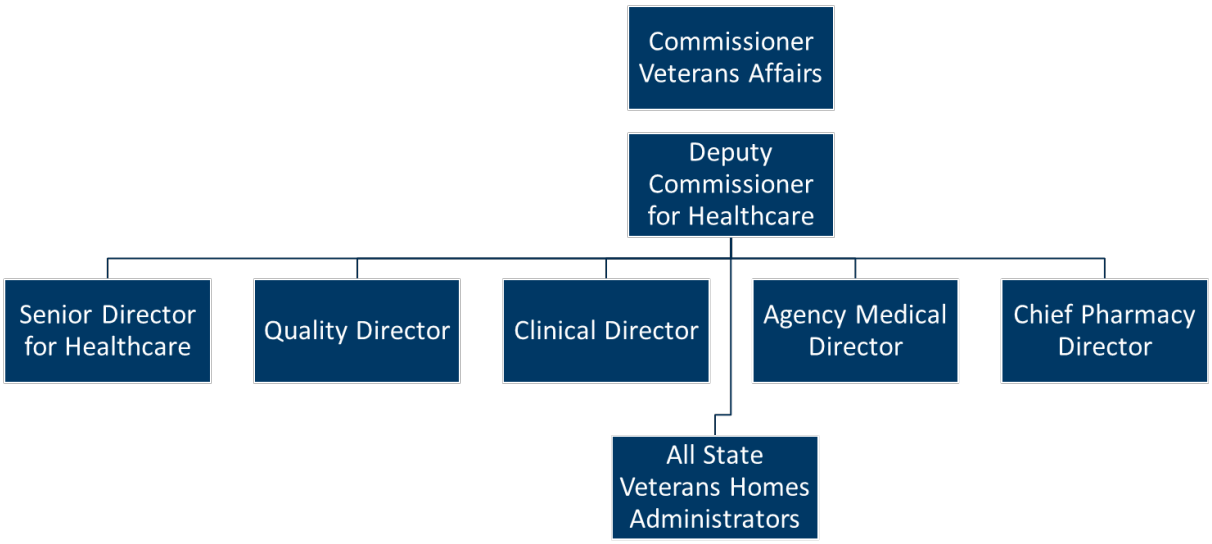
The Minnesota Model of Care

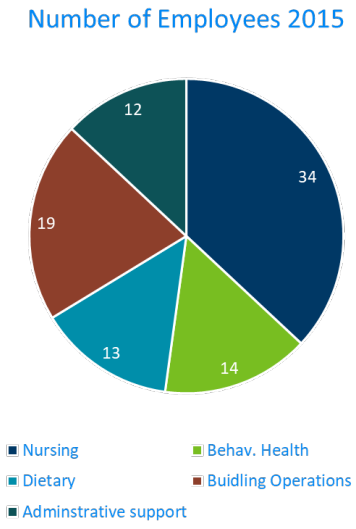
The Minnesota model of domiciliary services not only covers all services of the medical model (medical provider, nursing, dietary, recreation, and social work) but also provides mental, chemical, vocational, and life skill services. This holistic approach to care is critical to meeting the needs of the Veteran population that suffers from multiple medical and mental health diagnoses. In addition to the diagnosis need, many Veterans are facing homelessness and instability in their personal lives and need supportive services.

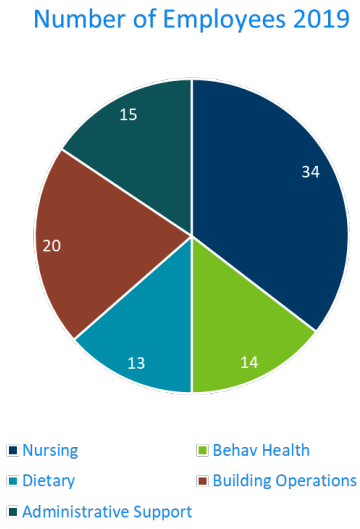
1.2 DOMs program operations & clinical services

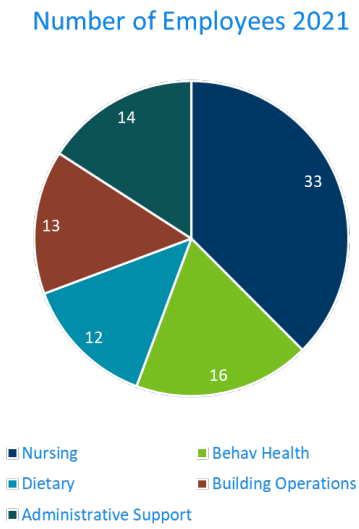
Costs of operations are supplied by a variety of sources. VA provide Per Diem for DOMs at $59 per day. By comparison, skilled nursing is reimbursed at $138 per day and Adult Day at $110. State appropriations make up a portion of operating costs, and resident maintenance fees which are based on individual financial circumstances. Each resident is assisted in applications for other insurance coverage by the Benefits Coordinator. MDVA does not receive Medicare A/B or Medicaid in the DOMs program.

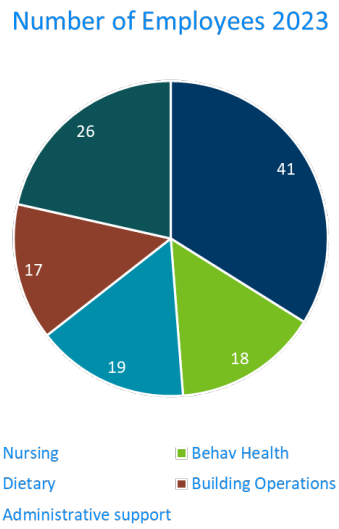
1.3 Organizational chart, staffing & reporting structure



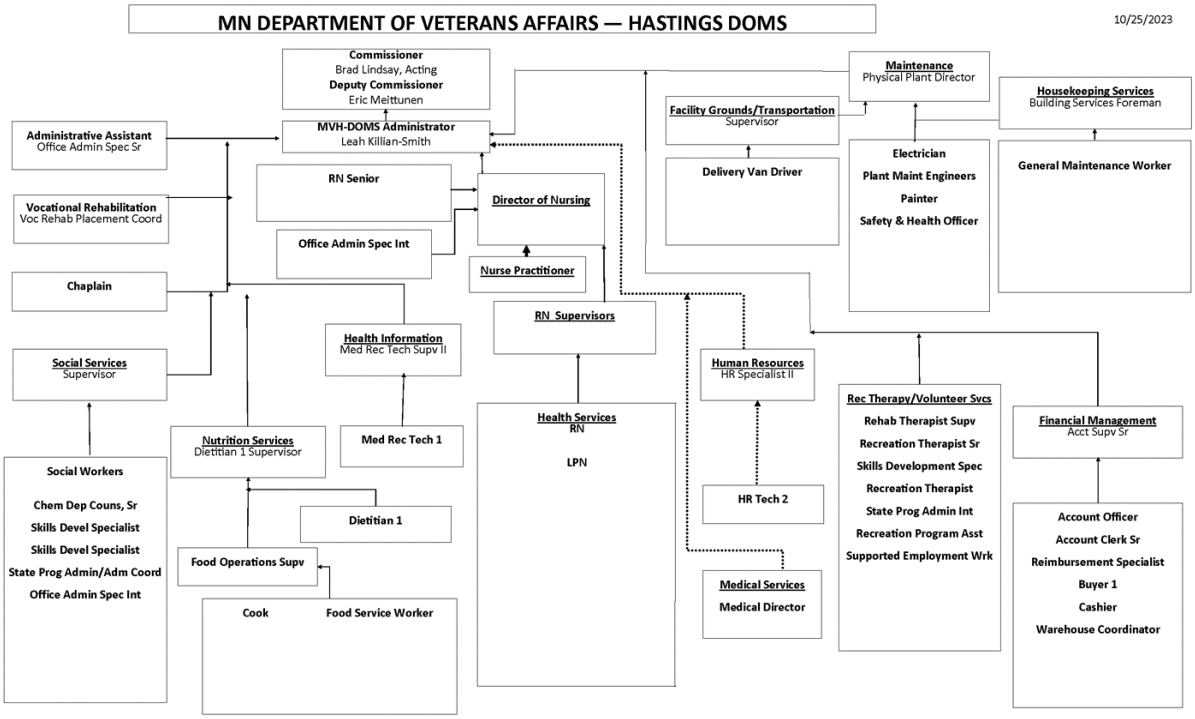








Reporting structure



1.4 Service delivery model & individual care plans

Determination of Appropriate Level of Care – overall goals of this process are to ensure that the interdisciplinary team has opportunities to review and address the services being offered and ability to meet care needs. Strongly driven by the clinical team and the ability to meet the clinical needs. The interdisciplinary team should be using their professional

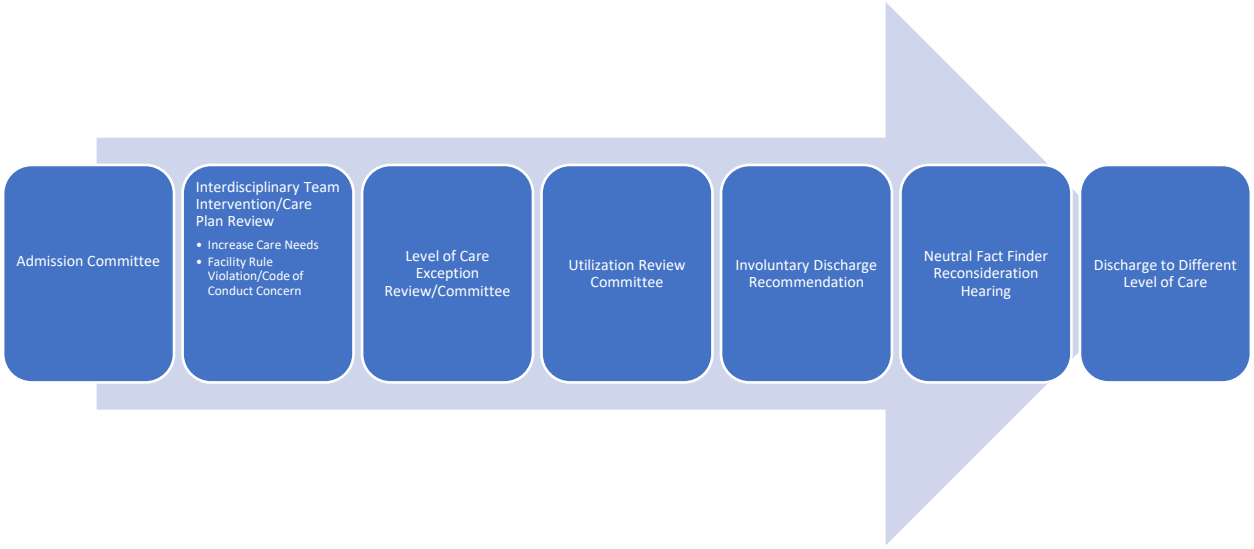
background, licensure expectations and resources to determine services met and ability to meet the clinical needs.

Person Centered Care – residents have the right to refuse care. This process ensures various individuals and various levels of the organization are evaluating needs. It allows for due process and various levels of support and intervention to achieve the best outcome. Regulatory compliance bodies evaluate the assessment of residents, care needs identified and care plan interventions in place.

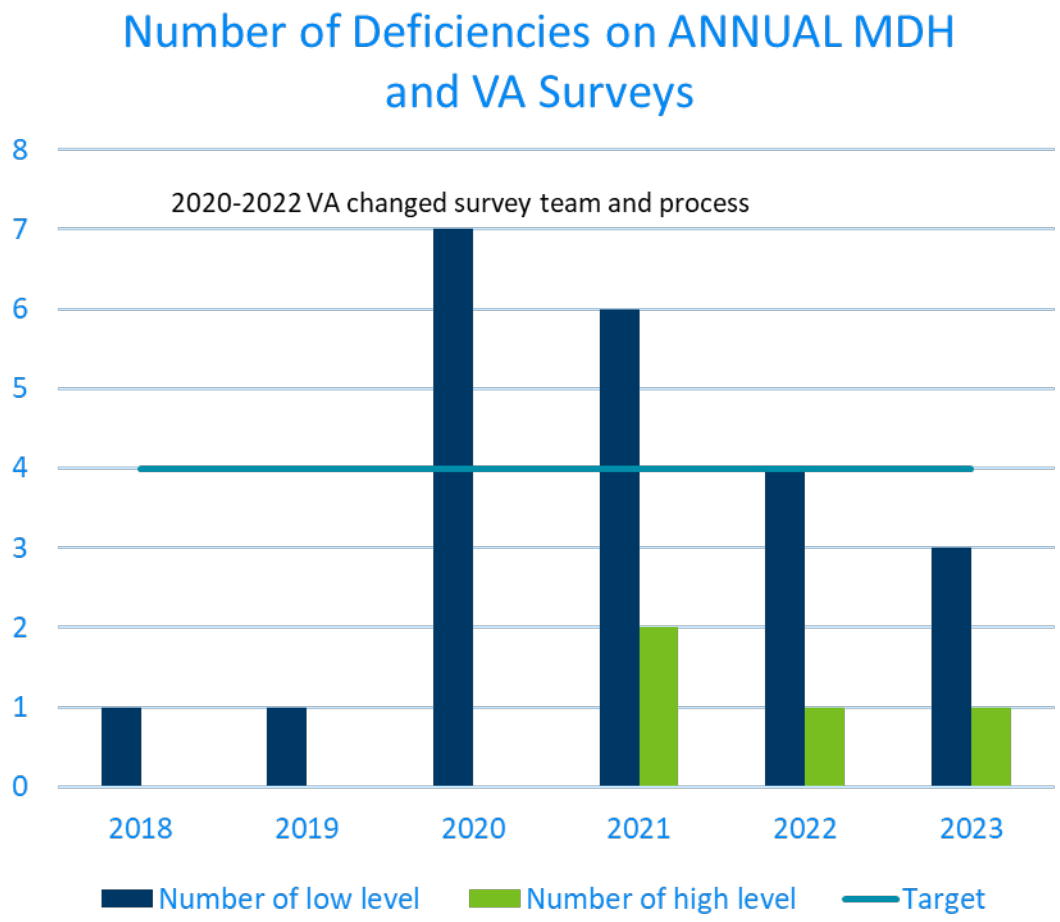
Resident care plans are reviewed every 6 months and as needed. Level of care assessments are completed by an Interdisciplinary Team with resident participation. Evaluations include Dietary/Nutrition needs, Mental Health Services, Nursing, Social Services, Therapeutic Recreation and Vocational Rehabilitation.

Various assessments, scenarios and timeframes guide the interdisciplinary assessment and recommendation for level of care. It is a constant evaluation. Each Interdisciplinary Team member should (and by licensure if appropriately required) articulate if a level of care change is recommended through the IDT process. Opportunities for these determinations include

- Daily Clinical Huddle – review with clinical team the incidents in past 24 hours and interventions
- IDT Review – scheduled review by assessment schedule
- As needed – opportunity to raise care concerns or resident needs



1.5 Quality oversight and performance outcomes



Section 2. Characteristics of the population currently served by MDVA's DOMs program

2.1 Residents: Eligibility criteria for admissions and discharge

For a Veteran to be eligible for admission to the DOMs Program, the following criteria must be taken into consideration.

- Must have no adequate means of support.
- <2 times a day need for Activities of Daily Living (ADL) or behavioral support.
- Medical and, if appropriate, psychiatric diagnosis from the attending physician indicating placement in a boarding care facility is a medical necessity.

• Alert and oriented to person, place, and time, and able to function within a structure of daily monitoring by the nursing staff of the boarding care facility.

• Able to recognize and appropriately react to hazards in the environment.

• Physically and mentally capable of providing personal care and hygiene including dressing, grooming, eating, toileting, and washing other than bathing.

• Assessed by a staff registered nurse as independent in transferring and mobility.

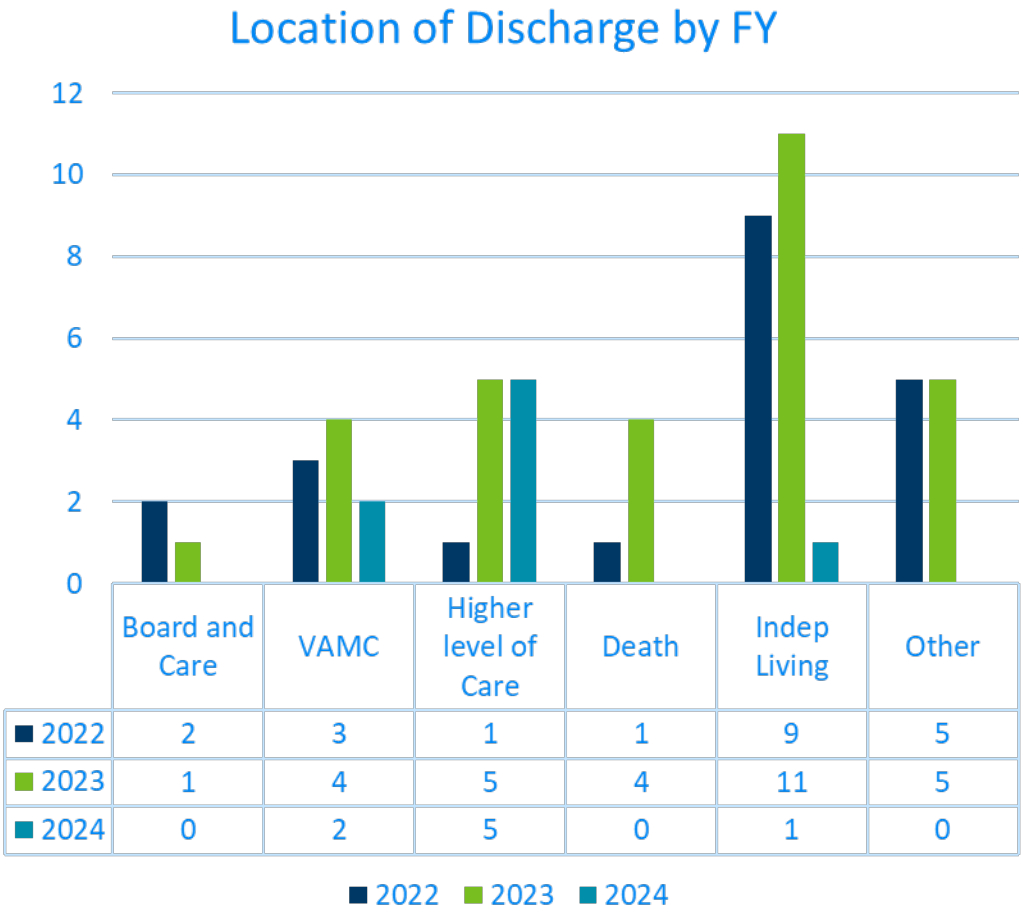
For discharge from the DOMs Program, the following criteria must be taken into consideration.

• Clinical care or behavioral needs exceed 2 times per day interventions outside of medication administration with no indication of resuming to baseline.

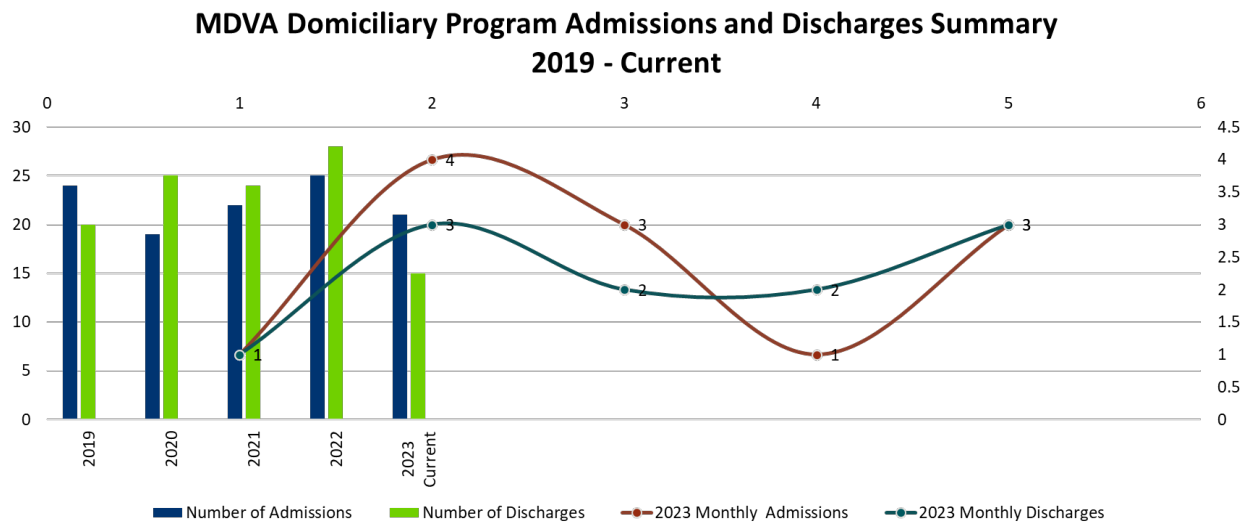
• Health and safety of staff or residents at risk from the resident remaining there.

• End of life services not being able to be met

• Continued non-adherence to facility rules



	Board and Care	VAMC	Higher level of Care	Death	Indep Living	Other
2022	2	3	1	1	9	5
2023	1	4	5	4	11	5
2024	0	2	5	0	1	0



2.2 Typical DOMs resident, representative acuities, and diagnosis

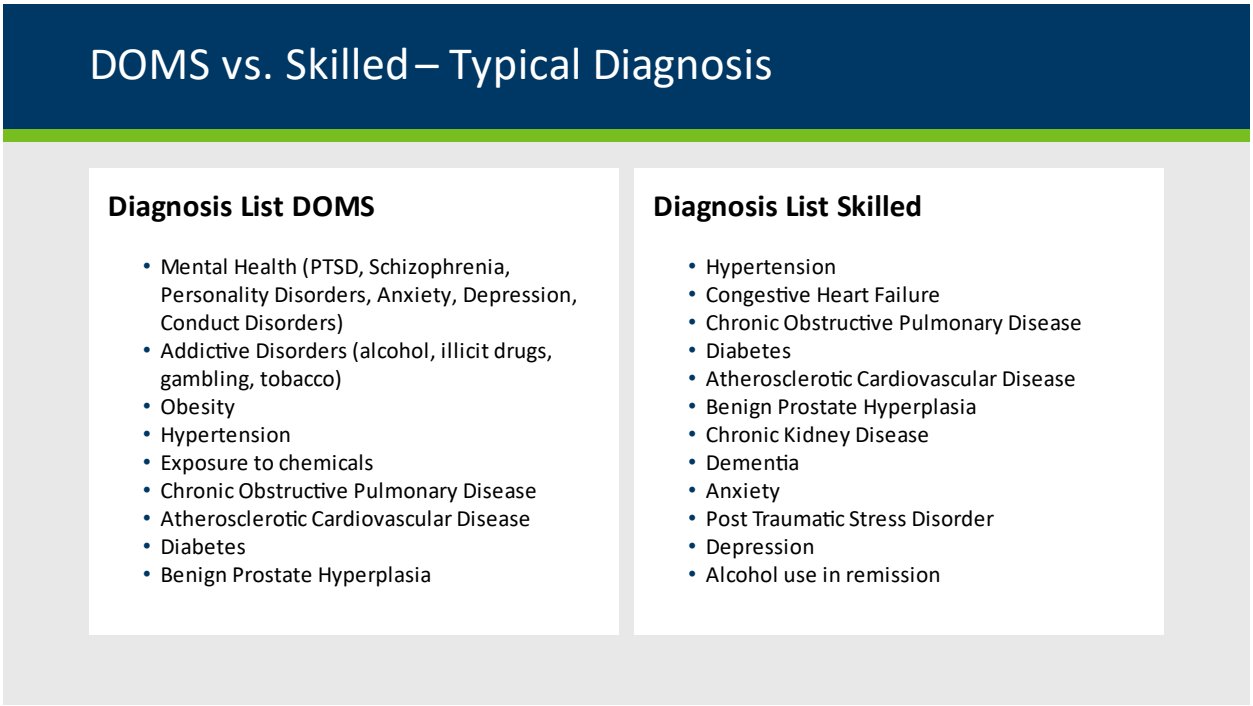
A typical resident of the DOMs program is a 65-year-old male (presently two female veterans in the program) with persistent mental illness as primary diagnosis. Generally, a resident will have several other medical co-morbidities (i.e., cardiac, respiratory, diabetes), be independent with ADLs and received medication administration assistance. Commonly, residents have life skills needs such as room order, hygiene, and appointment reminders, needs sobriety support and mental health support.

DOMs Program demographics and data
Male, 2 female residents
Predominately Caucasian
Mental Health Diagnosis (PTSD, Schizophrenia, Adjustment Disorders, Addiction Disorders, Depression, Anxiety)
35% of residents on Antipsychotics
Average 3 resident to resident behaviors per month • Average 3 MAARC reports per month YTD (30) • (previous years 28, 13, 14, 19)
<8 residents with BMI >40
Average 15 trips to UC, ER, or Hospitalizations per month
Average 56 special trips per month (dental, ER, Medical apt's)
Average 1-3 relapses per month

Average 117 work orders per month, and 52 preventative maintenance inspections per month
Average 2-3 admission and 2 discharges per month
Average 2-3 open positions open per month
No lift or transfer equipment
Semi-private or private rooms, communal bathrooms (Dorm style living)

An acuity determination is the measurement of care a person needs based on the severity of either an illness or mental condition. Factors include stability of illness, acute illness or injury, physical care needs, projection of the illness and cyclical events.

Assessments to determine acuity and care plan	
Safe Smoking	Pain
Nutrition	Monthly nursing summary
Recreational Needs	Falls risk
Self-Administration of Medications	Trauma informed care
Skin	PHQ9, Columbia Suicide
AIMS as needed	Pharmaceutical Reviews
BIMS as needed	Falls risk



2.3 Comparable Population & Operations: U.S. Dept. of Veterans Affairs (VA) mental health residential rehabilitation treatment programs

The U.S. Dept. of Veterans Affairs (VA) mental health residential rehabilitation treatment programs (RTP) share similar patient population characteristics as the DOMs Program. RTP is a distinct level of mental health residential care that serves veterans with mental illness or addictive disorders who require additional structure and support to address numerous psychosocial deficits, including homelessness, unemployment, and the mental health.

Residential rehab treatment program is an umbrella term for an array of programs and services that comprise mental health residential care. It is a more acute level of care than what is offered at the state, but it is not acute or long-term care. It is not a place where a veteran can a stay indefinitely; it's intended to be an opportunity for stabilization and then transition to a long-term plan.

Many of the Veterans served in this level of care are struggling with homelessness, substance use disorders, post-traumatic stress, needing a place to live and some compensated work therapy. The detailed standards of care for the mental health RTP are defined by VHA Directive 1162.02. These types of programs are accredited by the Commission on the Accreditation of Rehabilitation Facilities, otherwise known as CARF, and under the Joint Commission Behavioral Health Standards. All VA mental health programs are recovery oriented, and the type of care that's provided is veterans centric, individualized, integrated and focused on outcomes.

Some of the admission criteria that might be similar to a domiciliary at the state vet home level: they do not require acute inpatient mental health or a medical admission. They are assessed

as requiring a level of care beyond what can be offered in an outpatient setting. The outpatient setting is insufficient intensity to get the outcomes that are being sought.

They must be assessed as having a mental health, substance use, psychosocial or medical treatment needs that require this type of structured support and services that are offered at this residential level of care. However, they are not at imminent risk of harm to themselves or others, are capable of their basic self-cares and at risk for homelessness and able to benefit from compensated work therapy if that's one of the goals.

Section 3. Regulatory Oversight of DOMs care and boarding care homes

3.1 U.S. Dept. of Veterans Affairs (VA) Regulation of DOMs care of Veterans in State Homes

The United States Code of Federal Regulations (CFR), Title 38, Chapter 1, Part 51 establishes, "…VA's policies, procedures, and standards applicable to the payment of per diem to State homes that provide nursing home care, domiciliary care, or adult day health care to eligible veterans."

Per 38 CFR §51.2, *Domiciliary care* means the furnishing of a home to a veteran, including the furnishing of shelter, food, and other comforts of home, and necessary medical services as defined in this part. For purposes of the definition of "domiciliary care," necessary medical services means the medical services subpart E of this part [51] requires the State home to provide. As defined in 38 CFR §51.2, and as used throughout this report, *resident* means an individual receiving nursing home or domiciliary care.

38 CFR §51.51 Eligible Veterans –domiciliary care.

(a) A veteran is an eligible veteran for the purposes of payment of per diem for domiciliary care in a State home under this part if VA determines that the veteran is not barred from receiving care based on his or her service (see 38 U.S.C. 5303, 5303A), is not barred from receiving VA pension, compensation or dependency and indemnity compensation based on the character of a discharge from military service (see 38 CFR 3.12), and the veteran is:

(1) A veteran whose annual income does not exceed the maximum annual rate of pension payable to a veteran in need of regular aid and attendance; or

(2) A veteran who VA determines has no adequate means of support. The phrase "no adequate means of support" refers to an applicant for domiciliary care whose annual income exceeds the rate of pension described in paragraph (a)(1)of this section, but who is able to demonstrate to competent VA medical authority, on the basis of objective evidence, that deficits in health or functional status render the applicant incapable of pursuing substantially gainful employment, as determined by the Chief of Staff of the VA medical center of jurisdiction, and who is otherwise without the means to provide adequately for himself or herself, or be provided for in the community.

(b) For purposes of this section, the eligible veteran must be able to perform the following:

(1) Daily ablutions, such as brushing teeth, bathing, combing hair, and body eliminations, without assistance.

(2) Dress himself or herself with a minimum of assistance.

(3) Proceed to and return from the dining hall without aid.

(4) Feed himself or herself.

(5) Secure medical attention on an ambulatory basis or by use of a personally propelled wheelchair.

(6) Have voluntary control over body eliminations or have control by use of an appropriate prosthesis.

(7) Participate in some measure, however slight, in work assignments that support the maintenance and operation of the State home.

(8) Make rational and competent decisions as to his or her desire to remain in or leave the State home.

38 CFR §51.330 Nursing care.

The State home must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs of all residents within the facility, 24 hours a day, 7 days a week, as determined by their comprehensive assessments and their comprehensive care plans. The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing service's staff.

3.2 Minnesota Dept. of Health (MDH) responsibilities related to boarding care homes

The Minnesota Dept. of Health MDH holds Regulatory oversight of the MDVA Domiciliary Program under Minnesota Administrative Rules, Chapter 4655 - Boarding Care Homes.

Per MN Rule 4655.0100 Definitions, Subpart 3, “a "boarding care home" shall mean a licensed facility or unit used to provide care for aged or infirm persons who require only personal or custodial care and related services in accordance with these regulations. A boarding care home license is required if the persons need or receive personal or custodial care only. Nursing services are not required. Examples of personal or custodial care: board, room, laundry, and personal services; supervision over medications which can be safely self-administered; plus, a program of activities and supervision required by persons who are not capable of properly caring for themselves.”

MN Rules Chapter 4655 further guides the types of admissions to a boarding care home, including those charged with selection of program residents and broadly identifying those residents who are ineligible for admission, as well as defining the number of staff and staffing requirements for a boarding care home:

4655.1500 **Type of Admissions**.

Subpart 1. **Selection of residents and patients**. The administrator, in cooperation with the director of the nursing service in a nursing home or the person in charge in a boarding care home shall be responsible for exercising discretion in the type of patients or residents admitted to the home in accordance with the admission policies of the home.

Subpart. 2. **Patients not accepted**. Patients or residents shall not be accepted or retained for whom care cannot be provided in keeping with their known physical, mental, or behavioral condition.

4655.5100 **Adequate Staff**.

Subpart 1. **Amount of staff**. Adequate staff shall be provided to meet the nursing and personal care needs and the maintenance necessary for the well-being of the patients and residents at all times.

Subpart. 2. **Requirements for staff**. There shall be at least one responsible person awake, dressed, and on duty at all times. These persons shall be at least 21 years of age and capable of performing the required duties of evacuating the patients and residents.

Section 4. DOMs staffing and care delivery models

4.1 Management structure & staffing models

Since 2017, staffing models have been adjusted from a medical model to a psychosocial model to support the overall wellbeing/whole person and offer programs to ensure needs are met. Emphasis to staff has been to focus on “working up to your licensure” and have developed a comprehensive team approach to address all needs.

Interdisciplinary team at the DOMs program	
Medical Director	1/2 day per week
Nurse Practitioner (NP) for primary care	4 days per week
Care Manager RNs with specialty focus (Infection Prevention, Diabetes, Informatics, Wound Care)	4 FTE
Nursing Staff for clinical assessments, medication administration	3 FTE Day/Eve, 2 on NOC

Psychology	1 FTE (with VA Medical Center Support – Telehealth and In-Person Specialty Visits)
Social Work	Supervisor and 3 SW FTE
Chemical Health Counselor	1 FTE
Chaplain	.5 FTE
Recreation Therapy	Supervisor, Senior, and 3.5 FTE support
Work Therapy	1 FTE
Independent Living Skills/Life Coaching, Telehealth Coordinator, Fitness and Wellness, Registered Dietitian, Benefit Coordinator	
Numerous Food Service Workers, General Maintenance Workers, Drivers, Safety Officer, and Administrative Support Staff	

4.2 Staff deployment and utilization

Currently, daily staffing in the DOMs Programs is organized in the following pattern, reflective of the size and number of residents at the respective locations:

Hastings	Minneapolis
4 Social Workers	1 Social Worker
2 Independent Skills Workers	1 Independent Skills Worker (1 day/week)
1 Chemical Health Counselor (LADC)	1 Chemical Health Counselor (1 day/week)
1 Psychologist	1 Fitness/Wellness Coordinator (1 day/week)
1 Fitness/Wellness Coordinator	1 Dietician (1 day/week)
1 Dietician	1 Vocational Rehab Counselor (1 day/week)
1 Vocational Rehab Counselor	2 RN/LPNs Days, 2 RN/LPNs PM, 2 RN/LPN/HST Nights
1 Nurse Supervisor/3 RN Seniors	1 Rec Therapy
3-5 RN/LPN Days, 4-5 RN/LPN PMs, 2 RN/LPNs Nights	

2 Rec Therapy	

COVID-19 Response/Emergency Support

Background: Concerns raised regarding the DOMs leadership response and utilization of staff during the COVID-19 pandemic.

Circumstances: The COVID-19 Pandemic was a new experience for all healthcare leaders – testing knowledge, background, and decision-making to mobilize and respond swiftly. Early on in 2020, staff deployment and utilization decisions were made daily, based on changing guidance and regulatory requirements, PPE supply, the cases in the county, and what was happening with the DOMs workforce. Frequently, plans made to start the morning needed to be shifted by the time the afternoon came on, and communication in this climate of rapid change related was very challenging.

Early in the pandemic, MDVA Veterans Healthcare leadership initiated risk assessments, determining that, given the characteristics of the residents that lived there, the amount of residents that were smokers, the physical layout of the building and the communal rooms and bathrooms, and the difficulty with engaging in social distancing protocols and encouraging mask-wearing and encouraging COVID-positive resident quarantine, the DOMs setting in Hastings could be the hardest hit of the Veterans Homes. The facility faced few COVID outbreaks for many years.

From 2020 through 2023, throughout MDVA Veterans Homes campuses statewide, any COVID outbreaks were followed by discussions with staff and leaders who were involved and do after action reviews - SWAT analysis - to really look at how MDVA could have responded better. This allowed for shifting priorities, protocols and strategies based on what was learned with each different outbreak in each different campus. Some challenges were:

During an outbreak, if staff were exposed or tested positive with COVID, they were removed from schedule during the mandatory isolation period. At that time, staffing with sometimes 2 nurses on a shift, 3 nurses on a shift to begin with as baseline staffing and one of them goes out, it was challenging to mobilize the resources to cover the basic needs and make sure that everything covered.

Outcome: The DOMs structure was adjusted to put in place contracts, procedures, and resources to swiftly prioritize and continue to ensure residents were cared for and staff supported. The current model of emergency staffing is to utilize volunteer staff from MDVA Central Office or other Homes to provide support during critical periods.

MDVA has utilized this model since Fall 2020. It is a successful model for providing support but is resource challenged and labor intensive for coordination and ensuring compliance with Collective Bargaining Agreements while relying on volunteer support. Most recently, volunteer reassignments were provided to Hastings during a COVID-19 outbreak in Fall 2023.

During the same time, a state Enterprise Initiative included negotiated master contracts with temporary pool staffing agencies which offered additional staff as needed and where available.

Another outcome was to reevaluate staff position descriptions. It was recognized that DOMs and healthcare staff position descriptions should reflect specific responsibility during outbreaks and emergencies. Position descriptions have been or are being updated and expanded to include specific emergency responses to infectious outbreaks and pandemics, emerging pathogens and expanded PPE training and requirements to wear PPE to protect employees from exposure.

Healthcare Division Review/Development – Program Enhancement Winter 2023

New leadership group formed to specifically focus on the reassignment process and program during an emergency, tasked with removing barriers and obstacles to ensuring the mobilization and reassignment of resources and staff quickly and seamlessly. In addition to a focus on the utilization of existing and internal resources, the group can seek contracted staff to fill the need when other options have been explored but may be unavailable.

A recent example of this strategy was the deployment of 4 staff to Hastings over the course of a 10-day period to provide hands-on support and assistance to the DOMs program. Staff included LEC/Rec Therapy, SW, IP Nurse, Quality Director; also brought in 2 nurses from pool agency at end of outbreak to provide back-up support.

4.3 Defining & refining appropriate and adequate resident care practices

Ensure the highest levels of resident care

There is not a standardized quality assurance assessment for the domiciliary level of care, no acuity assessment available for the DOMs setting. The lack of this standardized tool can challenge staff doing clinical review. Currently, the quality of resident care is evaluated through VA and Department of Health survey performance, resident satisfaction surveys and the DOMs Quality Dashboard created specifically for the DOMs program in 2019.

DOMs Program dashboard: DOMs does not have access to CASPER reports or VA analytics or sales reports, so they created and maintain a dashboard in the DOMs setting which tracks resident outcomes. The dashboard includes a list of quality measures for tracking for quality assurance purposes. Measures being tracked include the number of falls, number of falls with major injury - industry standards for long term care - percentage of residents using antipsychotics - which is a skilled care measure – and number of incidents of resident-to-resident behaviors.

Some measures where are not tracked nationally include, the number of tobacco users, the number of residents with a BMI of 35-40, the percent of residents with BMI of 40 or more, and the number residents in the Minneapolis or Hastings DOMs that have experienced alcohol or

chemical relapse. These measures have been identified for tracking as determinative in resident outcomes and help to better understand and meet the needs of the DOMs residents.

DOMS Program Dashboard - 2023

Quality Measures	2019	2020	2021	2022	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec	Monthly Avg	Total
# of Falls	88	91	78	69	10	12	8	8	7	14	20	4	7	1			9	91
# of Falls with Major Injury	7	2	4	4	0	0	0	1	0	0	0	0	0	0			0	1
% of Residents Using Antipsychotics	39%	42%	38%	37%	39%	36%	35%	34%	34%	32%	34%	36%	36%	37%			35%	
# of Incidents of Resident-to-Resident Behaviors	3	4	3	25	3	3	2	3	4	4	3	3	4				3	29
% of Residents with BMI 35 - 40	86	84	84	861	13.5	15.5	16.6	16.1	18.1	16.2	16	16.8	15.2	12.5			15.65	156.5
% of Residents with BMI 40 or more					7.4	8	7.3	7.4	5.3	6.75	6.6	6.5	6.6	7.23			6.908	69.08
# of Residents with Unplanned Weight Loss	14	12	11	9	1	0	0	4	3	2	0	1	1	3			2	15
# of Tobacco Users	87	80	74	74	73	73	73	73	73	73	73	73	73	73			73	730
# of HAPUs	2	0	1	1	0	0	0	0	0	0	0	0	0	0			0	0
# of Adverse Drug Events (Medication Error #)	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0	0
# of Acute Care Visits: Trips to Emergency Room, Urgent Care, and Hospitalizations Total	97	137	114	124	21	14	10	14	19	22	8	10	15	16			15	149
Number of Telehealth Visits Conducted	0	873	902	555	38	38	37	40	42	24	28	32	21				33	300
Mpls Relapse	19	1	3	7	0	0	0	0	0	0	0	1	1	0			0	2
Hastings Relapse	60	18	35	13	1	2	1	2	2	3	2	1	3	1			2	18

Section 5. Workforce

5.1 Staff needs – guidance, support, training and individual development opportunities

Background: Concerns have been raised that clear guidance has not always been provided to the DOMs workforce.

Circumstances: Prior to the COVID-19 pandemic, it is acknowledged there existed opportunities to improve communications between staff, supervisors, and DOMs program leadership. Communications were not very well organized; it was an area of need that was thoroughly exacerbated by COVID in the work environment due to swiftly changing guidance, rapid implementation of emergency responses and challenges in how best to communicate these changes. Communication challenges were aggravated by an inadequate understanding of new systems, software, and platforms such as Microsoft Teams, and a diversity of personal communications preferences, all initiated under exceptionally stressful conditions.

Recognizing the impact to healthcare workers' wellness and perception of burnout, in 2023, Veterans Healthcare leadership for the entire division – both skilled nursing and DOMs – increased its focus and prioritized updates to policies and procedure related to communications and staff guidance. A Domiciliary Program communication strategy was put in place for all staff to include electronic communication systems/updates via Teams, in-person meetings involving those participants who desired to meet in person, and an acknowledgment that there were challenges with consistent messaging and communications with two separate locations.

During COVID, when staff were social distancing, leadership and supervisors would hold Friday updates, covering anything that had happened in the prior seven days as it related to COVID or changes or requirements that need to be administered. Messaging would be developed and was to be printed by supervisors and shared with their staff.

Opportunities were identified for the development of an engagement tool to evaluate staff perception about the DOMs program and their work. One area of focus was employee wellness. In 2021, MDVA implemented a Healthcare Employee Wellness Initiative. Utilized a wellness consultant to provide information, support, and resources to staff regarding their own personal wellness. Champions were present and engaged from the Domiciliary program in this work.

Another area of focus has been on expanding daily communications through clinical calls, daily leadership calls, all staff meetings, and Town Halls. These activities are currently in place and occur routinely and as needed. Examples include DOMs nurses doing "hand-off" communication shift-to-shift; the leadership team reviews all clinical care and issues and concerns every day, the administrative director of nursing reads through the staff report and reviews any documentation that has happened for all residents, and then feedback and discussions with nurses occur as appropriate.

Department Specific Meetings – Nurses meeting to allow nursing staff to share new ideas as well as frustrations and concerns, facilitated by nursing leadership.

Quality Assurance Performance Improvement (QAPI) meetings review the benchmarks set for quality and monitors any improvement or decline monthly.

Staffing considerations to include options for additional training opportunities

Training is a priority for the Minnesota Veterans Homes. Training is led by the Clinical Director and her team of Clinical Nurse Specialists and includes the use of outside resources, specifically in the areas of Veterans mental health. Recent initiatives related to expanded training opportunities

- During the summer of 2023, a Department Analysis was completed for Providers, Nursing and Behavioral Health Team which identified opportunities for department improvements and reallocation of FTE's.
- Added a new RN Senior focused on staff and resident education.
- Focused Education Committee at the DOMs to meet and strategically plan education based on needs expressed, staff ideas, and resident concerns and safety surveys.
- DOMs Education Committee to contribute their plan and ongoing adjustments in the monthly All Homes Education Committee Chaired by the Clinical Director

The average number of required training hours per employee/supervisor in the DOMs Program is as follows:

- 5.3 hours/employee/year in MDVA Mandatory Training
- Additional discipline-specific training to meet licensure
- 6.0 hours/supervisor/year

Mandatory On-boarding and Education for all DOMs program employees:

- Abuse, Neglect, and Exploitation Prevention
- Vulnerable Adult Protection Plan, Resident Rights
- Cultural Competency, Diversity and Inclusivity
- Person Centered Communication
- Ethics for Long-Term Care
- Hand Hygiene
- Tuberculosis, Blood borne pathogens, COVID, PPE, IP
- Safe Food Handling
- Challenging Behaviors and Trauma Informed Care
- Safe resident handling
- SAVE training, Mental Health First Aide (8 hours)

Additional Education Offered – All Staff 2023

- Incident Command System Training
- Military Culture
- COVID and PPE, N95/PAPR
- Emergency Response and Action Plans
- Leadership training (MDVA, CORE)
- CPR Training
- Mental Health ASSIST training (16 hours)

Opportunities following the March 21, 2023, Minnesota Senate hearing

- DISC Assessments
    - These assessments aim to predict job performance by categorizing individuals into four personality traits: dominance, inducement, submission, and compliance
    - This strategy was facilitated by DEI Director and Contract Consultant
    - Results must be carefully evaluated and utilized within a trusting environment as a way in which leaders and staff can better understand how they might best communicate, interact, and learn from one another
    - Process is currently in progress
- Ethics Enhanced Ethics Training and discussion- live training all staff attended
- Prevention and Intervention of Harassment Training- live training all staff attended
- Diversity Equity and Inclusion Office provided on site “office hours”
- Trash Compactor and other requested technical training

Additional Education Offered to Supervisors 2023

Leadership Cohort training (6-session course) covering various topics	Leadership/Wellness/DEI Lunch and Learn
Performance reviews overview	Merit System
Data Practices	Developing Interview questions and Best Practices
Investigation Training	Performance Management
Supervisor/lead worker-PELRA duties	Recruitment -Incentives
MHP and Affirmative Action	Vacancy filling process
Interview Best Practices	Accommodation Training
Vets Preference Hiring	Admin Procedure 10-Posting
Performance review template	Vets Preference Hiring

Section 6. Staffing and resident quality of care metrics

6.1 Metrics for Quality-of-Care Delivery (Resident Focused)

Survey Readiness and Response

MDVA Survey Readiness Visits

Annually, the MDVA Healthcare Division and Facility Team completes a survey readiness visit with the goal of evaluating each Veterans Home's current compliance with regulatory requirements in preparation for VA or MDH surveys. Some key components of these survey readiness visits include review and evaluation of responses to previously identified deficiencies – looking for sustainability in implementation of appropriate corrective action plans – and identifying opportunities for education, support or resources to put in place or reinforce compliance with regulatory requirements.

The survey readiness of review team to each home that includes the Quality Director and Clinical Director, and other subject matter experts who review the current compliance with the regulatory requirements. These are typically scheduled in the month before VA surveyors come – the VA comes on a consistent month every year. The survey readiness team looks at residents that the Home team has identified as more complex either typologically or socially or medically, and review those in depth. The survey readiness team conducts environment of care rounds and use CMS critical element pathways as the foundation for these reviews. The team does a learning needs assessment and looks for opportunities to provide education to staff and evaluate whether there's anything that needed for additional support and resources.

Outcomes Survey Readiness Visits serve as agency quality assessment tools and offer the opportunity to present recommendations to the facility leadership team on ways they and their teams can continue to identify and remedy potential issues, offer solutions, and enhance collaboration between Veterans Healthcare Central office and each of the facilities.

The team schedules time for exit reviews with the facility leadership team and keep records of all of these survey readiness reviews along with the surveys that have occurred and track those and see if there's any recurring themes.

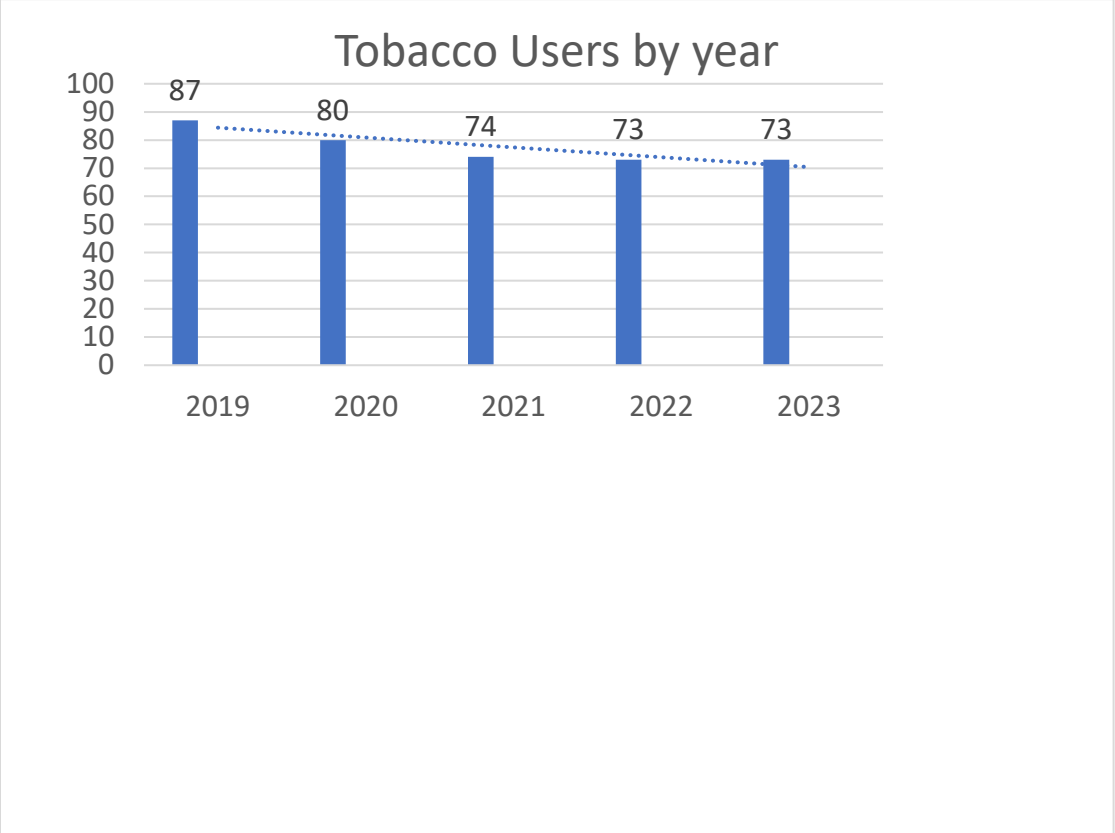
Of note, there are no specific metrics for survey readiness or response. The MDVA goal is to have no immediate jeopardy (IJ) tags, not have repeat findings on surveys, and strive to have lower-level findings on any service.

Facility Program Dashboard

The Healthcare senior leaders monitor the Facility Program Dashboard which combines metrics and reviews from all of Homes – facility-specific information is entered into the agency dashboard and tracked to be monitoring the quality of care for the residents.

Tracking various metrics primarily for resident care, but the predominant areas that MDVA Healthcare are measuring for quality of care for the residents in the DOMs program are the number of residents that are smoking, BMI/obesity, sobriety, falls and hospital days of care..

Smoking is permitted for residents of the DOMs program. It is difficult to discharge residents from the program when they do need a higher level of care if they are smokers. Many long-term settings do not allow residents to smoke. When residents of the DOMs have a change in their medical condition where they're exceeding the level of care available at the DOMs, the program needs to have the ability to move them to someplace else. As a result, smoking cessation is a focus.



BMI/Obesity The DOMs program tracks BMI, and sees many cases of residents with diabetes. Significant obesity in the resident population is an unhealthy trait. BMI monitoring is a good way to track resident activity levels, how engaged they are in their own health and well-being, and what they're doing in response.

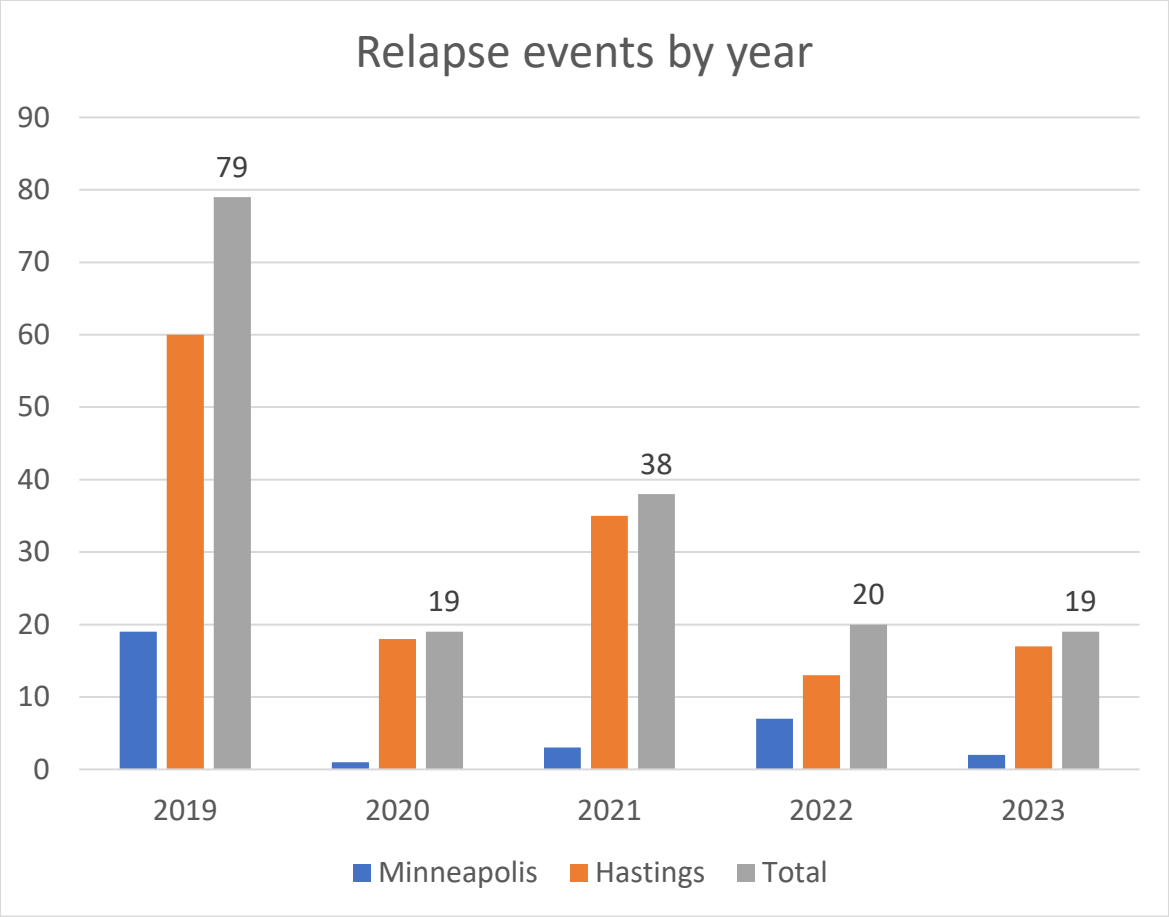
In response to staff concerned by the number of residents with elevated BMI and diabetes, MDVA hired a wellness and fitness individual who has implemented exercise programs, which in addition to weight loss, also contributes to improved balance, which can reduce falls and improve other aspects for resident care.

Sobriety & Relapse The DOMs program also monitors relapses. Since beginning to focus on working with residents in pursing sobriety, and monitoring residents sobriety, there has been a 75% reduction in relapses. Current data suggests the program averages about 20 to 25 episodes of relapses a year between the two campuses. Communication with residents is critical – when they live in the program – that they commit to living in a campus that is sober and to be supportive of other residents who live there that are sober.

There are specific actions taken if a resident is under the influence or suspected to be under the influence. The DOMs team have used evidence-based programs in chemical health to try and help develop and find the right system for addressing this concern.

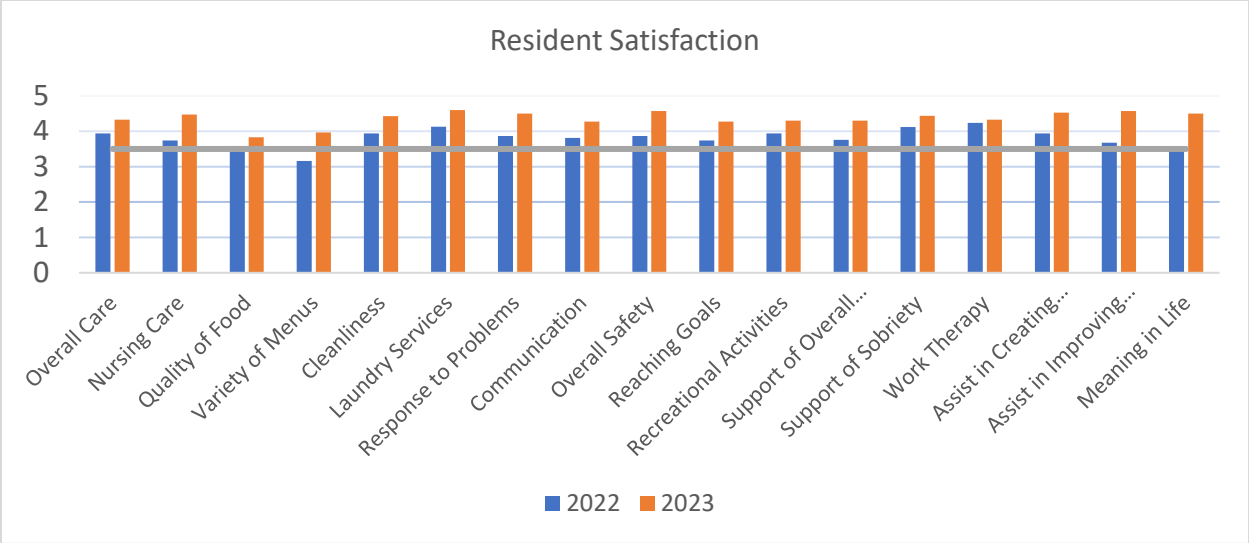
The dashboard also tracks the number of residents that are falling with injuries. Having a lot of residents falling and falling with injuries results in their medical conditions worsening. As relapses have lessened, the DOMs program has noted significantly fewer falls with injuries which suggests that as residents are not under the influence, frequently falling down and suffering an injury become less common.

One significant caveat is that, because MDVA is offering programming that is not typical in the domiciliary/boarding care industry, it's hard to benchmark and compare success without equivalent or similarly situated operations in the Veterans care setting.



Pinnacle Resident Satisfaction Survey - quarterly DOMs resident satisfaction survey that prior to 2022 utilized a slate of questions that were also used in long term care or assisted living settings. In 2022, the DOMs leadership team made an adjustment and made them very specific for our residents and the DOMS that addressed issues that were more related to the mission of that type of program.

Questions were customize based on the mission and the three paths. For example, is the Program helping you have a meaningful life - meaning in life - and is the program assisting in improving your overall health, are we assisting in creating some stability in your life? Every resident has an opportunity to participate at least once a year in this program and in providing the feedback, and response rate is at least half of residents provide responses. Results from 2022-2023 suggest that resident satisfaction is improving.



Quality Assurance Program Goals/Performance Improvement Programs

The Domiciliary Quality Assurance and Performance Improvement (QUAPI) Program was established in which many different departments provide input and data and have some department-specific metrics to be following. This program meets monthly and reports on outcomes to resident care.

6.2 Metrics for Staffing Needs (Staff Focused)

The **State of Minnesota Enterprise Engagement Survey** (every 2 years – January/Feb 2023), and received results in July 2023, approximately 6 months post evaluation. The Healthcare leadership reviewed the results, which are not specific to each Home, but representative of what was reflected at the Homes overall, and in collaboration with staff, worked to develop a response plan. Specifically, Healthcare leadership will be making a concerted effort to incorporate these into the Division's strategic plan.

Strengths:	Opportunities:
Satisfaction with employee benefits	Leaders make effort to gather opinions of others
Feel trusted to do my job	Career Advancement opportunities available
Mission driven	Communicate decisions regarding direction or allocation of resources that improve equity
Strive to do my best each day	

State of Minnesota Enterprise Safety Perception Survey (every 2 years – last completed in 2017, 2019, May 2023). Results received in November 2023, approximately 4 months post

evaluation. Again, this is at the enterprise level and does not break out what specific MDVA Homes or Homes employees are reporting. Homes leadership reviewed the results and in collaboration with staff, will be develop a response plan.

Strengths:	Opportunities:
Staff understand safety policies and expectations	Safety performance should be shared with staff
Staff understand that work should be performed safely	Lessons learned relating to accidents should be shared
Staff understand how to avoid injury/workplace hazards	Information relating to the organization shared with staff

Staff Metrics Communication Strategy with New DOMs Program Administrator

All Staff Meetings – Leah Killian-Smith, the new DOMs Administrator, will be holding in-person meetings every other month, with all shifts, for a total of 6 sessions offered. Meeting attendance will not be mandatory, but there is a baseline expectation that people will be invited and that they will come and have a chance to be in person with the administrator and be able to raise issues directly.

Monthly Policy Review Meeting – Staff have expressed a desire to continue to have access to policy review meetings. These ongoing meetings will be retained.

Department Specific Meetings and 1:1 with Department Managers – DOMs Administrator will continue to hold department specific meetings, but will institute monthly meetings, one-on-one, with department managers, with a goal of tracking what's going on in the specific departments, learning from the department managers directly if there are unresolved issues that she's not aware of which might need to be raised to a higher level,

Weekly Email Update – every Thursday, all staff receive an email summary of what's been happening in the Program in the past week, sharing information for their awareness, and scheduled events that are upcoming. Worked to ensure that every staff person in organization has a state email, so that every staff person has the opportunity to receive information via email directly, to improve communications.

Daily Clinical and Leadership Stand-up (morning huddle) will continue.

Staff Metrics – Evaluation of Staff Effectiveness

Additional Staffing Effectiveness Evaluation Tools include:

Federal VA Survey – Staffing report evaluates staff per resident day of care (VA Form 10-3567)

Lighthouse Anonymous Reporting Hotline – no Domiciliary Program reports in 2023

Healthcare Division Recruitment and Retention Strategic Plan – measures

Turn-over rate/data

Achievement Awards

Incentive Use

Staff Metrics – MDVA Response at end of 2023

New Deputy Commissioner – hired in May 2023

New permanent DOMs Program Administrator – hired in Fall 2023

Current evaluation of circumstance involving staff engagement and resident quality of care

With Program Leadership – complete a multi-year program strategic plan/road map to include the following components

Staffing Analysis – Program FTE and positions

QAPI and Therapeutic Interventions/Clinical Outcomes framework

Education Opportunities

Communication Strategy that involves staff and residents

Integration of feedback from Veteran Domiciliary Resident Quality of Care Working Group

MDVA's DEI Office – Weekly office hours at facility was initiated in Spring 2023

Employee Wellness Initiative – Monthly Champions effort and Leadership/DEI Lunch and Learn Series (Fall/Winter curriculum – Emotional Intelligence) – initiated in 2021; refresh with team Fall 2023

Safety Officer – an additional FTE for all Homes – Domiciliary Program hired in Spring 2023

Staff Metrics – MDVA Response Looking Ahead

Future Goals – 2024

MNIT/MDVA Technology Project – Employee Engagement Survey Tool

Environment Enhancements

Current state funding for new construction – pending federal VA grant (65%)

Initiate design process – 12/18/23

Goal to include staff/residents

Implementation of Electronic Communication Boards throughout facility

Appendix

1. Veterans Domiciliary Working Group Information and Recommendations
2. Additional working group member comments and feedback

Veteran Domiciliary Resident Quality of Care Working Group

Appendix 1 – Information and Recommendations

Introduction

The Veteran Domiciliary Resident Quality of Care Working Group was established by session law - Minnesota Session Law, 2023, Regular Session - Chapter 38, HF 1937, Art. 2, Sec. 8 https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/38/ and charged with specific duties to review information and make recommendations:

> *Subd. 2.* ***Duties****. The working group shall meet on a regular basis and the first meeting must be no later than 45 days after the effective date of this section. The working group shall review and analyze the acuity of domiciliary residents and the current care model, including admission, care plans, and day-to-day care, and the current staffing structure and ratios. The working group shall provide recommendations on:*
>
> *(1) staffing levels that are necessary to properly care for residents based on the residents' range of acuity;*
>
> *(2) a care delivery model that focuses on appropriate and adequate care for residents;*
>
> *(3) additional and ongoing training for domiciliary staff;*
>
> *(4) a sufficient management structure to ensure support and provide guidance to staff; and*
>
> *(5) outcomes to determine if staffing levels and care delivery are appropriate or if, based on the outcomes, adjustments are necessary.*
>
> *The working group shall provide information and recommendations to the legislature by January 15, 2024, that the legislature can use to make decisions and effectuate change to ensure that the standard of care and staffing levels are sufficient for different resident acuity levels in the domiciliary.*

The Working Group has reviewed the established Domiciliary Program (DOMs) staffing and care delivery models and found them to be consistent with or exceeding federal regulations, state rules and statutes relating to domiciliary care and boarding care homes' requirements.

Summary of Recommendations

Key
New Recommendation for Consideration
In Progress
Recurring or Completed Activity

1. Recommendations for development of a domiciliary board and care resident acuity assessment tools and process.	
	a. Support the development of a Veterans domiciliary resident acuity level (or a population-specific case mix) assessment.
2. Recommendation for improved financing for services models that enhance the highest level of resident care by seeking an increased VA reimbursement.	
	a. MDVA should continue to work with the VA and the National Association of State Veterans Homes on a rate structure change for the Domiciliary program.
3. Recommendations for staffing models that would further support the highest level of resident care within the current budget/reimbursement structure.	
	a. Continue MDVA's commitment to complete routine department analysis and FTE/staffing models in response to the census and resident care needs.
	b. Revisit MDVA domiciliary program admissions criteria and processes in comparison to other VA-supported domiciliary programs nationwide.
	c. Encourage residents to establish or maintain a Resident Council and offer a Family Council pursuant to Minn. Stat. sec. 144A.10.
	d. Continue to educate and support staff in accessing state employee reward/awards systems to encourage staff who are doing well and contributing to the DOMs success.
	e. Continue to leverage relationships with the VA to offer trainings and care consultation that are helpful.
4. Recommendations for providing support to employees in a healthcare setting.	
	a. Maintain a safe workplace where employees at all levels, especially frontline staff, can express concerns without retaliation. Acknowledge distrust in the workplace exists and pursue change that creates open safe dialogue to identify problems and resolve them.
	b. Refer employees to the state Employee Assistance Program (EAP) if they want help on their own.
	c. Consult with Management Analysis Division (MAD) in the MN Management and Budget Dept (MMB) to help employee teams and management work through problems and improve trust and communications.

5. Recommendations for innovative staffing models and utilization of resources during a facility emergency when needed.	
	a. Maintain the safety officer role in the facility to provide coaching, training and education regarding emergency response and utilization of local, enterprise and statewide resources.
	b. Contact local health care coalitions to help with emergency preparedness questions. Appendix Z within Nursing Home (NH) requirements have good guides on how to develop plans.
	c. Continue to participate in monthly LTC Provider Compendium Calls to hear guidance's and information from MDH (Health Regulation Division and Epidemiology Divisions).
6. Recommendations for ways to communicate clear guidance – day to day and during an emergency and to put in place strategies for support.	
	a. Continue daily stand-up meetings tracked with a written or electronic communication option. During those meetings, refer and reinforce emergency procedures that exist.
	b. Front line staff to resume roles in Quality Assurance Performance Improvement (QAPI) and bring day-to-day best practices to QAPI group. Establish performance improvement plans (PIP) to ensure staff and residents receive communications in their preferred or favored method.
	c. Provide electronic communication boards throughout campus
7. Recommendations for additional staffing considerations and opportunities for additional training.	
	a. Complete an analysis regarding education needs and offerings and provide recommendations based on regulatory requirements, mandatory education, and clinical best practice.
	b. Make additional mental health training, diagnosis and therapeutic response approaches available to staff.
	c. Evaluate the optimal staffing model for Behavioral Health Services within MDVA and the Domiciliary program that would lead behavioral health programming unique to Veterans healthcare.
	a. Develop a formal Central Office Director of Behavioral Health position for the MDVA who will continuously monitor, enhance, and promote uniformity of the Behavioral Health needs of Veterans who reside in the homes for all settings of care.
	b. Develop a Director of Domicile Behavioral Health who will continuously monitor, enhance, and promote uniformity of the Behavioral Health needs of Veterans who reside in the Domicile setting of care.
	d. Continue to develop a collaborative and employee engaging transformational culture, transformational leadership that empowers people and works collaboratively.

	e. Continue to sync resources between both locations of Minneapolis and Hastings to ensure that programming is available and supports the residents served in each location.
	f. Consult with Diversity, Equity, Inclusion and Belonging (DEIB) experts and train staff about the concepts including learning about implicit bias. Incorporate these concepts into the workplace.
	g. Explore opportunities to initiate or enhance partnerships with local healthcare organizations.
8. Other recommendations	
	a. Ask the Office of Ombudsman for Long-Term Care (OOLTC) to meet regularly and provide information about what they are seeing at both DOMs locations and offer resident-rights specific education to the staff of the Domiciliary program.
	b. Make sure DOMs leadership and OOLTC leadership are personally connected and meet regularly in addition to the above quality reporting meetings.
	c. Make sure frontline staff, including housekeepers, are part of QA efforts moving forward.
	d. Consider establishing an Office of the Inspector General (OIG) within the Minnesota Department of Veterans Affairs (MDVA).

Information

1. Recommendation for development of domiciliary board and care resident acuity assessment tools and process.

a. Support the development of a Veterans domiciliary resident acuity level (or a population-specific case mix) assessment.

Presently MDVA Domiciliary staff use standard tools that help to identify Resident needs prior to admission and during the stay in the facility. These acuity methodologies, tools and processes should be evaluated in detail and compared to the state-of-the-art methods presently used for Domiciliary and other care settings to determine the best future options for the Domiciliary Program.

The resident acuity assessment should be developed through review of current clinically established standard assessments from current senior living environments and the U.S. Dept. of Veterans Affairs (VA). It is recommended that a consultant be hired to research existing evidence- based tools and then develop a specific acuity tool for the MDVA Domiciliary Program. This could be applied to current and potential residents living in a Domiciliary setting within Minnesota.

Similar, though not strictly analogous, programs in assisted living, nursing homes, long term care settings and within the U.S. Dept. of Veterans Affairs (VA) mental health residential rehabilitation treatment programs (RTP) share some patient population characteristics and have established patient care needs for staffing purposes. The National Association of State Veterans Homes should be consulted and determine if another state has similar residents and philosophy of care.

There is an assisted living Uniform Assessment Tool found in Minnesota Rules, Part 4659.0150. 4659.0150 - MN Rules Part. This tool includes information about a resident's personal lifestyle preferences, activities of daily living, physical health status, emotional and mental health conditions, cognition, communication and sensory capabilities, pain, skin conditions, nutritional and hydration status and preferences, list of treatments, nursing needs, risk indicators, who has decision-making authority and the need for follow-up referrals. There are many more details within each topical area that are helpful. The recommended consultant would review and incorporate this option recognizing the need to customize it for Domiciliary residents who need to be independent in their activities of daily living.

The Domiciliary acuity process and tool would enhance existing processes and help determine the appropriateness of Veterans who are seeking admission. which may include being added to a wait list. The acuity process and tool would also be utilized for Veterans who are current residents of the Domiciliary program. As our Veterans age and have exacerbations of their illness, an acuity tool would assist the team in objectively measuring when the Veterans level of care has increased beyond what can and should be provided in the Domiciliary and other care options can then be identified.

2. Recommendation for improved financing for service models that enhance the highest level of resident care by seeking an increased VA reimbursement.

a. MDVA should continue to work with the VA and the National Association of State Veterans Homes on a rate structure change for the Domiciliary program to account for the required service delivery under federal regulations.

Our Veteran Residents continue to change over time, and so do their care needs. The healthcare services provided must adapt to these changes to optimally serve the Veterans in our Veteran Homes and Domiciliary Program. Veterans care needs are now recognized and associated with a much greater level of detail based on situational and/or specific conflict-related environmental and other related exposures. These conflict-related exposures are often associated with unique and different symptoms for Veterans and the healthcare systems' response needs to also continuously realign the care provided. The Domiciliary Program exemplifies these changes as an increasing number of Veterans who served in the Vietnam conflict reside in the Domiciliary. Their care needs differ significantly from other Residents served in the past. To support a Domiciliary Program that must be nimble and optimally realign with the needs of Veterans, funding methods must be aligned as well. As noted in the Work Group meetings, the MDVA Domiciliary Model of care has been and will be further aligned to provide the best care for our Veterans, yet the funding models for this care has not changed over time to facilitate the long-term viability of the program.

The current VA domiciliary program per diem only accounts for services such as basic dormitory-type living quarters and meals. The professional services provided by MDVA to Veterans in the program are in no way covered by the basic per diem and should be funded similar to that of the daily per diem for VA-funded Adult Day, which is equivalent to 65% of the Prevailing Rate (as determined by the VA for each individual State's Veterans Homes across the country).

3. Recommendations for staffing models that would further support the highest level of resident care within the current budget/reimbursement structure.

a. Continue MDVA's commitment to complete routine department analysis and FTE/staffing models in response to the census and resident care needs. This review would occur by the Domiciliary senior leaders in consultation with Health Care senior leaders and guide future staffing resources based on regulatory requirements, and the needs of the residents

b. Revisit MDVA domiciliary program admissions criteria and processes in comparison to other VA-supported domiciliary programs nationwide.

Leverage insights gained from the Acuity tool and process development into the decision regarding admissions, care during residency and discharge to the next level of care.

c. Encourage residents to establish or maintain a Resident Council and offer a Family Council pursuant to Minn. Stat. sec. 144A.10. Ask quality questions at these groups. As necessary, engage with the Office of Ombudsman for Long Term Care (OOLTC) to help establish one.

If Resident Councils have not been established, then continue to engage Residents via periodic Townhall meetings to share information about the program and facility.

d. Continue to inform and encourage staff to access state employee awards systems that reward staff who are doing well and contribute to the DOMs' success. The MDVA Healthcare Division Employee Wellness Initiative should continue with consultant support for education, resource sharing and providing additional recommendations for retention-related efforts. Celebrate staff at all levels.

e. Continue to leverage relationships with the VA to offer trainings and care consultation that are helpful.

4. Recommendations for providing support to employees in a healthcare setting.

a. Maintain a safe workplace where employees at all levels, especially frontline staff, can express concerns without retaliation. Acknowledge that distrust in the workplace exists and pursue change that creates open, safe dialogue to identify problems and resolve them.

b. Refer employees to the state Employee Assistance Program (EAP) if they want help on their own.

c. Consult with the Management Analysis Division (MAD) in the MN Management and Budget Department (MMB) to help employee teams and management work through problems and improve trust and communications.

DOMs management can consult in advance with MAD to discover best practices to approach challenges. MAD experts can be very helpful to management and employees in identifying ways to improve the workplace setting. Staff should feel comfortable enough to raise concerns including resident quality of care concerns.
www.mn.gov/mmb/mad/services/effectiveness

5. Recommendations for innovative staffing models and utilization of resources during a facility emergency and utilization when needed.

a. Maintain the safety officer role in the facility to provide coaching, training and education regarding emergency response and utilization of local, enterprise and statewide resources.

b. Contact local healthcare coalitions to help with emergency preparedness questions. Appendix Z within Nursing Home (NH) requirements include guides to develop plans. ASPR Tracie Healthcare Coalitions | ASPR TRACIE (hhs.gov) has NH resources that could translate to the DOMs setting.

c. Continue to participate in monthly LTC Provider Compendium Calls to hear guidance and information from MDH (Health Regulation Division and Epidemiology Divisions). Applies directly to NHs but would be applicable to the DOMs setting. Contact the state ICAR team for consultation and education during active COVID outbreaks as needed. Continue to report COVID infections in NHSN per the VA reporting requirements for Domiciliary settings.

6. Recommendations for ways to communicate clear guidance – day to day and during an emergency and to put in place strategies for support.

a. Continue daily stand-up meetings tracked with a written or electronic communication option. During those meetings, refer and reinforce emergency procedures that exist.

b. Front line staff to resume roles in Quality Assurance Performance Improvement (QAPI) and bring day-to-day best practices to QAPI group. Establish performance improvement plans (PIP) to ensure staff and residents receive communications in their preferred or favored method.

c. Provide electronic communication boards throughout campuses.

7. Recommendations for additional staffing considerations and opportunities for additional training.

a. Complete an analysis regarding education needs and offerings and provide recommendations based on regulatory requirements, mandatory education and clinical best practice.

b. Make additional mental health training, diagnosis and therapeutic response approaches available to staff.

c. Evaluate the optimal staffing model for Behavioral Health Services within MDVA and the Domiciliary program that would lead behavioral health programming unique to Veterans healthcare.

i. Develop a Healthcare Division Central Office Director of Behavioral Health position for the MDVA who will monitor, enhance and promote uniformity of the Behavioral Health needs of Veterans who reside in the homes for all settings of care.

ii. Develop a Director of Domiciliary Behavioral Health position who will monitor, enhance, and promote the establishment and continuity of care for the Behavioral Health needs of Veterans who reside in the Domiciliary setting of care.

d. Continue to develop a collaborative and employee engaged transformational culture, that is led by leaders who empower people and work collaboratively toward improvement.

e. Continue to sync resources between both DOMs locations of Minneapolis and Hastings to ensure that programming is available and supports the residents served in each location.

f. Consult with Diversity, Equity, Inclusion and Accessibility (DEIA) experts and train staff about the concepts including learning about implicit bias. Incorporate these concepts into the workplace.

g. Explore opportunities to initiate or enhance partnerships with local healthcare organizations.

8. Other recommendations

a. Ask the Office of Ombudsman for Long-Term Care (OOLTC) to meet regularly and provide information about what they are seeing at both DOMs locations and offer resident-rights specific education to the staff of the Domiciliary program.

b. Ensure DOMs leadership and OOLTC leadership are personally connected and meet regularly in addition to the above quality reporting meetings.

c. Ensure frontline staff, including housekeepers, are part of QA efforts moving forward.

d. Consider establishing an Office of the Inspector General (OIG) within the Minnesota Department of Veterans Affairs (MDVA).

Veterans are familiar with the Inspector General (IG) functions (I.e., inspections, audits, and investigations) from their service in the US Military. Establishing an OIG will lessen the burden on the OOLTC and allow for more thorough investigations. While both ombudsmen and IGs serve the purpose of accountability and addressing complaints, ombudsmen focus on internal conflict resolution and promoting fairness, whereas an OIG will primarily focus on and uncover waste, fraud, and abuse within MDVA. An alternate option would be to utilize the MDVA Compliance and Ethics roles and structure who could provide additional oversight and audits.

MDVA will review and update the agency/healthcare division Compliance and Ethics roles to provide oversight and consultation support as it relates to regulatory compliance and complex resident care issues.

Veteran Domiciliary Resident Quality of Care Working Group

Appendix 2 – Additional working group member comments and feedback

Participation by members of the working group included comments and observations which fall outside the scope of the summary of recommendations which make up the group-approved *Veteran Domiciliary Resident Quality of Care Working Group Final Report* and *Appendix 1 – Veteran Domiciliary Resident Quality of Care Working Group Information and Recommendations*.

Members expressed a desire that their additional remarks be shared with the Legislature, for their awareness and consideration.

I don't think it was ever established that the staffing was adequate to meet residents' needs. I recall we were told that an RN Senior, another nurse and a HST/NA were on duty every day. Information received from an employee indicated that Minneapolis has not had an RN Senior full time since July 2023.

1. I recall we were told that the DOMS cannot care for residents with a higher acuity. Information received from an employee revealed that the DOMS currently has residents with walkers, residents with a risk for falling, residents who require meal assistance. It is difficult to determine if staffing is adequate without an accurate picture of the current residents.

   I agree that developing an assessment tool would be helpful. I would suggest using the MDH Assisted Living Assessment Tool at least on a trial basis would be beneficial. There was a lot of input establishing this tool and it could be used now and revised later if needed. A procedure could be developed regarding how the form would be utilized. If front line staff are not consulted regarding the daily needs of the residents and their input is not recognized, any assessment tool would be inadequate.

   I never got the full picture of why the census is low at Minneapolis. Are individuals not expressing a desire to be admitted? Should more outreach be done to find potential residents. I understand the reasons why admissions would not be a good idea at Hastings considering the adequacy of the building.

2. I don't recall ever discussing the need for a rate structure change. I think it needs to be established what type of resident can be cared for in the DOMS first. If residents have

increased needs and potential admissions have more needs, it may be necessary to change the licensure to Assisted Living rather than Boarding Care.

3. I would recommend an analysis of the staffing etc. by an outside person/group. It appears that employees are very distrustful of senior leadership so a review by these individuals would not be accepted as accurate by employees.

   Establishing a resident council would be a good idea. I am sure the Ombudsman Office could provide help with developing a council.

4. Seeking assistance from MAD would be beneficial. They could meet with employees and managers to get a full picture of what is working and not working in the program.

5. No comments.

6. Determine how information from stand- up meetings is provided to staff that are not on duty or evening and night staff.

   I agree front line employees should be part of the QAPI group.

7. Based on comments from an employee, there is not a collaborative and employee engaged transformational culture. There is a lot of work to be done to make that happen.

   I don't know if adding Directors would be of benefit. In my opinion, managers who are onsite daily to determine if staff need additional training, if staffing is adequate etc. would be more beneficial.

8. Requesting ongoing assistance from the Office of Ombudsman would be beneficial to the residents and staff.

   Extending the term of the work group would be helpful. In my opinion, inclusion of some current employees would be of benefit. If this is not possible, I would suggest members of the work group meet with employees to try to determine their needs/wants and goals.

5. Recommendations for innovative staffing models and utilization of resources during a facility emergency when needed.	

Veteran Domiciliary Resident Quality of Care Working Group

Additional working group member comments and feedback

Yes, but should "have a plan in place"	b. Contact local health care coalitions to help with emergency preparedness questions. Appendix Z within Nursing Home (NH) requirements have good guides on how to develop plans.
6. Recommendations for ways to communicate clear guidance – day to day and during an emergency and to put in place strategies for support.	
Yes – huddles – may want to frame as part of QI or QAPI work	a. Continue daily stand-up meetings tracked with a written or electronic communication option. During those meetings, refer and reinforce emergency procedures that exist.
Yes – maybe frame as "engage front line staff in QAPI roles", not certain why "resume" was used.	b. Front line staff to resume roles in Quality Assurance Performance Improvement (QAPI) and bring day-to-day best practices to QAPI group. Establish performance improvement plans (PIP) to ensure staff and residents receive communications in their preferred or favored method.
Yes, need to assess if effective	c. Provide electronic communication boards throughout campus
7. Recommendations for additional staffing considerations and opportunities for additional training.	
Yes, but need to act on the analysis	a. Complete an analysis regarding education needs and offerings and provide recommendations based on regulatory requirements, mandatory education, and clinical best practice.
Support but would not "develop" until evaluation in "C" completed. Would change prose to "consider" or "explore" development of ……	a. Develop a formal Central Office Director of Behavioral Health position for the MDVA who will continuously monitor, enhance, and promote uniformity of the Behavioral Health needs of Veterans who reside in the homes for all settings of care.
Same as above	b. Develop a Director of Domicile Behavioral Health who will continuously monitor, enhance, and promote uniformity of the Behavioral Health needs of Veterans who reside in the Domicile setting of care.
Yes – strong support	d. Continue to develop a collaborative and employee engaging transformational culture, transformational leadership that empowers people and works collaboratively.

Veteran Domiciliary Resident Quality of Care Working Group

Additional working group member comments and feedback

Yes, give example?	g. Explore opportunities to initiate or enhance partnerships with local healthcare organizations.
8. Other recommendations	
Yes, connected to what?	b. Make sure DOMs leadership and OOLTC leadership are personally connected and meet regularly in addition to the above quality reporting meetings.
No, may need skills of different folks for the "next steps"	d. Extend the term of this Working Group - enhance opportunities for heightened communication and interaction at each meeting and encourage increased dialogue.
Neutral – don't know enough, doesn't make sense on the surface.	e. Consider establishing an Office of the Inspector General (OIG) within the Minnesota Department of Veterans Affairs (MDVA).

I want to qualify my response to the item regarding extending this work group *"Extend the term of this Working Group - enhance opportunities for heightened communication and interaction at each meeting and encourage increased dialogue."* The "no" response I provided does not indicate that this work should not continue, rather, this may not be the right mix of participants and setting for continued work. Based on the additional letters from staff and the Ombudsman, there is much work that needs to be done to repair relationships and improve psychological safety between employees and MDVA management. Bringing in a consultant or some other type of mediation should occur in order for Veteran Domiciliary residents receive the quality care deserved in an environment where employees are focused, engaged and generally content with their employer.

The Minnesota Department of Health (MDH) Workgroup members, Susan Winkelmann, Sarah Grebenc and Daphne Ponds, in their roles as state regulators of these settings, declined to endorse the statement that the workgroup established that DOMS' staffing and care delivery models exceeded federal and state laws, and did not answer whether the MDVA should continue to work with the VA and the National Association of State Veterans Homes on a rate structure change for the DOMs.

Veteran Domiciliary Resident Quality of Care Working Group

Additional working group member comments and feedback