DEPARTMENT OF ADMINISTRATION
STATE OF MINNESOTA

MANAGEMENT AUDIT

MINNESOTA VETERANS HOMES

DEPARTMENT OF VETERANS AFFAIRS

NOVEMBER, 1980

MANAGEMENT ANALYSIS DIVISION

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PREFACE

THIS MANAGEMENT STUDY OF THE MINNESOTA VETERANS HOMES WAS CONDUCTED AT THE REQUEST OF GOVERNOR ALBERT QUIE AND COMMISSIONER OF VETERANS AFFAIRS DONALD MILLER. THE STUDY EXAMINED THE MANAGEMENT OF THE HOMES AND THE CARE PROVIDED TO THE HOMES' RESIDENTS.

ALL RECOMMENDATIONS THAT EMERGED AS A RESULT OF THE ANALYSIS ARE DIRECTED TOWARD THE OVERALL OBJECTIVE OF IMPROVING THE QUALITY OF CARE PROVIDED RESIDENTS SERVED BY THE HOMES.

ACKNOWLEDGEMENTS

THROUGHOUT THE CONDUCT OF THIS STUDY A NUMBER OF PERSONS AND ORGANIZATIONS ASSISTED THE STUDY TEAM IN GATHERING AND ANALYZING INFORMATION AND IN HELPING THEM TO UNDERSTAND THE WORKINGS OF THE HOMES. IN PARTICULAR, WE ARE GRATEFUL FOR THE ASSISTANCE OF THE MINNESOTA HEALTH DEPARTMENT'S QUALITY ASSURANCE AND REVIEW SECTION WHICH INTERVIEWED ALL MINNEAPOLIS HOME RESIDENTS AND REVIEWED ALL MEDICAL RECORDS TO ASCERTAIN THE QUALITY OF CARE PROVIDED. WE ARE ALSO GRATEFUL FOR THE ASSISTANCE OF BOCK ASSOCIATES IN DESIGNING A RESIDENT INTERVIEW QUESTIONNAIRE, ABACUS IN PROCESSING AND ANALYZING RESIDENT DATA, AND RESIDENTIAL PROGRAM CONSULTANTS IN HELPING US TO UNDERSTAND RESIDENTIAL AND CLINICAL CARE PROGRAMS.

WE ALSO WISH TO THANK STAFF AT THE DEPARTMENTS OF FINANCE AND EMPLOYEE RELATIONS, THE MINNESOTA BOARD ON AGING, THE OFFICE OF HEALTH STATISTICS AND THE SURVEY AND COMPLIANCE SECTION OF THE MINNESOTA DEPARTMENT OF HEALTH, THE LEGISLATIVE AUDITOR, AND THE UNITED STATES VETERANS ADMINISTRATION. WE WISH TO THANK REPRESENTATIVES OF THE VETERANS ORGANIZATIONS WITH WHOM WE MET.

THE ASSISTANCE AND COOPERATION RECEIVED FROM THE STAFF AND RESIDENTS OF THE MINNESOTA VETERANS HOMES WERE OF PARTICULAR BENEFIT.

INTRODUCTION

On March 17, 1980 Governor Quie and Commissioner of Veterans Affairs Donald Miller requested the Department of Administration's Management Analysis Division to conduct a special management audit of the Minnesota Veterans Homes in Minneapolis and Hastings. The audit was requested in response to criticisms of operations at the Minneapolis Home by the Legislative Auditor, the abrupt resignation of William Gregg as the Home's Administrator, and complaints of Mr. Miller's role as Commissioner by staff and residents.

The management audit was conducted from April to October, 1980. The Study Team analyzed the financial, personnel, and general management of the Homes, administrative structure, written policies and procedures, staffing needed to operate, operating costs, fees charged residents for care, relationships between the Commissioner's Office and the Homes, and the quality and adequacy of residential and nursing care.

The report, which includes both findings and recommendations, is divided into six chapters. Financial management, including a review of operating costs and current resident maintenance charges, is discussed in Chapter I. Chapter II is an assessment of administrative services and functions. Chapter III discusses personnel management and the staffing needed to operate the Homes. Chapter IV contains findings and recommendations on residential living, clinical, and program services offered residents. Future development and expansion of the Homes is discussed in Chapter V. In the final chapter the Study Team draws a series of conclusions regarding the Homes. The study's methodology is outlined in the report's introduction.

A summary of recommendations can be found on page 6.

Philosophy

The underlying philosophy guiding the study and generation of this report is based on the belief that the Minnesota Veterans Homes should provide community-based health care services. Unlike institutional care, community-based care actively seeks to be involved with, instead of isolated from, surrounding community activity. This care model implies:

- Plans for the future role of the Homes be developed with the understanding that the plans are part of a larger health care system.
- Rehabilitation services be secured whenever possible from providers outside the Homes.
- Residents are encouraged to be involved in activities outside the Homes.
- An active volunteer program be maintained.

Current Population and Licensed Capacity of the Homes

In April, 1980 the Minnesota Veterans Home, Minneapolis had 433 residents. Ninety-one were receiving nursing care and 342 were receiving domiciliary care. The Minneapolis Home is licensed to have 181 nursing and 398 board and care (domiciliary) beds.[1] With the completion of a new nursing facility in late 1980, the licensed bed capacity will be 250 nursing and 290 domiciliary beds. At present, only 90 of the nursing beds are set up and staffed. The other 91 nursing beds have been converted to domiciliary care. The occupancy rate of domiciliary beds set up and staffed (489 beds) for the first six months of 1980 was 70%.

In April, 1980 the Minnesota Veterans Home, Hastings had 141 residents, all of whom were receiving domiciliary care. The Home's licensed capacity was 200 board and care beds. The Home's occupancy rate for the first six months of 1980 was 67%.

History of the Homes

The Minnesota Veterans Home, Minneapolis was established by the 1887 Legislature as a home for honorably discharged veterans, their spouses, and mothers, who for medical, social or economic reasons, needed assistance in living. The Home operated under a Board of Trustees appointed by the Governor, confirmed by the Senate and representing each of the state's congressional districts.

In essence, the Home operated as a semi-state agency. The chief administrator was a Commandant who was appointed by the Board and served at its pleasure. All staff were appointed and their salaries set by the Commandant with the Board's approval. The primary goal of the Home was custodial care, that is, the provision of room and board. Medical care was limited and other rehabilitative programs were not provided. The Home operated on a military model. There were weekly white-glove inspections of residents' rooms by the Commandant and military rules of conduct applied to residents and staff. Neither the Board, who exercised considerable control over admissions to the Home and daily operations, or the Commandants were trained in administration or health care. Trustees and Commandants were appointed primarily on the basis of their military service and service with the state's veterans' organizations.

Beginning in 1972, a number of changes occurred at the Home. In 1972, the position of Commandant was abolished and a person trained in health care administration was appointed as Administrator of the Home. In 1973, the Home began to provide licensed nursing home care for approximately 95 residents. In 1975, the Board of Trustees was abolished and authority for operation of the Home was transferred to the Commissioner of Veterans Affairs. In 1978, the Minnesota Veterans

[1]The U.S. Veterans Administration requires that domiciliary beds be licensed by state and/or local licensing authorities. In Minnesota, "domiciliary" beds are licensed at a "board and care" level by the Minnesota Department of Health.

Home, Hastings was opened to provide domiciliary care to 150 to 200 residents. The Hastings Home was operated as an extension of the Minnesota Veterans Home in Minneapolis until 1979, at which time it was established as a separate institution under the Commissioner of Veterans Affairs. In 1980, a new 250-bed nursing care facility was completed at the Minneapolis Home.

In summary, since 1972, the Homes have changed from a military to a health care model, have increased medical and related rehabilitative services, and have come directly under the review and operating authorities and responsibilities of the Departments of Veterans Affairs, Administration, Finance and Employee Relations.

Over the past 13 years, the Homes have been the subject of a number of critical reports. The most comprehensive report was that authorized by the Legislative Building Commission and conducted by the EBS Management Consultants in July, 1968. Other reports include a study of the Minneapolis Home by the Minneapolis Health Department in August and September, 1968, audits of the Home by the Public Examiner and Legislative Audit Commission in 1973, 1977, and 1980, and annual inspection reports of the Homes by the Minnesota Department of Health and the U.S. Veterans Administration.

The Study Team has reviewed these reports and concluded that, despite the changes noted above, most of the administrative and programmatic problems identified in earlier studies continue. While it is not our intent to summarize the finding of these reports here, we do discuss specific findings in the body of this report.

METHODOLOGY

At the beginning of this project, the Study Team defined five major areas of effort in order to collect adequate information about the operations of the Homes. While each of these areas was independent and self-contained, much of the work was conducted simultaneously.

Staff Interviews

It was determined the best method for collecting basic background information regarding the operation of the Homes was to interview supervisory staff. An interview guide was used to insure the collection of data was done uniformly. In all, 24 supervisory and administrative staff persons were interviewed. A copy of the Interview Guide is found as Appendix B to this report.

Resident Interviews and Resident Related Information

While it was important to interview staff, the team also felt a strong obligation to interview residents of the Homes. A resident interview form was designed. Its purpose was twofold: to develop an accurate data base describing resident characteristics, and to solicit comments regarding the quality and adequacy of care. A draft

instrument was piloted at Hastings, results were reviewed, and modifications made in the questionnaire.

In order to select an unbiased sample of interviewees, a random sample of 33% of the population was drawn. Interviewers contacted resident supervisors in each building and requested their assistance in locating residents. A sample of 203 names was drawn. In all, 157 interviews were completed. Forty-six interviews were not completed. In most cases, this was due to resident discharges and vacations. A copy of the survey form is found as Appendix C to this report.

In addition to collecting information through the interview process, much resident related data was drawn from existing files. These records included data regarding:

- Admissions and discharges.
- Income and monthly maintenance charges.
- Deaths.

Financial Audits

To gather additional financial information, the Management Analysis Division Internal Auditor (a member of the Study Team) conducted financial audits of three contractual services offered to residents of the Homes: dental, optical, and podiatry.

The information base was extracted from reviewing several thousand dental invoices and several hundred optical and podiatry invoices, spanning a six-year period from July 1, 1973, to June 30, 1979. Invoices were examined with two purposes:

- To measure the degree of compliance with fee schedules established in the contracts.
- To determine whether duplication of payment had occurred.

All data (invoices) were audited using three commonly accepted criteria:

- Amount of payment.
- Recipient of payment.
- Time period (fiscal year).

The Study Team also analyzed the Homes' financial and budgetary records in order to determine operating costs.

Policies, Procedures and Operations

The Study Team reviewed all existing policies and procedures and spent many hours observing staff and operations at both Homes.

Minnesota Health Department Quality Assurance and Review Survey

Through an interagency agreement, the Minnesota Department of Health agreed to assist the Study Team by conducting a Quality Assurance and Review Survey. The review was conducted utilizing the same methodology used in the annual review of 30,000 Minnesota Title XIX (Medicaid) recipients in 650 long term care facilities. The review team members were registered nurses and social workers. The review consisted of an examination of a resident's medical record to determine care needs and the provision of services, a resident interview and verification of care needs with knowledgeable staff persons. A total of 421 residents at Minneapolis were reviewed. A copy of the QA & R instrument can be found as Appendix D to this report.

Other Resources

Besides the five major areas of effort mentioned, the Study Team contacted Federal VA officials, administrators of other veterans homes, and outside health care experts in order to gain additional information and perspective.

SUMMARY OF RECOMMENDATIONS

This summary provides a brief overview of recommendations, organized by subject area, for the reader's convenience. Detailed rationale for the recommendations is presented in Chapters I-V.

Chapter I — Financial Management

Recommendation One: The Study Team endorses the findings and recommendations of the Legislative Auditor in his report of March 21, 1980 on the Minneapolis Veterans Home. The Department's Administrative Management Director should draft a detailed plan and timetable to correct all LAC-cited deficiencies by January 1, 1982.

Recommendation Two: The Administrative Management Director should develop position descriptions defining the authorities and responsibilities of each staff member under his supervision, develop written policies and procedures, and train staff accordingly.

- Inefficiency and ineffectiveness of current Minneapolis accounting and business office staff stem from failure to define authorities and responsibilities of each staff member and to adequately train them.

Recommendation Three: Responsibility for budgeting and fiscal management of the department should be decentralized.

- Responsibility for budgeting and fiscal management is concentrated in the department's top management.
- Supervisors do not prepare their unit's biennial budgets and annual spending plans.
- Supervisors are unaware of the size and detail of their unit's budget.

Recommendation Four: The Minnesota Veterans Homes must develop and implement a reporting system which accurately identifies revenues and costs and which is useful for decision-making by both top management and line managers.

- The department's program budget structure does not correspond to the current organizational structure so current Statewide Accounting reports are not useful to the Homes' line managers for decision-making.

- Quarterly Federal Aid Reports sent to the Veterans Administration provide no detail to top management or line managers on costs and revenues.

- Allocation of costs between the nursing and domiciliary programs are not made on the basis of actual expenses but on "best guesses" of various Home staff.

Recommendation Five: The Department of Veterans Affairs should attempt to recover overpayments made by the Minneapolis Home to its contract dentist, podiatrist, and opthalmologist. The Homes must develop and implement immediately a system to monitor all payments on service contracts to prevent duplicate and overpayments and to insure the quality of service provided.

- Examination of dental invoices disclosed 594 overpayments and two duplicate invoices for a total of $7,242.

- Examination of opthalomology invoices disclosed overpayments of $6,571.

- The Minneapolis Home does not monitor the time or services of its medical contractors.

Recommendation Six: The Minnesota Veterans Homes must reduce per diem costs of domiciliary care at Hastings and nursing care at Minneapolis so that costs are no higher than those in the community for similar levels of care.

- Per diem costs for domiciliary care during the first three quarters of FY 1980 were $29.44 at Hastings and $15.34 at Minneapolis. Per diem costs for nursing care were $37.39.

- Per diem nursing care costs at the Minneapolis Home are higher than the statewide average for non-profit nursing care facilities.

- Per diem domiciliary costs at Hastings are significantly higher than the statewide average for similar levels of care at both profit and non-profit community facilities.

- Per diem costs for domiciliary care at Hastings and nursing care at Minneapolis are rising faster than the statewide averages for similar levels of care at both profit and non-profit facilities.

- Per diem domiciliary care costs at Minneapolis have been lower than the statewide averages for similar levels of care at profit and non-profit facilities.

Recommendation Seven: The Minnesota Veterans Homes must reduce State costs at Hastings to a level equivalent to that at Minneapolis.

- Residents paid only 19.6% of the cost of operating the Hastings Home in FY 1980, the V.A. paid 17.8% and the State paid 62.6%.

- Minneapolis domiciliary residents paid 53.4% of the cost of their care, the V.A. paid 34.5%, and the State paid 12.1%.

- Minneapolis nursing care residents paid 45.4% of the cost of their care, the V.A. paid 29.6%, and the State paid 25.2%.

- The State's share of operating costs at the Hastings Home can be expected to decline somewhat as the Home reaches full capacity.

Recommendation Eight: The Minnesota Veterans Homes should seek Medicare/Medicaid certification of portions of the Homes so that Medicare/Medicaid payments can be used to reimburse the cost of care for peace-time veterans and non-veteran residents. As an alternative, the Homes should consider placing non-veterans and peace-time veterans in certified community facilities.

- Twenty of the Homes' residents are non-veterans. The State picks up 100% of all costs that the non-veteran is unable to pay.

- Annual cost to the State of providing nursing care to a non-veteran at the Homes is $10,330, three times the cost to the State of providing such care to a veteran.

- Annual cost to the State of providing domiciliary care to a non-veteran at the Minneapolis Home is $3,350, five times the cost to the State of providing such care to a veteran.

- Most peace-time veterans aren't eligible for V.A. benefits so the State also picks up 100% of all costs that the veteran is unable to pay.

- State costs for the care of peace-time veterans and non-veterans would be reduced at least 56% if these residents were covered by Medicare or Medicaid.

Recommendation Nine: The Minnesota Veterans Homes must develop comprehensive written policies, guidelines, and procedures for determining individual maintenance charges and exceptions from the established rate schedule. Written notifications of changes in maintenance charges should be sent to residents in advance, and a formal mechanism by which residents can appeal decisions on maintenance charges should be established.

- The Homes do not have any comprehensive written policies and procedures for determining maintenance charges and exceptions.

- Residents are not sent bills or written notification of changes to their maintenance charges.

Recommendation Ten: The Minnesota Veterans Homes should revise the current rate schedule so that personal income exemptions are increased, no resident is charged more than the cost of his or her care, and financial incentives are given to younger residents to return to the community.

- Seventy four residents pay more than the the cost of their care.

- The current maintenance rate schedule takes a disportionate share of all income cost-of-living increases residents receive, thereby effectively reducing the amount of spending money available to residents. The personal income exemption hasn't been increased since 1970.

- The current maintenance rate schedule discourages residents capable of returning to the community from building up the necessary financial resources to start out again.

Chapter II Administrative Management

Recommendation One: All managerial staff must be trained in how to plan and schedule work and how to use these tools to manage staff and accomplish goals. The Veterans Homes must adopt a mission statement and develop long and short range plans for the Homes and each of the work units.

- Top management has not developed comprehensive long-range plans for the Homes.
- Top management and line managers do not prepare annual or monthly work plans.

Recommendation Two: Decision-making at the Minneapolis Home should be decentralized. Greater coordination of decision-making is needed at Hastings.

- No effective authority is given to line managers on fiscal, budgetary, personnel and program matters.
- Top management is heavily involved in day-to-day operations, often overturning line managers' decisions.
- Little effort has been made to train managers.
- Hastings suffers from a lack of coordination among departments.

Recommendation Three: Decision-making between the Homes must be improved, communications increased, and program and support services better coordinated.

- Currently, there exists a serious lack of coordination and staff interaction between the two Homes.
- Joint discussions regarding budget, staff allocation and program planning do not occur.

Recommendation Four: The administrative organization which delineates responsibility and authority for operation decisions should be clarified.

- Department structure is now unconnected to program delivery.
- Unclear relationships exist between departmental managers, administrator, assistant administrator and the assistant to the administrator at the Minneapolis Home.
- Responsibility for the Minneapolis Home has been assigned to two people. Department managers are confused about delineation of their responsibility and authority.
- An unclear relationship between the roles of the two Homes exists.
- There are unclear relationships between the Commissioner and the Homes.

Recommendation Five: A comprehensive institution-wide staff development training program should be initiated.

- The Minnesota Department of Health has repeatedly cited the Minneapolis Home for poor staff training.
- In-service training should be more readily available for supervisory and management staff.

Recommendation Six: Top priority must be given to developing written policies and procedures for all of the Homes' operations. The policies and procedures must be compiled into a manual for use by all staff.

- The current Minneapolis policy and procedure manual is a conglomeration of general policy statements, intra-Home memos, handwritten notes and xeroxed portions of manuals from other nursing homes.

- Hastings has no policies and procedures manual currently.

- The current Minneapolis manual is not sufficiently detailed to act as a guide to employees and does not pinpoint staff responsibilities.

Chapter III Personnel Management and Staffing

Recommendation One: The Minnesota Veterans Homes must, as required by the Department of Employee Relations, develop valid position descriptions for all employees, implement an employee performance review system, and insure that all personnel are working in the job class to which they have been appointed.

- Supervisors reported in April that only 32 of their 183 employees had current valid position descriptions.
- Fewer than 5% of all employees of the Homes had received formal employee performance reviews.
- Some staff are working in the wrong classification.

Recommendation Two: The Department of Veterans Affairs should develop a personnel policy and procedures manual, train supervisors as to their responsibilities, and improve communication on personnel matters among all levels of staff. An additional Personnel Aide is needed.

- Authorities and responsibilities of the Personnel Officer, top management, and line supervisors are confused in the areas of recruitment, reclassification, promotions, performance appraisals, and discipline of staff.

Recommendation Three: The Homes should develop and implement a personnel management and staffing plan.

- The Homes currently lack a personnel management and staffing plan.
- For several months the Homes did not meet the Health Department program standard of 2.0 hours of nursing care per patient per 24 hour day.
- In another instance, the Commissioner ordered the number of patients in the nursing care unit to be reduced as a solution for meeting the 2.0 hour standard.

- The Minneapolis Home has experienced particular difficulty recruiting nursing staff.

- Volunteers are not used effectively in the Homes. They are used primarily to conduct evening and weekend activities--that is, to conduct bingo games, to put on short programs and the like.

Recommendation Four: The Minnesota Veterans Homes must clarify delegations of authority to staff and improve formal lines of communication.

- Staff generally are unsure of their authorities and responsibilities.

- In some cases, delegations are overlapping.

- Delegations are ill-defined.

- Delegations tend to be inconsistent with results expected.

- Formal channels of communications are used infrequently.

- Communication in the Homes between staff in different work units is particularly weak.

Recommendation Five: The Minnesota Veterans Homes should develop and implement plans for resolving staff dissatisfaction and improving staff morale.

- Staff morale at the Homes is low.

- Minneapolis staff, in response to a Department of Employee Relations survey, are dissatisfied with compensation, staffing, meetings, employee performance appraisals, training opportunities, job challenge and creativity, communications and conflict management.

- Hastings staff, in response to the same survey, are dissatisfied with meetings, compensation, staffing, and job advancement.

- Staff were found to be unsure about the mission of the Homes--whether the Homes are to serve younger veterans or older; whether the Homes are nursing homes, retirement homes, half-way houses for the mentally ill or chemically dependent, or simply residences for veterans; whether the Homes are to provide treatment or just room and board; and whether the Homes are to serve all veterans or only the indigent.

Recommendation Six: The Homes' authorized complement is sufficient to operate 150 nursing and 490 domiciliary care beds. The current assignment of staff and staff positions within the Homes, however, must be adjusted to meet program requirements and licensing standards. Forty-five additional positions are needed to operate 250 nursing and 490 domiciliary care beds.

- The Minnesota Veterans Homes currently have an authorized complement of 247.5 staff: 58 at Hastings and 189.5 at Minneapolis.

- As of October 16, 1980, there were 53 vacancies at Minneapolis and 6 at Hastings.

- The department's current assignment of staff positions reflects its plan to provide only minimal services to 490 domiciliary residents and the provision of intermediate nursing services (ICF-I) to 250 nursing residents.

- If the Homes are to meet V.A. domiciliary guidelines and Minnesota Health Department nursing standards, however, the present authorized complement is only sufficient to staff 150 nursing and 490 domiciliary beds.

- To meet standards for 250 nursing and 490 domiciliary beds, an additional 45 positions are needed.

- The Homes currently have approximately 500 domiciliary and 120 identified nursing care residents.

Chapter IV Program Management

Recommendation One: In addition to providing residential living services, the Homes should provide full-time structured clinical and program services for all residents.

- Currently no standardized assessments are conducted to determine the individualized service needs of residents.
- Services for individual residents are not coordinated. Inter-disciplinary program teams do not exist.
- Basic skills training to reduce dependency is not offered residents.

Recommendation Two: Admission and discharge procedures and policies must be developed and implemented immediately.

- Interviews with staff reveal considerable confusion regarding admission criteria and reasons for discharge.
- Decisions on admissions are made on a unilateral basis, often without adequate medical and social data.
- Comprehensive written admission and discharge procedures and policies do not exist.
- No procedure exists for maintaining a waiting list that is regularly received and used to fill vacancies.
- Decisions on discharges occur non-systematically, and residents do not have the formal right to appeal decisions.
- There are no written definitions of service characteristics for the three units (Minneapolis Nursing Home, Minneapolis Domiciliary, Hastings Domiciliary) that permit cogent admissions, discharge and transfer decisions.

Recommendation Three: The role of patient care meetings in overall program planning at the Homes should be redefined. Patient care meetings should be attended by all managerial staff responsible for resident care. The primary purposes of the meetings should be to adopt individual resident care plans prepared by the interdisciplinary teams, to systematically review changes, problems, and exceptions in the plans, and to review progress of residents before discharge. The meetings must be conducted according to procedures used in most community health care facilities.

- Decisions regarding resident programs and care are often made without substantiating data. There is no systematic procedure for reviewing resident progress or problems.

Recommendation Four: The Minnesota Veterans Homes should conduct a formal annual review of each resident's program plan and conduct at least quarterly formal planning sessions for possible revisions.

- V.A. regulations require that an annual assessment of needs and skills be made of each resident. No such assessments are conducted.

Recommendation Five: The Minnesota Veterans Homes should adopt the American Medical Records Association standards for record-keeping.

- Present health care information recording is outdated and lacks uniformity.
- Standards relating to storage and retrieval of records have not been established.

Recommendation Six: The Minnesota Veterans Homes should contract with physicians who have an expertise in psychiatry and geriatric care to evaluate existing diagnoses and change them as necessary to reflect current accepted practice.

- The Minnesota Health Department identified numerous disparities in diagnoses and subsequent treatment at Minneapolis.

- The current physician, for example, has diagnosed 87% of the residents at Minneapolis as having some mental disorder. Only 1.3% of the residents receive psychotherapeutic medications and only .01% receive any type of therapeutic service, according to the Home's records.

- Until July 1980, the Minneapolis Home shared its physician with Hastings.

Recommendation Seven: Following the review of existing diagnoses, the Homes should fully and accurately assess the medical needs of all residents. The assessment should utilize resources at the Veterans Administration Medical Centers, Hennepin County Medical Center, and other medical specialists as needed.

- Thirty-two percent (32%) of Minneapolis residents are currently in need of a medical assessment, according to the Minnesota Department of Health.

Recommendation Eight: In addition to conducting a complete medical assessment, assessments must be conducted for occupational therapy, physical therapy, corrective therapy, social services, and personal interests.

- The Minnesota Health Department, in its review of resident records in Minneapolis, found that social histories were not present for the majority of residents, activity and/or interest assessments had not been done, and goals could not be identified or resident progress ascertained in the medical records.

- Overall, the Minnesota Health Department found "a lack of assessments in all areas and a need for individualized plans of care based on individual needs. It appears that no one is coordinating the services that are being provided."

Recommendation Nine: The Minnesota Veterans Homes must develop a drug management and monitoring program.

- The Minnesota Health Department found that no staff were monitoring and periodically reviewing medications for self-medicating residents. Two-thirds of the residents taking drugs are self-medicators.

Recommendation Ten: The Homes should contract with a dermatologist to provide and maintain a skin care program which includes an educational program to make all residents aware of basic dermatological hygiene.

- The Minnesota Health Department identified 55% of the nursing care residents as requiring some type of special skin care.

Recommendation Eleven: Prior to developing their own rehabilitative and restorative programs, the Homes must explore the use of programs that already exist in the community to serve the identified needs of residents.

- The Homes do not actively use the resources of the Hennepin and Dakota County Mental Health Centers, the Veterans Resource Center, the University of Minnesota, and the Veterans Administration Medical Centers and outpatient clinics.

- Use of existing community programs would improve the care of residents by involving them in activities outside the institution and would reduce the need for specialized clinical and program staff at the Homes.

Recommendation Twelve: The Minnesota Veterans Homes should operate their resident work programs in accordance with both federal and state minimum wage laws. The programs should be designed to meet the needs of a broad range of residents, and should be funded on a permanent basis.

- The current resident work program pays $1.10 per hour in violation of both federal and state minimum wage laws.

Recommendation Thirteen: The Minnesota Veterans Homes must adhere strictly to the state patient bill of rights (Minn. Statutes 144.651) and Veterans Administration regulations concerning resident councils.

- Veterans Administration domiciliary care regulations require the establishment of an elected resident council.
- Veterans Administration nursing care regulations require that residents be permitted to voice grievances and recommend changes in policies and services with impunity.
- State law requires all nursing and board and care homes to adhere to the State's patient bill of rights.
- Residents at Minneapolis indicated that they felt the Minneapolic council was dominated by staff and that the management of the Home and department has refused to respond meaningfully to concerns voiced by the council.

Chapter V Future Development

Recommendation One: The Minnesota Veterans Homes should continue to serve all age groups and to provide both nursing and domiciliary care. In fiscal year 1981 the Homes' licensed capacity should be 150 nursing and 490 board and care beds. In fiscal year 1982 or fiscal year 1983, depending upon the establishment of need and the availability of state funds, the Homes' capacity should be increased to 250 nursing and 490 board and care beds.

Recommendation Two: The Department of Veterans Affairs should develop by January 1, 1983 a detailed long-range plan for meeting the health care needs of the state's veterans through the year 2000. Until the plan has been approved by the Governor and Legislature, the Homes' capacity should remain at 250 nursing and 490 board and care beds. In the plan the department should seriously investigate such alternatives as subsidizing veteran care in private community facilities rather than adding beds at the current Homes or opening new state facilities.

- The Minnesota Veterans Homes have serious administrative problems and do not meet Minnesota Health Department standards and Veterans Administration guidelines for nursing and domiciliary care. Current problems must be resolved before the Homes expand.

- Expansion of the Homes beyond the 250 nursing care bed/490 domiciliary care bed level should be approved only on the basis of a detailed assessment of the needs of all Minnesota veterans.

- According to updated 1970 census data and Minnesota Health Department statistics, the greatest need for additional nursing and board and care beds in Minnesota is for women aged 75 and over and not for veterans. The need for beds by veterans will not increase significantly until the late 1980's or early 1990's and will decline after the year 2000.

- On the basis of cost and program needs, the department should consider community alternatives for serving the needs of Minnesota veterans.

Recommendation Three: Until the department submits its detailed, long-range plan for meeting the health care needs of the state's veterans through the year 2000, no further state funds should be allocated for capital improvements.

- Since 1969, $13,272,834 has been expended, committed, or projected for capital improvements to the Minnesota Veterans Homes. The state has appropriated 40.5%, or $5,377,712 of this amount.

- The last master plan for capital improvements was developed in 1970 by the former Veterans Home Board. No other long-range capital improvement plans exist.

CHAPTER I

FINANICAL MANAGEMENT

CHAPTER I FOCUSES ON FINANICAL MANAGEMENT. IT INCLUDES A REVIEW OF THE HOMES' ACCOUNTING AND CASHIER OPERATIONS, SELECTED AUDITS OF CONTRACTUAL SERVICES, AND AN ASSESSMENT OF BUDGETING AND FINANICAL REPORTING. THE CHAPTER ALSO INCLUDES AN ANALYSIS OF CURRENT OPERATING COSTS AND CURRENT RESIDENT MAINTENANCE CHARGES.

THE RECOMMENDATIONS CONTAINED IN THIS CHAPTER ARE BASED ON THE ASSUMPTION THAT AS PUBLIC BODIES, THE MINNESOTA VETERANS HOMES HAVE AN OBLIGATION TO ASSURE THE PROPER AND EFFICIENT MANAGEMENT OF THEIR MONIES.

DATA FOR THIS CHAPTER CAME FROM INTERVIEWS WITH DEPARTMENT AND HOME STAFF AND FROM AN ANALYSIS OF THE FINANCIAL AND RESIDENT RECORDS OF THE HOMES.

FISCAL MANAGEMENT

Recommendation One: The Study Team endorses the findings and recommendations of the Legislative Auditor in his report of March 21, 1980 on the Minneapolis Veterans Home. The department's Administrative Management Director should draft a detailed plan and timetable to correct all LAC-cited deficiencies by January 1, 1982.

The Legislative Auditor in his report of March 21, 1980 issued 83 findings and recommendations on financial management at the Minneapolis Veterans Home. The Study Team reviewed the LAC findings and recommendations and conducted its own review of financial management of the Home during the spring and summer, 1980. The Legislative Auditor and the Study Team found the following:

- Failure to monitor and control payments for contractual medical services, resulting in over-payments to contractors.
- Failure to properly account for pharmaceuticals.
- Lack of written policies and procedures covering financial transactions at the Homes.
- Inadequate controls to safeguard cash and other receipts of the state and residents, including lack of security and the preparation of receipts and deposits by the same person.
- Poor administration of residents' personal accounts, including failure to regularly reconcile resident depository accounts to the control ledger. (The Home provides banking services for residents, including the maintenance of depository accounts for the residents.)
- Poor administration of deceased members' funds.
- Unauditable resident maintenance charges due to inadequate documentation of how maintenance charges are determined.
- Inadequate controls over accounts receivable, including reconciling accounts receivable and collections to the maintenance control total.
- Unauditable payrolls due to inconsistencies and

inaccuracies in time sheets, inconsistent use of leave requests, lack of current time and leave records, and unapproved overtime.

- Violations of state procurement laws and regulations.
- Inadequate fixed asset inventory procedures and internal control systems to safeguard the property of Minnesota Veterans Homes from loss, theft, or misuse.
- Inadequate controls and accountability to safeguard consumable plumbing, electrical, and gasoline inventories.
- Poor control over canteen and related funds.
- Lack of records showing disposition of general purpose and designated contributions to the Homes.
- Misuse of the imprest funds for emergency travel and personal needs of indigent residents and cash for social activities for residents.
- The provision of free or below cost meals to staff.

The Minneapolis Veterans Home has been consistently cited between fiscal year 1969 and fiscal year 1980 by the Public Examiner and Legislative Auditor for serious violations of statewide accounting, procurement, inventory, and payroll policies and procedures. In the March 21, 1980 report, the Legislative AUditor also reviewed the disposition of prior audit recommendations. Thirty-eight of the 49 recommendations made during the previous audit for years ending June 30, 1973, 1974, and 1975, were not implemented or only partially implemented.

A key defense of the Home and the department has been lack of staff to correct the problems and to operate properly. We disagree. After reviewing the number of administrative and support staff in comparable institutions and state agencies, and analyzing the workload of the Home, we conclude the Home and department have had ample staff to operate the Home's fiscal and other administrative activities. From interviews with various staff, it is clear the problem has been either the lack of commitment by or ineffectiveness of top management in the department and at the Home to correct the problems and adopt the Legislative Auditor's recommendations.

Initially the Study Team was particularly concerned about the lack of controls over contracts, payroll, cash, and accounts payable and receivable. Bills for medical contracts had often been paid without verification of services provided and in amounts above those established in

contracts. The person responsible for hiring staff and completing and maintaining all personnel records was also responsible for approving the bi-weekly payroll and distributing the payroll checks. The Cashier's Office was responsible for receiving and dispersing cash and maintaining the accounts receivable records. Until recently, there had been little supervision of the Accounts Payable staff. The lack of controls created opportunities for malfeasance, fraud, and misappropriation of funds.

The Minneapolis Veterans Home increased security and internal controls over cash and state receipts, improved payroll records, increased attempts to reconcile accounts to the control ledger, and increased prices of staff meals during the summer of 1980. Top management, however, delayed any major attempt to correct deficiencies until it received funding from the 1980 Legislature for an Administrative Management Director and additional administrative staff. The Department of Veterans Affairs also requested Department of Administration assistance in determining the administrative structure and other changes necessary to improve fiscal control at the Minnesota Veterans Homes and Department of Veterans Affairs.

The Study Team concurs with the department's appointment of an Administrative Management Director to direct the fiscal affairs of the entire department. The appointment should free the current Deputy Commissioner for general management responsibilities and should bring needed financial expertise to the department as a whole and the Minneapolis Home in particular. The Study Team reviewed drafts of the Administrative Management Director's position description at the request of the department and had several meetings with the department's top management concerning fiscal management problems in the department.

The Study Team and top management agreed that:

- The Administrative Management Director should report directly to the Commissioner and supervise the present Central Office accounting staff.

- The Minneapolis accounting and business office staff should remain at the Minneapolis Home.

- The Director should directly supervise the Minneapolis accounting and business office staff during the transition to a new Administrator. The Commissioner would review with the Director and the Administrator every six months when supervision of the staff would be returned to the Administrator. The transition should not exceed 12 months. At the

end of the transition, the Director should have responsibilities similar to those outlined below for Hastings.

- The Director should provide technical and professional support and have only indirect supervisory responsibility for the Hastings accounting and business office staff.

- The Director's position description should reflect that 50% of the time during the transition will be spent at the Minneapolis Home and 50% in the Central Office handling department-wide fiscal and administrative matters.

The agreement reflects the belief that financial responsiblities of the Homes should remain with the Homes' management so that program, fiscal, and administrative concerns are tied. The Department's Administrative Management Director should play a strong technical support role but have only indirect supervisory responsibilities for fiscal matters at the Homes. In other words, the Department of Veterans Affairs should model its financial operations after those of the Department of Corrections and the Department of Public Welfare. This scheme would improve efficiency and increase controls without divorcing program and administrative concerns from fiscal ones.

An Administrative Management Director was appointed to the position August 4, 1980.

Since then increased controls over cash, accounts payable, and accounts receivable have been implemented. Cash is balanced daily. A fixed asset inventory system has been initiated. Written policies and procedures are being developed. The Minneapolis fiscal staff has been reorganized, position descriptions are being written on the basis of new assignments, staff training has begun, and performance measures are being developed. Activity managers have been designated at both Homes and the Central Office, and fiscal management training of these managers has begun. Appendix E is a detailed report by Mr. Singer of accomplishments to date.

On the basis of this significant progress, the Study Team believes that all deficiencies can be corrected by January 1, 1982. This length of time is needed due to the seriousness of the problems. Significant progress on implementation should be expected by the end of fiscal year 1981, and increased controls over fiscal matters and adherence to Department of Finance, Department of Administration, and Department of Employee Relations rules and procedures must begin immediately. We recommend that the Administrative Management Director reduce to writing his detailed plan and timetable to correct all fiscal management deficiencies. We recognize that Mr. Singer

has begun to address some of the problems identified in the recommendations that follow.

Recommendation Two: The Administrative Management Director should develop position descriptions defining the authorities and responsibilities of each staff member under his supervision, develop written policies and procedures, and train staff accordingly.

The inefficiency and ineffectiveness of current Minneapolis staff stems in part from a lack of leadership and direction as well as commitment by the Home's top management to fiscal affairs. They also stem from a failure to define the authorities and responsibilities of each staff member, to adequately train staff in statewide accounting procedures and proper accounting practices, to develop standard operating policies and procedures, and to use automated office equipment. The Minneapolis Veterans Home presently has sufficient staff in its cashiers and business offices. In fact, the Study Team believes after a transitional period in which LAC-cited deficiencies are corrected, the present staff of six should be reduced to four.

During the transition the office's six staff should be organized as follows. The accounts supervisor should report directly to the Administrative Management Director for day-to-day operations and be responsible to him for the fiscal integrity of the Home's accounts. The Senior Accounting Technician and two Account Clerks should report to the Accounts Supervisor. This accounting staff should be responsible for:

- preparing monthly resident maintenance bills and posting to resident accounts;
- posting and verifying resident depository accounts;
- verifying all receipts;
- monitoring and processing all accounts payable;
- preparing the resident worker payroll;
- maintaining the canteen, gift, investment, and other special funds;
- conducting and maintaining the fixed asset inventory;
- testing periodically the perpetual inventory; and
- preparing reports as directed by the Administrative Management Director.

The Cashier should also report directly to the Administrative Management Director with the Clerk 2 reporting to him. The Cashier's responsibility should be limited to receiving resident depository and maintenance funds, preparing deposits of cash and state receipts, and cashing checks and making change for residents. The Clerk 2 should act as a backup to the Cashier and be available to assist the accounting section. The exact split of responsibilities among staff and administrative structure should be determined by the Administrative Management Director after the development of a plan for correcting LAC-cited deficiencies and an assessment of the capabilities of current staff.

The Hastings Home has sufficient staff for its Cashier's operation but not enough for its Business/Accounting Office. There is not, however, enough work for an additional position. Some of the accounting work should be shifted to the Cashier's staff, and the Administrative Management Director should devise a backup system for the Hastings staff to cover vacation and sick leave. With only three staff, it is difficult to implement all the internal controls dictated by good accounting practices. The Administrative Management Director should consider procedures by which he or members of the Central Office or Minneapolis accounting staffs make periodic checks of accounting and cashier transactions. The Central Office has sufficient staff for its accounting operation.

The Minneapolis Veterans Homes' Procurement Officer has responsibility for purchasing at Minneapolis Veterans Home, Minnesota Veterans Home at Hastings, and Big Island Camp, but reports directly to the Assistant Administrator at Minneapolis Veterans Home. The officer's department-wide responsibilities should be formally recognized in his position description. He should also be given responsibility for Central Office purchasing and should report directly to the Administrative Management Director. The position should be reclassified from Executive I to a professional level classification, such as Buyer I or Accounts Officer to reflect the position's actual responsibilities and authorities.

Recommendation Three: Responsibility for budgeting and fiscal management of the department should be decentralized.

Responsibility for budgeting and fiscal management of the department is concentrated in the Department of Veteran Affairs top management (Commissioner, Deputy, Administrative Management Director, and the two Home Administrators). Supervisors, particularly those at the two Homes, do not prepare their units' biennial budgets and annual spending plans; for the most part, are unaware of the size and detail of their unit's budgets do not receive monthly reports on

their units' fiscal activities; and consequently, feel no personal responsibility for their units' fiscal condition.

The Study Team believes that each manager must be held responsible for the financial affairs of their unit. The Study Team suggest:

- The Commissioner of Veterans Affairs issue a policy statement to that effect and that he appoint a committee of his Deputy, Administrative Management Director, Home Administrators, and department's controller to work out details and implement the policy.
- Each manager's position description reflect their responsibilities for fiscal matters and each manager should be reviewed annually on the ability to handle fiscal matters.
- The Administrative Management Director and the department's training director work together to provide training to all department managers on fiscal matters.

Recommendation Four: The Minnesota Veterans Homes must develop and implement a reporting system which accurately identifies revenues and costs and which is useful for decision-making by both top management and line managers.

Essential to fiscal control and management of the department is the development of a reporting system which accurately identifies revenues and costs and which is useful for decision-making by both top management and line managers. The Department's program budget structure does not correspond to the current organizational structure at the Homes so current Statewide Accounting reports are not useful to the Homes' line managers. The quarterly Federal Aid Reports sent to the Veterans Administration provide no detail to top management or line managers on costs and revenues. The reports are based, except for salaries, on bills paid rather than expenses actually incurred during the reporting period. The costs of medical services provided to the Homes' domiciliary and nursing home programs are not allocated on the basis of actual expenses, but on "best guesses" of various medical staff on how they will split their time between the two programs during the fiscal year. Per patient costs of all other services are assumed to be equal for domiciliary and nursing home residents.

Therefore, the Administrative Management Director must devise with the assistance of the Department of Finance a new financial reporting system for the Homes. He should meet

with the Commissioner, Deputy, Administrators, and line managers to identify expense and revenue centers and develop a program budget structure based on those centers. The Administrative Management Director should then meet with managers and administrators to define what reports in addition to those from Statewide Accounting are needed to manage the department.

Recommendation Five: The Department of Veterans Affairs should attempt to recover overpayments made by the Minneapolis Home to its contract dentist, podiatrist, and opthalmologist. The Homes must develop and implement immediately a system to monitor all payments on service contracts to prevent duplicate and overpayments and to insure the quality of service provided.

At the request of the Department of Veterans Affairs, the Department of Administration's internal auditor conducted an audit of the Minneapolis Veterans Home's invoices for dental, opthalmology, and podiatry services from July 1, 1973, to June 30, 1979. The Minneapolis Home contracts dental, opthalmology, and podiatry services for its residents from private clinics. The contracts during this period called for all services to be provided according to fee schedules established by the Department of Public Welfare.

Our examination of dental invoices during this period disclosed 594 overpayments and two duplicate invoices for a total of $7,242. The Legislative Auditor discovered an additional $940 in dental overpayments between July 1, 1979, and September 14, 1979. Our examination of opthalmology invoices disclosed overpayments of $6,571.55 during the period. See Appendix F for the Department of Administration audit reports and recommendations.

The Minneapolis Home also contracts medical and corrective therapy services. Compensation in these contracts is based on an hourly rate. The Home requires contractors to maintain records of the time spent and services provided, but does not monitor either the time or services and often pays contractors without detailed invoices and written documentation of the hours actually worked or services provided.

Monitoring of hours worked and the quantity and quality of services provided is the responsibility of the Home's top management and program staff, not its fiscal staff. Performance criteria must be developed, formal evaluations conducted, and

a process established for bringing performance into line with standards set. Hastings, which has written its first service contracts this year, must establish the same monitoring process.

OPERATING COSTS

General operating costs of the Minnesota Veterans Homes were $4,631,000 in fiscal year 1980: $3,184,200 at Minneapolis and $1,446,900 at Hastings.[1] Table 1 traces the Homes' operating revenues and expenses since 1970. Operating costs have more than tripled in the past eleven years with the largest increases occurring between 1974 and 1975 with the initiation of nursing care at Minneapolis and between 1978 and 1979 with the opening of the Hastings Home. Fiscal year 1981 operating expenses are budgeted at $5,980,000: $4,300,100 at Minneapolis and $1,679,000 at Hastings. Fiscal year 1981 expenses at Minneapolis will increase 45% over fiscal year 1980 expenses, due primarily to the opening of the new nursing facility.

Recommendation Six: The Minnesota Veterans Homes must reduce per diem costs of domiciliary care at Hastings and nursing care at Minneapolis so that costs are no higher than those in the community for similar levels of care.

Table 2 details per diem (that is, per day per patient) costs for the past three fiscal years. In the last three quarters of fiscal year 1980 per diem costs for domiciliary

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1. General operating costs are defined as those funded through the State General Fund. In addition, the Homes receive income from four other sources: gifts, endowments, a revolving agency fund to support the Homes' canteens, coffee shops, and resident stores, and special federal funding for the Work Incentive Program. In fiscal year 1980, the Homes received $202,300 from these sources, 90% of which was from the agency revolving fund.

Table 1

COST OF OPERATION - MINNEAPOLIS VETERANS HOME

STATE FISCAL YEAR	BUDGETED/ACTUAL GENERAL FUND EXPENDITURES	MAINTENANCE CHARGES COLLECTED	TOTAL VA REIMBURSEMENT	STATE COST
1981 (estimated)	4,300,100.00	1,701,247.47 (39.6%)*	1,102,852.53 (25.6%)*	1,496,000.00 (34.8%)*
1980	3,184,200.00	1,545,428.17 (47.8%)	1,001,850.50 (31%)	636,921.33 (20%)
1979	2,985,296.00	1,370,787.72 (45.9%)	1,045.531.50 (35%)	568,976.78 (19.1%)
1978	2,644,537.00	1,234,750.97 (46.7%)	998,313.52 (37.8%)	411,472.51 (15.5%)
1977	2,383,500.00	1,049,792.28 (44%)	915,561.48 (38.4%)	418,146.24 (17.6%)
1976	2,173,708.00	932,158.79 (42.9%)	781,950.00 (36%)	459,599.21 (21.1%)
1975	1,898,904.00	777,825.67 (41%)	744,309.00 (39.2%)	376,769.33 (19.8%)
1974**	1,553,113.00	632,288.36 (40.7%)	659,612.00 (42.5%)	261,212.64 (16.8%)
1973	1,435.349.00	506,064.77 (35.3%)	458,976.00 (32%)	470,308.23 (32.7%)
1972	1,353,622.66	375,756.88 (27.8%)	410,900.00 (30.3%)	566.965.78 (41.9%)
1971	1,089,079.06	294,633.82 (27.1%)	381,125.50 (35%)	413,319.74 (37.9%)
1970	1,070,392.38	262,776.51 (24.6%)	366,495.50 (34.2%)	441,120.37 (41.2%)

** Nursing Care Provided Officially For First Time

* Projections Based On Historical Collections/Reimbursements As A Percentage of Overall Costs

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COST OF OPERATION - HASTINGS VETERANS HOME

STATE FISCAL YEAR	BUDGETED/ACTUAL GENERAL FUND EXPENDITURES	MAINTENANCE CHARGES COLLECTED	TOTAL VA REIMBURSEMENT	STATE COST
1981 (estimated)	1,679,900.00	403,413.57 (24%)*	346,286.43 (20.6%)	930,200.00 (55.4%)*
1980	1,446,900.00	283,081.00 (19.6%)	256,954.97 (17.8%)	906,864.03 (62.6%)
1979	1,325,219.00	183,542.00 (13.9%)	157,526.00 (11.9%)	984,151.00 (74.2%)
1978	180,828.00	3,569.00 (2%)	--0--	177,259.00 (98%)

* Projections Based On Historical Collections/Reimbursements As a Percentage Of Overall Costs

Table 2

PER DIEM BY SOURCE OF FUNDS

MINNEAPOLIS VETERANS HOME[1]
Nursing Care

State Fiscal Year	Member's Charges	VA Per Diem	State Per Diem	Total Per Diem
1978	$12.05	$10.50	$4.81	$27.36
1979	$13.71	$10.50	$9.32	$33.53
1980	$16.03	$10.50	$8.93	$35.46
	As A Percentage of Total Per Diem			
1978	44%	38.4%	17.6%	
1979	40.9%	31.3%	27.8%	
1980	45.2%	29.6%	25.2%	

MINNEAPOLIS VETERANS HOME[1]
Domiciliary Care

State Fiscal Year	Member's Charges	VA Per Diem	State Per Diem	Total Per Diem
1978	$6.99	$5.50	$ .07	$12.56
1979	$7.29	$5.50	$1.19	$13.98
1980	$8.52	$5.50	$1.94	$15.96
	As A Percentage of Total Per Diem			
1978	55.7%	43.7%	.6%	
1979	52.2%	39.3%	8.5%	
1980	53.4%	34.5%	12.1%	

HASTINGS VETERANS HOME[1]

State Fiscal Year & Quarter	Member's Charges	VA Per Diem	State Per Diem	Total Per Diem
10/1/78-9/30/79	$4.71	$5.50	$11.17	$21.38
1980 - 2nd	$5.87	$5.50	$16.93	$28.30
1980 - 3rd	$6.07	$5.50	$16.44	$28.01
1980 - 4th	$6.00	$5.50	$20.52	$32.02
	As A Percentage of Total Per Diem			
10/1/78-9/30/79	22%	25.7%	52.3%	
1980 - 2nd	20.7%	19.4%	59.9%	
1980 - 3rd	21.7%	19.6%	58.7%	
1980 - 4th	18.7%	17.2%	64.1%	

[1] Source of Data: a) Quarterly Federal Aid Reports and supporting work papers prepared by Minneapolis and Hastings Veterans Home staff and filed with the United States Veterans Administration.
b) Monthly Statewide Accounting System reports of receipts and disbursements for the Minneapolis and Hastings Homes.

Table 3

AVERAGE PER DIEM COSTS FOR CALENDAR 1975 TO 1979

Seven County Metropolitan Area[1]

	ICF-II		ICF-I		SNF	
	Profit	Non-Profit	Profit	Non-Profit	Profit	Non-Profit
1975	$12.46	$10.03	$17.95	$15.87	$21.24	$22.31
1976	$15.36	$11.31	$21.38	$20.10	$25.68	$24.95
1977	$17.86	$13.00	$23.91	$23.12	$28.66	$28.68
1978	$19.60	$14.76	$27.52	$25.56	$32.08	$32.57
1979	$22.06	$17.27	$30.92	$28.93	$36.22	$36.17

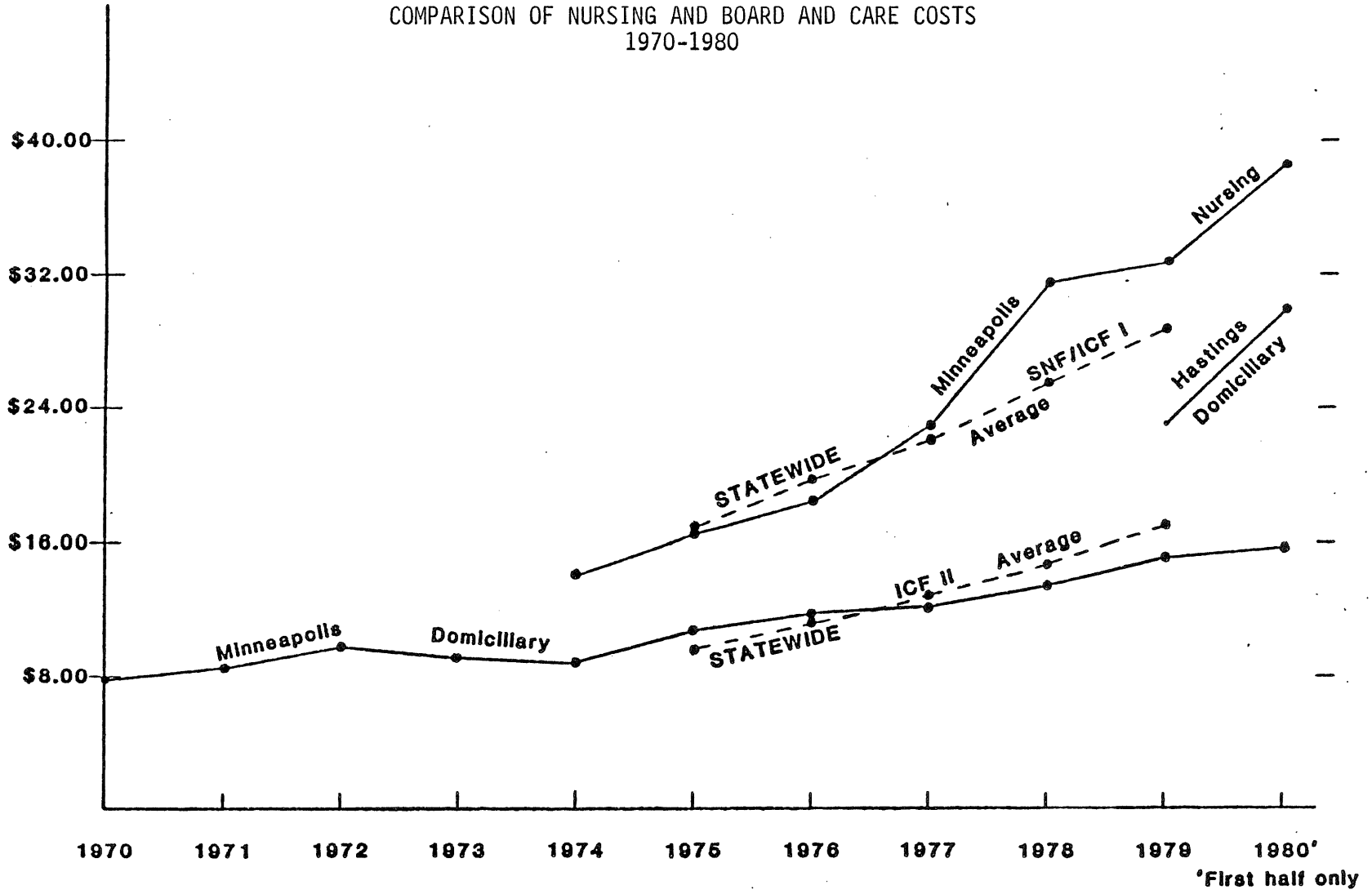
Statewide Averages[1]

	ICF-II		ICF-I		SNF	
	Profit	Non-Profit	Profit	Non-Profit	Profit	Non-Profit
1975	$11.62	$ 9.72	$16.90	$14.78	$20.26	$19.20
1976	$14.52	$11.34	$19.57	$17.68	$24.09	$21.94
1977	$16.67	$12.98	$21.81	$19.72	$26.81	$24.84
1978	$18.68	$14.90	$25.12	$22.50	$30.19	$28.26
1979	$21.13	$17.24	$28.54	$25.48	$34.50	$31.83

[1] Source: Audit Division, Minnesota Department of Public Welfare.

FIGURE 1

COMPARISON OF NURSING AND BOARD AND CARE COSTS
1970-1980



care were $29.44 at Hastings and $15.34 at Minneapolis.[2] Per diem costs for nursing care were $37.39. Overall, per diem nursing and domiciliary care costs at Minneapolis have increased 25% since fiscal year 1978, while per diem costs at Hastings have increased 38%.

Table 3 and Figure I compare per diem costs at the Homes to costs for similar levels of care in the community. Specifically, the Homes' costs are compared to statewide average per diem costs of both profit and non-profit facilities. Costs have been calculated on a calendar rather than state fiscal year basis.

Several important comparisons should be noted:

- Since 1977 per diem nursing care costs at the Minneapolis Home have been higher than the statewide average for non-profit nursing care facilities. In fact, in 1978 and 1979 the Homes' per diem costs were even higher than those at "for profit" facilities.[3]

- Per diem domiciliary costs at Hastings in 1979 were significantly higher than the statewide average for ICF-II care (intermediate board and care) at both profit and non-profit facilities.

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2. Per diem costs are those reported quarterly by the Homes to the Veterans Administration for purposes of federal reimbursement. Using the reported per diems, the Study Team calculated annual per diem costs on both State fiscal and calendar year bases. The latter was necessary in order to compare costs with those of community facilities which report costs only by calendar year. In materials given to the Study Team first quarter fiscal year 1980 costs at Hastings were included as part of general report to the Veterans Administration for federal fiscal year 1979. A single annual per diem rate was reported and thus the Study Team was unable to separate costs by quarter. Comparable quarterly data for the two homes consequently, was only available since October 1, 1979.

3. To compare nursing costs with those in the community, the Study Team has chosen to compare then with a combined statewide average of skilled (SNF) and intermediate nursing (ICF-I) costs. Comparison of the Home's costs solely to statewide average ICF-I costs would not be justified because it would not reflect the cost of providing services to certain residents requiring a higher level of nursing care. Costs cannot justifiably be compared solely to average statewide SNF costs since the Home does not provide many of the specialized services found in SNF community facilities. While the Home has residents classified by the Minnesota Health Department as needing SNF care, the Home provides only limited SNF services. Finally, the Home does not differentiate between SNF and ICF-I costs, making more detailed comparisons impossible.

- Per diem costs for domiciliary care at Hastings and nursing care at Minneapolis are rising faster than the statewide averages for similar levels of care at both profit and non-profit facilities.

- Since 1977 per diem domiciliary care costs at Minneapolis have been lower than the statewide average for ICF-II care at profit and non-profit facilities.

When comparing the Homes' per diem costs with those in the community, some care must be taken. First, the Homes' per diem costs, as reported above, do not include the costs of building construction, major repairs, and equipment paid out of non-operating funds. If these costs were included in the per diem figure as they are in most community facilities, Minneapolis' per diem costs would increase by approximately $1.00 and Hasting's costs by approximately $.75. Second, under the Homes' current accounting system, the cost of most shared services are not allocated between the nursing and domiciliary programs on the basis of actual expenses but rather on the basis of annual or quarterly estimates by various managers. The small amount of expenses and staff time allocated to the domiciliary program in Minneapolis (when compared to those reported in staff interviews) would indicate that some of these costs may be incorrectly allocated to nursing care. Finally, the Homes calculate resident days differently than do community facilities. We cannot, however, readily determine from the Homes' admissions and accounting records and from the statewide statistics on community facilities the effect of the differences on the Homes' per diem costs.

While these reservations make it impossible for us to determine the exact differences in cost between the Homes and community facilities, the general findings are clear. Domiciliary costs at Hastings and nursing costs are significantly higher than those in the community, while domiciliary costs at Minneapolis are slightly lower.

Hastings' high per diem costs are primarily the result of three factors:

(1) The facility has been staffed since 1978 to serve 200 residents, but the Home's daily census has never been higher than 155 to 160. Its current population is 135; and until January 1, 1980, the Home was licensed to serve only 150 residents.

(2) The facility has too many medical staff for a domiciliary program and too many support staff for the size of the institution, according to U.S. Veterans Administration and Minnesota Health Department guidelines. Furthermore, the Home has a large number of staff who are at senior classifications with long seniority and near the top of their pay scales.

(3) The facility's physical plant is old and costly to maintain and operate.

These problems stem directly from the difficulty of closing the State Hospital and adapting it to a veterans' home.

The department and Home have tried to reduce per diem costs in two ways. First, the department requested the 1979 Legislature to raise the Home's capacity from 150 to 200 beds. Per diem costs will be reduced by about 25% when the Home reaches full capacity. Second, the Hastings staff has reduced the operating costs of the physical plant. Major portions of the facility have been closed, the Home's heating plant is operating at minimum capacity, the facility's electrical generating and sewage treatment plants remain shut down, and the Home has an active winterization and energy conservation program. The department's decision, however, to separate administration of the Hastings and Minneapolis Homes has increased both administrative and program costs at Hastings.

To further reduce costs at Hastings will require serious consideration of two alternatives:

(1) To activate several of the buildings currently vacant and increase the Home's capacity to 300 beds. The Department of Public Welfare testified in 1977 at legislative hearings on the closing of the State Hospital that unless the Veterans Home had 300 residents, it would be more costly than comparable community facilities. Presently Hastings' indirect costs are twice its direct care costs. Increasing the Home's capacity would spread the indirect costs over more beds and thereby lower per diem costs.

To increase the Home's capacity above 200 beds would, however, require major expenditures for renovation and remodeling of facilities and for additional direct care staff and minor increases in other operating expenses. Furthermore, it is questionable whether another 100 domiciliary beds are needed at the Veterans Homes. The domiciliary population of the two Homes has remained steady for the past two years, and the combined occupancy rate for domiciliary beds set up and staffed has been only 69%.

The department's top management has discussed shifting domiciliary residents from Minneapolis to Hastings over the next several years and converting vacant domiciliary beds at Minneapolis to nursing care. Discussion of this alternative has just begun, and no decision is likely in the near future. The alternative has serious programmatic and financial implications and thus can only be considered in the context of long-range plans for both Homes and a

serious evaluation of their missions. The alternative, consequently, does not offer an immediate way to lower costs at Hastings.

(2) To share administrative and indirect care staff and operate joint direct care programs with the Minneapolis Home.

Animosity between the staffs and the substantial distances between the campuses will complicate implementation of this alternative. Nonetheless, it is the quickest and most realistic strategy of reducing costs and is reflected in the Study Team's recommendations elsewhere in this report on staffing, resident programs, and administrative structure.

The Study Team could not determine conclusively why per diem nursing care costs were higher and Minneapolis' per diem domiciliary costs were lower than the statewide averages for community facilities. Part of the differences may be the result of incorrect allocation of costs between programs and differences between the Home and the community in calculating patient days. Domiciliary costs are probably low because the Home offers few programs other than room and board to its domiciliary residents. On the other hand, high nursing care costs cannot be attributed to providing more services than do community facilities. The Home basically provides intermediate rather than skilled nursing care and has been cited by the Minnesota Health Department for program deficiencies, including failure to provide the required two hours of nursing care per patient per day. Poor management and ineffective use of staff appear to be primary causes of the high nursing costs.

An important caveat must be made to our recommendations on reducing costs. The Homes would be justified having per diem costs higher than statewide averages if, after assessing the needs of residents, the Homes provided special nursing and domiciliary programs for restoring, rehabilitating, and caring for residents.

Recommendation Seven: The Minnesota Veterans Homes must reduce State costs at Hastings to a level equivalent to that at Minneapolis.

The Homes have three major sources of income: maintenance receipts from residents, federal aid from the Veterans Administration, and state general fund appropriations.

Residents paid 47.8% of the cost of operating the Minneapolis Home in fiscal year 1980, the Veterans Administration paid 31%, and the State paid 21.2%. In contrast, residents paid only 19.6%

of the cost of operating the Hastings Home in fiscal year 1980, the Veterans Administration paid 17.8%, and the State paid 62.6%. Differences between the Homes are even more marked when Minneapolis' nursing and domiciliary programs are analyzed separately. Minneapolis domiciliary residents paid 53.4% of the cost of their care, the Veterans Administration paid 34.5%, and the State paid 12.1%. Minneapolis nursing care residents paid 45.4% of the cost of their care, the Veterans Administration paid 29.6%, and the State paid 25.2%. See Tables 1 and 2 above for a breakdown of the Homes' revenues over time. Figure II, below, illustrates the differences in revenue sources for the two Homes in fiscal year 1980.

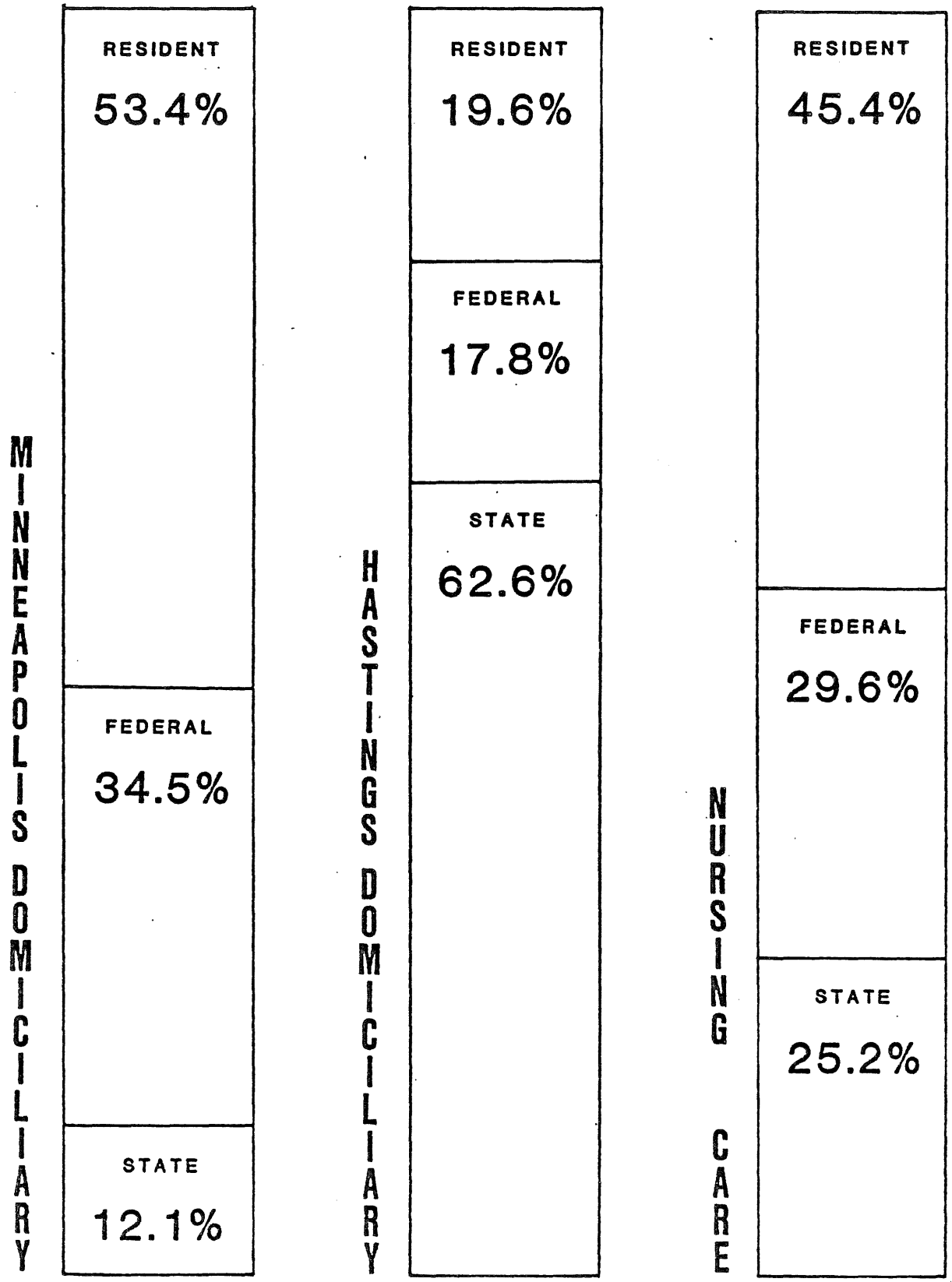
The high cost to the State of operating the Hastings Home is the direct result of the low occupancy rate, high per diem cost, and the way in which the State's Veterans Homes are funded. The Veterans Administration pays half of an eligible veteran's cost of care up to an established amount, currently $5.50 per day for domiciliary care and $10.50 per day for nursing care. Residents are charged fixed percentages of their income. The State picks up the remaining costs. Under this scheme , total revenues from residents and from the Veterans Administration depend primarily upon the number of residents at the Home (that is to say, the occupancy rate) while the size of the State's contribution depends primarily upon the overall costs of the Home.

The reason for this effect is twofold. First, the Veterans Administration's cap on reimbursement means that when per diem costs are more than $11.00 for domiciliary care and $21.00 for nursing care, the contribution of the Veterans Administration (as a proportion of total costs) decreases as overall per diem costs increase. The cost burden shifts to other revenue sources. Second, few residents have incomes sufficient to cover the cost of care. Most residents are on fixed incomes, and other than the differences between those 65 and over and those under 65, there are no sifnificant differences in the incomes of residents. Since most of residents' incomes are already taken in maintenance charges, the only ways to significantly increase revenues from residents are to increase the overall number of residents or the number of residents 65 and over. In essence, the amounts of revenue which the Homes can receive from residents and the Veterans Administration are fairly fixed (depending more on the number of residents served than on actual per diem costs). Consequently, the burden of high and rapidly increasing per diem costs is shifted to the State. It is the State's contribution, not that of residents' or the V.A., which fluctuates directly with changes in overall costs of care.

The State's share of operating costs at the Hastings Home can be expected to decrease as the Home reaches full capacity. In fact, the State's share has already decreased from 74.2% in fiscal year 1979 to 62.6% in fiscal year 1980. The State's

FIGURE II

COMPARISON OF PER DIEM COSTS
BY PROPORTIONS PAID
FIRST THREE QUARTERS F.Y. 1980



share, however, will not decrease substantially below 50%, even at full capacity, unless overall operating costs are reduced, the Veterans Administration significantly increases its ceiling on reimbursement, or incomes of Hastings' residents increase substantially. Prospects for increasing resident and V.A. revenues are small. Even if Congress were to appropriate funds for the increased reimbursement ceilings it approved last year ($6.35 domiciliary and $12.10 nursing), V.A. revenues would increase only 15%. The only realistic proposal for reducing state costs at Hastings is to reduce overall operating costs.

In our discussion of Recommendation Six above, we referred to the serious fiscal implications of converting vacant domiciliary beds in Minneapolis to nursing care. The implications are particularly significant for the State. See Table 2. In fiscal year 1980, the State paid $1.94 per day on average for a veteran in domiciliary care and $8.93 per day on average for a veteran in nursing care. Converting beds from domiciliary to nursing care would have increased State costs for those beds over four and a half times. The bottom line is that while V.A. and resident revenues will increase by shifting beds from domiciliary to nursing care, so will State costs. In fact, State costs will increase at a much faster rate than V.A. and resident revenues.

Recommendation Eight: The Minnesota Veterans Homes should seek Medicare/Medicaid certification of portions of the Homes so that Medicare/Medicaid payments can be used to reimburse the cost of care for peace-time veterans and non-veteran residents. As an alternative, the Homes should consider placing non-veterans and peace-time veterans in certified community facilities.

Minnesota Statutes 198.022 authorizes the Commissioner of Veterans Affairs to admit the spouses, surviving spouses, and parents of eligible veterans. To be admitted a non-veteran must be at least 55 years of age and a resident of Minnesota. At the time of our study, twenty of the Homes' residents were non-veterans. Four were receiving nursing care; sixteen were receiving domiciliary care. Because the Veterans Administration does not reimburse the State for non-veteran care, the State picks up 100% of all costs that the non-veteran is unable to pay.

Nursing care at the Veterans Homes currently costs approximately $13,750 per resident per year. Non-veterans pay 25% of the cost of their care, and the State pays the remaining 75%. In contrast, veterans pay 45.4% of the cost of their care, the Veterans Administration pays 29.6%, and the State pays only 25.2%. The annual cost to the State of providing

Table 4

PER ANNUM COSTS
NURSING AND DOMICILIARY CARE FOR NON-VETERANS
MINNESOTA VETERANS HOME

Nursing Care:		
	Current Per Patient Cost	$13,750
	Average Collection Per Patient	3,420
	Current Cost to the State	$10,330
	Total Cost of Care for four Non-Veterans	$55,000
	Total Collections from Non-Veterans	13,680
	Total State Costs	$41,320
Domiciliary Care:		
	Current Per Patient Costs[a]	$ 5,400
	Current Collections	2,050
	Current Cost to the State	$ 3,350
	Total Cost of Care for 16 Non-Veterans	$92,700
	Total Collections from Non-Veterans	32,250
	Total State Costs	$57,450
Total State Costs		$98,770

[a] Per patient costs are based on the 15 non-veterans in domiciliary care at Minneapolis. The cost to provide care to the one non-veteran at Hastings is included in our total cost figures for domiciliary care.

nursing care to a non-veteran at the Minneapolis Home is $10,330, three times or $6,865 more than the cost of providing such care to a veteran. See Table 4.

Domiciliary care at the Minneapolis Home currently costs about $5,400 per resident per year. The State pays only 12% of the cost of care for veterans, but 67% of the cost of care for non-veterans. Veterans themselves pay 53% of the cost of their care; the Veterans Administration pays the remaining 35%. Non-veterans, in contrast, pay only 33% of the cost of their care. The annual cost to the State of providing domiciliary care to a non-veteran is $3,350, five times or $2,700 more than the cost of providing such care to a veteran.

Total cost to the State of providing care to non-veterans was an estimated $98,770 in fiscal year 1980. Under Medicaid and Medicare, State costs would have been reduced at least $55,000. Under Medicaid, the federal government picks up 56% of all costs a patient is unable to pay. The State is required to pick up 40% of these costs, and counties 4%. Under Medicare, the federal government assumes 100% of all such costs.

At the time of the study, 10 of the Homes' residents were veterans who had served in the armed forces during peace-time. Peace-time veterans were first eligible for admission to the Home in 1980. Like non-veterans, they are not eligible for V.A. reimbursement. Consequently, the State is picking up 100% of all costs that these residents are unable to pay. State costs would be reduced at least 56% if these residents were covered by Medicare or Medicaid.

Recommendation Nine: The Minnesota Veterans Homes must develop comprehensive written policies, guidelines, and procedures for determining individual maintenance charges and exceptions from the established rate schedule. Written notifications of changes in maintenance charges should be sent to residents in advance, and a formal mechanism by which residents can appeal decisions on maintenance charges should be established.

Minnesota law (Minn. Statutes 198.03) requires all residents with adequate means of support to sign a contract with the Commissioner of Veterans Affairs to pay for all or part of the cost of their care. In reviewing admission and maintenance records, the Study Team did not find any such contracts or any comprehensive written policies and procedures for determining maintenance charges and exceptions.

On the admission application residents are required to

report all income and net worth and to sign a general statement committing the resident to paying all maintenance charges as determined by the Veterans Homes. According to the application and the Homes' printed rate schedule, maintenance charges are based on a resident's income. No written policy defining gross and net incomes exists, however. As a result there is no consistency in the determination of residents' incomes and maintenance charges.

Sometimes a resident's net worth is included in calculating gross income and sometimes it is not. Sometimes all monthly income is included in calculating gross income and sometimes only V.A. and/or Social Security payments are included. Sometimes Medicare insurance is deducted from gross income and sometimes it is not. Sometimes exemptions for dependents are allowed and sometimes they are not. As the Legislative Auditor noted, there is little documentation in the files to support how maintenance charges for individuals have been determined.

Furthermore, at the Minneapolis Home, no single individual has been given responsibility for determining maintenance charges and exceptions. In our review of records, the Study Team identified four different staff who during the past two years have approved maintenance charges and authorized exceptions currently in effect. The Homes do not routinely review a resident's income and maintenance charges once he or she has been admitted except when changes in a resident's V.A. and/or Social Security payments occur. The Homes then automatically increase the resident's maintenance charges.

Residents are not sent bills or other written notification of changes to their maintenance charges. There is no formal mechanism by which residents can appeal decisions regarding charges. Residents are generally informed of changes only when they come to the Cashier's Office to pay their month's bills. Disagreements are resolved informally by the Cashier or top management. The lack of an overall policy and detailed procedures on maintenance charges has resulted in conflicts between residents and the staff of the Minneapolis Home in particular. Allegations of forgery, favortism, withholding of mail, and tampering with the mails have been made by various Minneapolis residents - though no action has been taken by them. While valid explanations have and could be offered by the Home, the easiest way to deal with the problem is to establish an open and equitable policy.

We recommend that a written policy defining gross and net income, allowable income exceptions, maintenance charges and exceptions be adopted immediately. We further recommend that one person at each Home be assigned sole responsibility for determining allowable income exemptions, maintenance charges, and a formal mechanism be established by which a resident can appeal that person's decision to the Administrator or Commissioner.

To meet the letter of the law, the Commissioner should formally delegate his authority to approve individual maintenance charges and the maintenance schedule should be formally approved by the Department of Finance. Each resident's maintenance charge should be fully documented, particularly if it is an exception to the established rate schedule. All residents should be informed in writing at least two weeks in advance of any change in their maintenance charges and the Homes should formally review with each resident his or her income and maintenance charge at least every two years.

Recommendation Ten: The Minnesota Veterans Homes should revise the current rate schedule so that personal income exemptions are increased, no resident is charged more than the cost of his or her care, and financial incentives are given to younger residents to return to the community.

The Homes' current rate schedule is found in Table 5. Residents are allowed personal net income exemptions of $40 per month and are then charged 60% of all net monthly income between $40 and $110 and 90% of all net monthly income over $110.

Rate schedules, the Study Team believes, should be judged on the basis of six criteria:

- equity, which we will define as the imposing of an equal financial burden on all residents. Essentially, an equitable schedule is one in which rates are based on ability to pay and no one pays more than the cost of his or her care.
- capacity to raise needed operating revenues.
- responsiveness to inflation, that is to say,the effects of inflation on operating costs are offset by increased revenues without affecting the underlying equity of the schedule.
- affects on a resident's incentive to seek needed care.
- affects on a resident's incentive to seek additional income.
- ease of administration.

The current rate schedule:

- Is equitable in that it is progressive but is not equitable in that there is no cap on the maximum

Table 5
MINNESOTA VETERANS HOME
RATE SCHEDULE EFFECTIVE MAY 1, 1970

Computation of Maintenance Charges:

Step 1 Add all income elements. Deduct Medicare payment from this total. Resulting total will be lowered to next even dollar amount, dropping all cents through 99¢.

Step 2 Income total up through $40.00 - no charge.

Step 3 Income total from $41.00 and up, use following chart to determine Maintenance Rate:

Total Income	Maintenance Rate	Total Income	Maintenance Rate
$41.00	$ .60	$76.00	$21.60
42.00	1.20	77.00	22.20
43.00	1.80	78.00	22.80
44.00	2.40	79.00	23.40
45.00	3.00	80.00	24.00
46.00	3.60	81.00	24.60
47.00	4.20	82.00	25.20
48.00	4.80	83.00	25.80
49.00	5.40	84.00	26.40
50.00	6.00	85.00	27.00
51.00	6.60	86.00	27.60
52.00	7.20	87.00	28.20
53.00	7.80	88.00	28.80
54.00	8.40	89.00	29.40
55.00	9.00	90.00	30.00
56.00	9.60	91.00	30.60
57.00	10.20	92.00	31.20
58.00	10.80	93.00	31.80
59.00	11.40	94.00	32.40
60.00	12.00	95.00	33.00
61.00	12.60	96.00	33.60
62.00	13.20	97.00	34.20
63.00	13.80	98.00	34.80
64.00	14.40	99.00	35.40
65.00	15.00	100.00	36.00
66.00	15.60	101.00	36.60
67.00	16.20	102.00	37.20
68.00	16.80	103.00	37.80
69.00	17.40	104.00	38.40
70.00	18.00	105.00	39.00
71.00	18.60	106.00	39.60
72.00	19.20	107.00	40.20
73.00	19.80	108.00	40.80
74.00	20.40	109.00	41.40
75.00	21.00	110.00	42.00
		111.00 and up -- 90% of excess over $110.00, plus $42.00.	

amount a resident can be charged. Seventy-four residents pay more than the cost of their care and thus help to subsidize the care of others.

- Raises maximum revenue while still recognizing the need of residents for spending money.

- Is highly responsive to inflation, generating increased revenues for the Homes but taking a disportionate share of all cost-of-living increases granted to residents and thereby effectively reducing residents' spending money.

- Does not differentiate between levels of care and therefore does not discourage residents from seeking needed care.

- Discourages residents, particularly those capable of returning to the community, from seeking additional income. With no cap on the maximum amount that a resident can be charged and with all additional income charged at a rate of 60% or 90%, residents are in effect prohibited from building up the necessary financial resources to start out again in the community.

  Furthermore, Minneapolis' unwritten policies of discouraging residents from seeking outside employment because of possible reductions in government pensions and of asking residents with outside jobs to leave on short notice have the effect of encouraging younger residents to stay at the Home and to make any transition to the community difficult. The overall effect is to encourage recidivism.

- Is, on its face, simple and should be easy to administer. As noted in Recommendation Nine above, it is not. The administrative difficulties, however, are caused by the lack of written policies and procedures on income determinations and the competency of staff, in particular the inability of some staff to relate effectively and sensitively to residents. To illustrate this point, one only needs to compare Hastings and Minneapolis. The Hastings staff by its personal involvement with residents and general competency, has developed a smoothly running system. In Minneapolis, the system is cumbersome and combative.

The Homes should consider:

- Increasing the net personal income exemption and indexing it to inflation. The personal exemption has not been increased since 1970. If the exemption had been indexed for inflation, it would currently be $85. The Study Team suggests that the Homes consider

indexing the exemption beginning in fiscal year 1982 to increases in Social Security and/or Veterans Administration benefits.

- Charging all income above the personal exemption at a single rate of 90%, if the personal exemption is raised to $85.

- Establishing a cap on maintenance charges so that no resident is charged more than the cost of his or her care. The Study Team would suggest establishing separate caps for nursing and domiciliary care and for veterans and non-veterans. At the beginning of each year the Homes would project per diem costs for nursing and domiciliary care. These projected costs would be the cap for non-veterans for the coming year. The veteran's cap would be these projected costs minus projected V.A. per diem reimbursement. If at the end of the fiscal year, a resident paid more than the cost of care, he or she would be granted an allowance in the coming year.

- Adopting a policy that would allow residents wishing to return to the community to exclude part of their income from maintenance charges. The policy would provide incentives for residents to return to the community and enable them to save money needed for the transition. The policy must be part of a comprehensive care, rehabilitation, and discharge program and thus should be aimed primarily at individuals who are admitted to the Homes for treatment programs of less than one year.

To adopt the changes suggested above would increase the equity of the system but decrease the Homes' revenues from maintenance charges and shift the cost burden to the State. We estimate that raising the personal income exemption from $40 to $85 would decrease maintenance revenues approximately 9% and establishing a cap on maintenance charges would reduce resident revenues about 7%. Revenue losses from adopting an income exclusion policy for short-term residents would depend upon how the policy was structured and the number of participants.

Part of the revenue loss could be offset by including net worth and all personal income when establishing residents' gross incomes and by charging residents 90% of all non-exempt income. The Homes' should also consider the merits of hiring a full-time reimbursement officer who could assist each resident in identifying and seeking all funds available for his or her support.

The Study Team recognizes the difficulty of balancing equity and the Homes' need for operating revenues. While the Study Team feels strongly that some changes must be made to improve the equity of the system, it recognizes that the extent and exact nature of the changes can only be determined by the department itself after an open discussion with all concerned.

CHAPTER II

ADMINISTRATIVE MANAGEMENT

CHAPTER II CONTAINS STUDY FINDINGS AND RECOMMENDATIONS UNDER THE GENERAL HEADING OF ADMINISTRATIVE MANAGEMENT. IT INCLUDES AN ASSESSMENT OF THE HOMES' PLANNING, DECISION-MAKING, ADMINISTRATIVE STRUCTURE, STAFF TRAINING, AND WRITTEN POLICIES AND PROCEDURES.

THE RECOMMENDATIONS ARE BASED ON THE ASSUMPTION THAT ADMINISTRATIVE SERVICES EXIST TO PROMOTE AND FACILITATE THE DEVELOPMENT AND IMPLEMENTATION OF INDIVIDUALIZED CARE FOR RESIDENTS. PROGRAM NEEDS OF RESIDENTS DICTATE ADMINISTRATIVE STRUCTURE AND SERVICES, NOT VICE VERSA.

DATA FOR THIS CHAPTER WERE ACQUIRED THROUGH INTERVIEWS WITH DEPARTMENT AND HOME STAFF, OBSERVATION OF THE HOMES' OPERATIONS, AND ANALYSIS OF THE HOMES' STAFF TRAINING PLANS, WRITTEN POLICIES AND PROCEDURES, ORGANIZATIONAL CHARTS, AND PLANNING DOCUMENTS.

ADMINISTRATIVE MANAGEMENT

Recommendation One: All managerial staff must be trained in how to plan and schedule work and how to use these tools to manage staff and accomplish goals. The Veterans Homes must adopt a mission statement and develop long and short range plans for the Homes and each of the work units.

Planning, simply put, is deciding in advance what to do, how to do it, when to do it, and who is to do it. It involves the establishment of agency objectives and long and short-range program and work plans by line managers.

A major weakness of the Homes has been the absence of good planning by top management and line managers. Top management has not developed comprehensive long-range plans for the Homes detailing the mission of the Homes, the population to be served, the services to be provided, the capital needs of the Homes, and the staff and financial resources required. To date, long-range planning has been undertaken primarily in connection with preparation of the capital and biennial operating budgets. It has emphasized fiscal rather than programmatic concerns; for the most part, has not been based on an objective, documented assessment of the needs of residents or veterans as a whole; and has accepted the continuation of existing programs without a serious analysis and consideration of alternatives. Line managers have not been involved in long-range planning.

Furthermore, top management and line managers do not prepare annual or monthly work plans. Most line managers prepare weekly or monthly work schedules in the absence of work plans. Schedules focus staff attention and resources on ongoing and short term work; they emphasize when such work is to be done and by whom rather than what work should be done and how.

Planning will not occur unless it is forced. This involves, at each level of management, setting goals; establishing and publicizing applicable, significant planning premises; involving all managers in the planning process; reviewing subordinate plans and their performance; and assuring appropriate staff assistance and information. The often encountered failure to plan by managers at all levels is frequently not caused by inability or unwillingness to plan but rather by lack of knowledge concerning the agency's objectives, its planning premises, its major policies, and those plans made by superiors and colleagues in the organization which necessarily affect a subordinate's area of planning.

Logically, basic goals from which others stem must be agency-wide, and therefore, must be set at the top management level. The example and drive of top management is the most important single force in planning. When it rigorously reviews subordinates' programs, it naturally stimulates planning through an organization. The best planning occurs when everyone has access to complete information affecting their areas of responsibility. This implies that objectives, premises, policies, plans of others, and other pertinent information which clearly affect their planning should be available to all managers concerned.

To begin the planning process, the Study Team prepared a mission statement (found as Appendix G), which was adopted informally by the Commissioner in August, 1980.

Recommendation Two: Decision-making at the Minneapolis Home should be decentralized. Greater coordination of decision-making is needed at Hastings.

The Minneapolis Veterans Home operated until 1972 on a military model. One of the legacies of the model is decision-making concentrated at the top. No effective authority is given to line managers on fiscal, budgetary, and personnel matters or even on most program matters. Consciously or unconsciously managers are encouraged to buck decisions to the top. Top management is heavily involved in the day-to-day operations and decision-making of the Homes' departments and often overturn line managers' decisions. There has been little effort to train managers and develop staff.

Our analysis of management at the Hastings Home indicates problems opposite to those at Minneapolis. Essentially, authority is decentralized at Hastings. Decisions are made by the line managers. Decentralized decision-making around specific "problem" areas, however, causes an imbalance in the operation of the Home as a whole. Hastings suffers from a lack of coordination between departments, caused in part by the absence of a well-defined program structure for the Home. The lack of coordination has been critical for budget control, staff allocation, and overall program planning.

Recommendation Three: Decision-making between the Homes must be improved, communications increased, and program and support services better coordinated.

At present, there is a serious lack of coordination and staff interaction between the two Homes. Since April, 1979 when Commissioner Miller separated administration of the Homes, communication and coordination have occurred primarily

at the administrator or assistant administrator levels. Line managers have been discouraged from contacting each other and coordinating programs without the involvement or prior approval of top management. No joint discussions regarding budget and staff allocation or joint efforts at overall and individual resident program planning occur.

Recommendation Four: The administrative organization which delineates responsibility and authority for operational decisions should be clarified.

The Minnesota Veterans Homes are currently organized and operating under a departmental rather than program design model. Various other forms of organization have been discussed by the Homes, but not adopted. Analysis of the current organization pinpoints the following organizational problems:

1. A department structure unconnected to program delivery, (e.g. a centralized nursing service with unclear lines of authority and responsibility to program components).

2. Unclear relationships between departmental managers, the administrator, the assistant administrator, and the assistant to the administrator at the Minneapolis Home.

   During the tenure of past administrator, the authority and responsibility of the assistant administrator and assistant to the administrator for line functions were ill-defined. Department managers such as the chemical dependency counselor and each of the Home's social workers in reality reported directly to the administrator.

   Since the administrator's resignation in April, 1980, the responsibility for running the Home has been split between the assistant to the administrator and the assistant administrator. The former is responsible for medical and program services and the latter for administrative services. The Commissioner has declined to appoint a single acting administrator. The assistant administrator and assistant to the administrator have overlapping responsibilities and authorities for admissions, disciplinary actions against residents, maintenance, housekeeping, and certain administrative services. Managers have told members of the Study Team they are confused about the responsibilities of the two assistants and the Commissioner, who has been acting as surrogate administrator of the Home.

3. Unclear relationships between the two Homes.

Until April, 1979, the Hastings Home was operated as a satellite of the Minneapolis Home. In general, department managers in Minneapolis supervised their counterparts in Hastings; and the Minneapolis assistant administrator coordinated activites on the Hastings campus. Authorities and responsibilites of managers, however, were not well defined and much confusion existed.

The Commissioner established Hastings as a separate institution with its own administrator reporting directly to him in April, 1979. Until July, 1980, the Hastings Home continued to share Minneapolis' medical director and contract dentist. The Hastings Home still utilizes the Minneapolis Home's admissions office, dietitian, pharmacy, and purchasing officer. No written delineation of the relationship between the two Homes exists. The authority and responsibilities of the shared staff, in particular, is unclear.

4. Unclear relationships between the Commissioner's Office and the Homes.

   According to Minnesota Statutes 198.06 and 198.31, the Minnesota Veterans Homes are to be governed by the Commissioner and managed by the Homes' administrators. Exact authorities and responsibilities of the administrators were not defined, however, until this past spring when position descriptions for the administrators were written. Since then, the Commissioner and his Deputy have ignored the position descriptions and have continued their involvement in the daily operations of the Homes. This involvement has undercut the authority of the two "acting" administrators at Minneapolis and the administrator at Hastings. Because neither the Commissioner nor his Deputy can spend full time at the Homes, an authority vacuum has developed and management control at the Homes, particularly Minneapolis, has disintegrated.

It is recommended that the organizational model detailed in Organization Charts 1 through 3 be adopted.

Chart 1 suggests the program and administrative components of the Department of Veterans Affairs be directed by three line administrators: the Administrator of the Minnesota Veterans Homes, the Administrative Management Director, and an Assistant or Deputy Commissioner of Veterans Affairs.

The Assistant Deputy Commissioner should be responsible for all department programs outside the Veterans Homes. According to Minnesota Statutes 15.05, Subd. 7, a Deputy Commissioner can have no specific line duties. In order to

improve the management of programs outside the Veterans Homes while not increasing administrative staff, the department should consider eliminating the deputy position and creating an assistant commissioner position in its stead.

The Administrative Management Director should be responsible for department-wide personnel, fiscal, and administrative activities. The department's personnel officer, purchasing officer, and Central Office accounting section should report directly to the Administrative Management Director, and he should provide technical supervision to the business offices at the Veterans Homes. A separate administrative unit reporting directly to the Commissioner is needed at this time due to the serious personnel and fiscal problems at the Homes. Once these problems have been resolved, the need for a separate administrative unit should diminish and responsibilities can be transferred to the Assistant Commissioner and Veterans Homes Administrator.

Chart 1 also suggests administration of the Minneapolis and Hastings Homes be combined in order to reduce costs and improve services for residents. Program and administrative services should be directed by five line administrators: Assistant Administrator of Clinical and Program Services, Assistant Administrator of Support Services, Director of Domiciliary Living at Minneapolis, Director of Domiciliary Living at Hastings, and Director of the Nursing Care Unit in Minneapolis.

Chart 2 details the administrative relationships of the Assistant Administrator of Clinical and Program Services. Chart 3 details the administrative relationships of the Assistant Administrator of Support Services.

Recommendation Five: A comprehensive institution-wide staff development training program should be initiated.

Staff development and/or in-service training in health care residential institutions is a critical issue. Demands are being made on programs to reflect contemporary philosophy in residential and clinical care, and training must keep pace with these demands. Reorganization of existing facilities requires extensive retraining of new and existing staff.

An analysis of the training function at the Minnesota Veterans Homes revealed the Minneapolis Home has been repeatedly cited in the past by the Minnesota Health Department for its poor staff training. A departmental training director was hired during the past year and the first meaningful departmental training plan was completed July, 1980. An analysis of the curriculum indicated major training efforts are directed at developing staff skills in basic nursing care

CHART ONE

Minnesota Department of Veterans Affairs
Proposed Reorganization

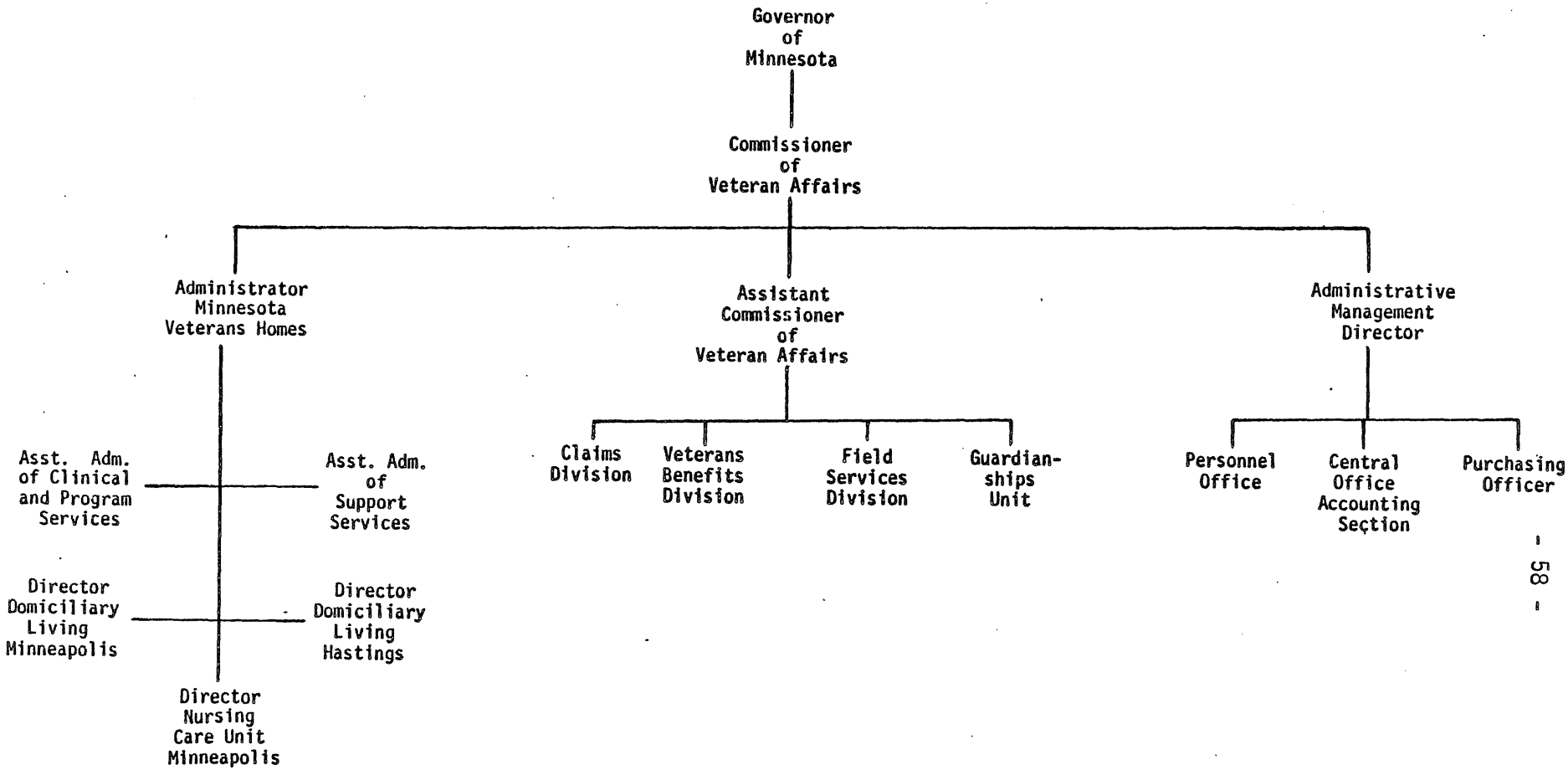


CHART TWO

Minnesota Veterans Home
Clinical and Program Services Division
Proposed Reorganization

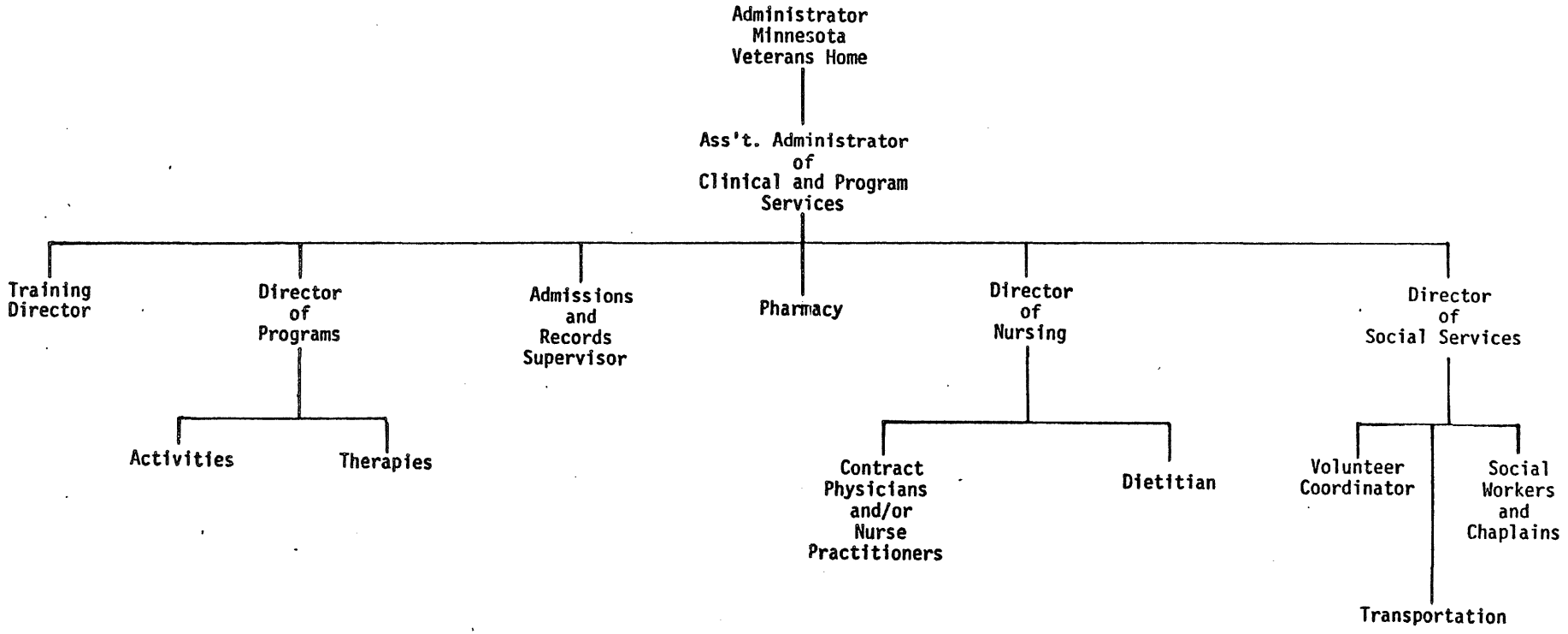
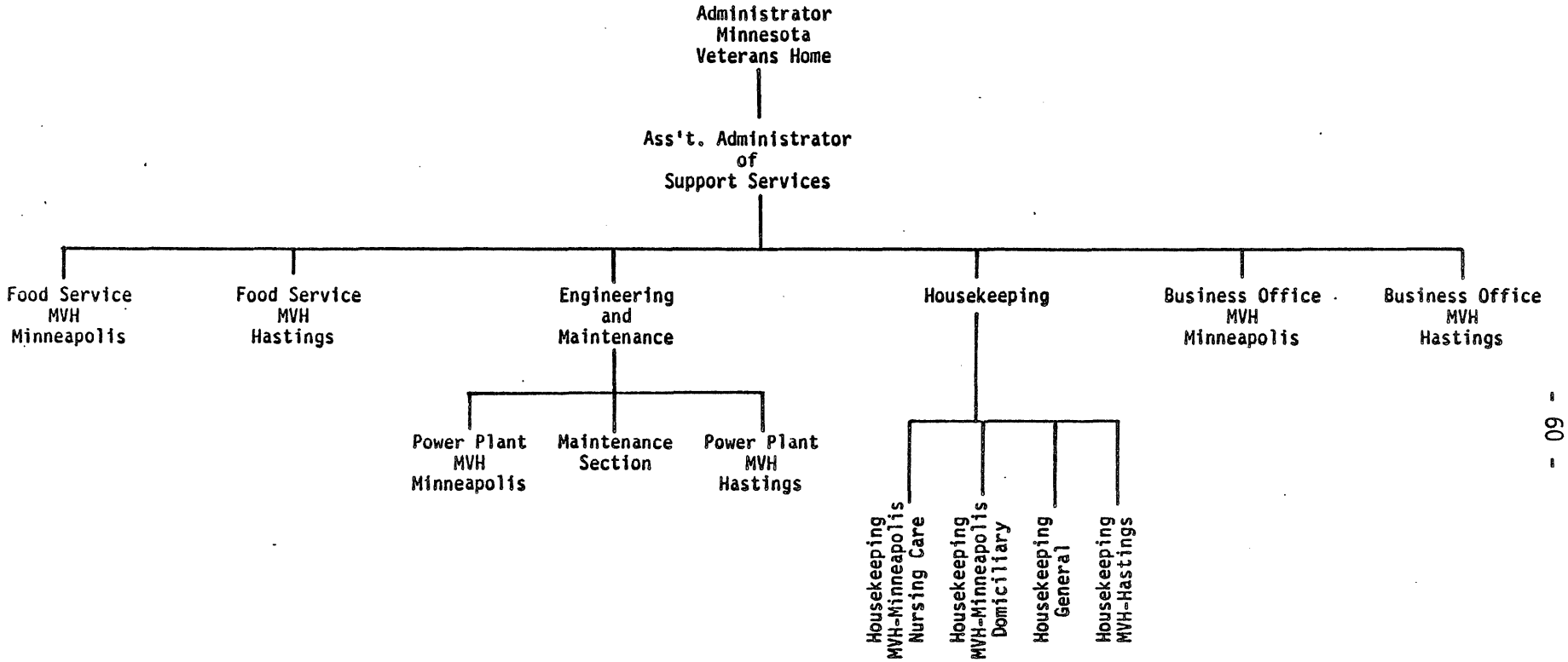


CHART THREE

Minnesota Veterans Home
Support Services Division
Proposed Reorganization



techniques with some training in health safety and first aid techniques. Further analysis indicated resistance by many staff and managers to following the prescribed training plan. A number of staff continue to attend and seek state reimbursement for courses not approved by the training director.

The Study Team recommends:

1. The training director initiate a result-oriented management training program (management by objectives), such as the one developed by the American Management Association.

2. The primary objectives of the training director be to:

   a. Develop a comprehensive staff assessment of training needs,
   b. Develop an appropriate curriculum for staff development, and
   c. Design a data collection system for the purpose of evaluation of both staff skills and staff development activities.

3. The department refuse to reimburse staff for any training not approved in advance by the training director.

The following content areas should be included in an overall staff development curriculum:

- General Orientation. This section should deal with the nature of the Homes' programs, their broad goals and objectives and philosophical basis, the characteristics of the residents, and finally, the administrative organization of the Homes and Department of Veterans Affairs.

- Individual Resident Assessment. This section should emphasize the need for an individual approach to the assessment of each resident served by the Minnesota Veterans Homes. Consideration must be given to the roles of various staff members in the assessment process. This section should also include training in the use of the Minnesota Health Department's Quality Assurance and Review Assessment Survey or a similar assessment instrument adopted by the Minnesota Veterans Homes.

- Individual Program Planning. Since the proposed organization of the Minnesota Veterans Homes emphasizes the development of individual programs by all staff members working with each resident, it is critical this area be emphasized in the training curriculum. The program planning format proposed by the Study Team is explained in Chapter 4.

- Basic Resident Care/Management Techniques. Current curricula should be reviewed, updated, and addressed to the training needs of the staff, as identified by the staff training needs assessment process.

- Health Safety and First Aid. Competence in this area is critical to insure the safety and proper care of residents. Specific content of this area should be developed in accordance with the standards established by the Minnesota Departments of Health and Public Safety.

- Manager Training. All managers should be trained in general supervisory techniques and decision-making and in specific fiscal, personnel, and other administrative responsibilities.

While the recommended content is seen as basic to a staff development program, it should not be construed as the total training needs. Other areas for training should be determined from the needs assessment, particularly for non-direct care staff.

An adequate staff development program designed for all existing and new employees, with specific curricular emphasis matched to job function,is a critical element for organizational change. It is the recommendation of the Study Team that special emphasis be given to in-service training for the supervisory and management staff. This matter is more critical if the proposed reorganization of the Minnesota Veterans Homes is adopted.

Recommendation Six: Top priority must be given to developing written policies and procedures for all of the Homes' operations. The policies and procedures must be compiled into a manual for use by all staff.

The current policies and procedures manual of the Minneapolis Home is a conglomeration of general policy statements approved by the Home's administrator, intra-Home memos, handwritten notes detailing work schedules and specific procedures, and xeroxed portions of policy and procedure manuals from other nursing homes. The manual does not cover all policy areas and procedures of the Home, is not sufficiently detailed to act as a guide to employees, and does not pinpoint staff responsibilities. Copies of the current complete Minneapolis "manual" are supposed to be found at 19 locations. Seventeen of these locations, however, did not have copies when interviews of supervisors were conducted in May.

It is obvious from our interviews with supervisory and

administrative staff that the current manual was put together hurriedly from various sources in order to meet minimum Minnesota Health Department standards during an annual licensing inspection. The Home had been cited in previous inspections for its failure to have written policies and procedures in the social services, activities, and corrective therapy departments.

Hastings has no policies and procedures manual currently. Establishment of written policies and procedures is a necessary condition of good administration. Written policies and procedures eliminate confusion on the part of staff who need guidance, establish rules of operating conduct, serve as guides for measuring performance, and promote uniformity, consistency, and integration of action throughout the organization.

It is recommended that:

- Top management of the department and Homes give priority to the development of relevant, well-written, up-to-date manuals for the two Homes.
- One person be assigned responsibility for coordinating development of the manual. That person should be trained to write policies and procedures. The University of Minnesota Continuing Education and Extension Department and other extension programs offer courses on the subject.
- The Homes request technical assistance in preparing the manuals from the Minnesota Department of Health.
- Managers be held responsible for drafting their units' policies and procedures, after being trained by the Homes' manual coordinator.
- Drafts be reviewed by top management for their acceptability, by the manual coordinator for their logic, format, and comprehensiveness, and by subordinate staff for their applicability, comprehensiveness, and readability.
- Managers' job performance reviews include assessment of their performances in developing policies and procedures.
- A new manual be completed by July 1, 1981, and a system of regular, periodic review and a formal procedure for revising the manual should then be implemented.

CHAPTER III

PERSONNEL MANAGEMENT

CHAPTER III FOCUSES ON PERSONNEL MANAGEMENT. IT INCLUDES A REVIEW OF THE PERSONNEL OFFICE; EMPLOYEE POSITION DESCRIPTIONS, PERFORMANCE REVIEWS, AND JOB CLASSIFICATIONS; EMPLOYEE SATISFACTION; SUPERVISORY SKILLS OF THE HOMES' MANAGERS AND SUPERVISORS; AND STAFF COMMUNICATIONS. THE CHAPTER ALSO INCLUDES AN ASSESSMENT OF THE NUMBER AND TYPE OF STAFF NEEDED AT THE HOMES.

THE RECOMMENDATIONS CONTAINED IN THIS CHAPTER ARE BASED ON THE ASSUMPTION THAT AS PUBLIC BODIES, THE MINNESOTA VETERANS HOMES HAVE AN OBLIGATION TO ASSURE THE PROPER AND EFFICIENT MANAGEMENT OF THEIR STAFFS.

DATA FOR THIS CHAPTER WERE COLLECTED THROUGH INTERVIEWS WITH DEPARTMENT AND HOME STAFF, OBSERVATION OF THE HOMES' OPERATIONS, AND ANALYSIS OF STAFF POSITION DESCRIPTIONS AND PERSONNEL OFFICE RECORDS. A DEPARTMENT OF EMPLOYEE RELATIONS SURVEY WAS USED TO ANALYZE EMPLOYEE SATISFACTION. STATE AND FEDERAL STAFFING GUIDELINES AND STANDARDS WERE REVIEWED.

PERSONNEL MANAGEMENT

Recommendation One: The Minnesota Veterans Homes must, as required by the Department of Employee Relations, develop valid position descriptions for all employees, implement an employee performance review system, and insure that all personnel are working in the job class to which they have been appointed.

Most employees do not have current position descriptions which accurately reflect their responsibilities and authorities, their freedom to act, and the amount of time spent on each responsibility. During the April-May interviews with supervisors, only 32 of the 183 employees supervised by these supervisors had current valid position descriptions. Since then there has been an effort by the Personnel Office and the supervisors to write position descriptions for all personnel, particularly for the nursing and janitorial staff.

According to the Personnel Office, half of the Homes' employees now have position descriptions - most written in the last six months. The Study Team has two concerns with the recently prepared position descriptions: they are not based on any long or short-range program and staffing plans for the various work units and the Homes as a whole, and there is a greater emphasis on tasks to be performed than on goals and objectives and measures of acceptable performance.

At the time of the supervisor interviews, fewer than five percent of all employees had received a formal employee performance review . Department of Employee Relations rules require that employees in the classified and unclassified service be evaluated and counseled on work performance at least once each year. Performance appraisals must be based on position descriptions and result oriented performance standards approved by the Commissioner of Employee Relationships. Standards are to be specific, measurable, and related to the quality and quantity of work performed. Anniversary date salary increases and achievement awards must be based on formal performance appraisals.

Since May, the Personnel Office and line supervisors have attempted to institute a formal employee performance system. Many of the reviews conducted, however, have not been based on currently valid position descriptions or specific measurable standards approved by the Commissioner of Employee Relations.

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Since May, the Personnel Office and line supervisors have attempted to institute a formal employee performance system. Many of the reviews conducted, however, have not been based on currently valid position descriptions or specific measurable standards approved by the Commissioner of Employee Relations.

Some staff are working in the wrong class, that is, performing duties of a class other than the one to which they were appointed.

The Minneapolis Home's volunteer coordinator, who also acts as the activities director for the Home's 350 domiciliary residents, is classified as a Human Services Specialist (starting monthly salary for the class is $966). On the other hand, the staff person who coordinates activities for the Home's 90 nursing care residents and has no connection with the volunteer program is classified as a Volunteer Services Coordinator (starting monthly salary for the class is $1,157). The Central Stores Clerk is classified as a Janitor rather than a Stores Clerk. A Registered Nurse I at Hastings supervises eight nursing staff, while a Registered Nurse III at Minneapolis supervises only four nursing staff.

The Personnel Office has begun to address this problem. It needs to assess all jobs as part of an overall personnel management and staffing plan and actively seek reclassification and reallocation of jobs in accordance with the plan.

Recommendation Two: The Department of Veterans Affairs should develop a personnel policy and procedures manual, train supervisors as to their responsibilities, and improve communication on personnel matters among all levels of staff. An additional Personnel Aide is needed.

The authority and responsibilities of the Personnel Officer, top management, and line supervisors are confused in the areas of recruitment, reclassifications, promotions, performance appraisals, and discipline of staff. Policies and procedures that clarify the authorities and responsibilities of various management and supervisory staff must be developed. Training must be provided supervisors in personnel management, employee relations, and employee development.

The Personnel Officer should report to the Administrative Management Director. The Personnel Office should be staffed with a Personnel Officer, a Personnel Aide for the Minneapolis campus, a part-time (.25 FTE) Personnel Aide for the Hastings campus, and a full-time Personnel Aide for the Central Office who would also assist the Personnel Officer in department-wide responsibilities.

Recommendation Three: The Homes should develop and implement a personnel management and staffing plan.

The Homes currently lack a personnel management and staffing plan. The plan should detail the work needed to be done in the Homes; the number, classification, and level of pay of staff needed to do the work; and the authorities and responsibilities of each staff member. Past budget and staff requests submitted to the Governor and Legislature have not been based on objective assessments of program needs of residents and work measures and, in some instances, do not even reflect licensing requirements.

Responsibility for development of the personnel management and staffing plan should be given to the Homes' administrators, with technical assistance and advice provided by the Personnel Officer. The creation, reclassification, and reallocation of positions and the appointment, compensation, and training of incumbents should be consistent with the plan.

One particular point that should be addressed in the plan is improvement of career ladders within the Homes. Most positions are classified at the bottom of a job series. There is little differentiation of job responsibilities and little opportunity for advancement. For example, the Human Services Technician ladder consists of four classifications ranging from Grades 53 to 61. All 25 current Human Service Technicians at Minneapolis are classified at the lowest level and all 28 vacancies are to be filled at that level. Personnel tend to be appointed only at the first step of a classification, regardless of experience, and salary increases and promotions are granted on the basis of incumbency rather than appraisals of performance.

Current staff are not used effectively and few part-time employees and volunteers have been recruited to augment the full-time staff. In Minneapolis, the Chief of Nursing, in particular, does not schedule staff to maximize coverage. For several months this spring and summer, the Home did not meet the minimum Health Department program standard of 2.0 hours of nursing care per patient per 24 hour day. This deficiency could have been avoided with better scheduling of nursing staff. Later this summer the Commissioner ordered the number of patients in the nursing care unit to be reduced as a solution for meeting the 2.0 standard. Again, better scheduling could have been a solution, without any negative impact on residents.

The Minneapolis Home has experienced particular difficulty recruiting nursing staff due partly to the shortage of nurses in the Twin Cities and the relatively low pay vis-a-vis the private sector. The Home, however, has not explored the use of part-time staff. The Chief of Nursing refuses to use part-time staff or to experiment with flexible hours in order to fill the 25 nursing and 28 Human Service Technician vacancies.

Volunteers are used in the Homes primarily to conduct evening and weekend activities - that is, to conduct bingo games, to put on short programs and the like. The Homes have not explored the use of volunteers in other areas such as nursing, transportation, and social services.

The Homes' administrators should instigate a major review of staff scheduling and the use of part-time staff and volunteers. Their findings should be included in the personnel management and staffing plan. Until scheduling problems are resolved, the administrators should review and approve all work schedules.

Recommendation Four: The Minnesota Veterans Homes must clarify delegations of authority to staff and improve formal lines of communication.

The process of delegation involves the determination of results expected, the assignment of tasks, the delegation of authority for accomplishing these tasks, and exaction of responsibility for their accomplishment. Delegation by results expected implies:

1. that goals have been set and plans made;
2. these are communicated and understood; and
3. jobs have been designed to fit them.

The Study Team found staff generally unsure of their authorities and responsibilities. In some cases, delegations are overlapping such as in the case of the Assistant Administrator and Assistant to the Administrator in Minneapolis. In other cases, delegations are ill-defined. Delegations tend to be inconsistent with results expected. Furthermore, superiors tend to interfere with the work of their subordinates, refusing to allow subordinates to use their authority, and subordinates tend to go to their bosses for every decision.

Responsibility for weak delegation lies with both top management and line supervisors, who should:

1. Define assignments and delegate authority in the light of results expected.
2. Include all delegations of authority in position descriptions.
3. Maintain open lines of communication.
4. Establish proper controls. Because no manager can relinquish responsibilities, delegation should be accomplished by techniques to make sure that the authority is properly used. But if controls are

not to interfere with the delegation, they must be relatively broad and designed to show deviations from plans rather than interfere with detailed actions of subordinates.

5. Reward effective delegation and successful assumption of authority.

A Department of Employee Relations' survey of department employees indicated dissatisfaction with meetings and communications. The Homes' communication problems stem largely from the infrequent use of formal channels of communication such as staff meetings, written policies and procedures, memos, and written directives and reports. Communication is almost exclusively oral either through formal superior-subordinate channels or through the Homes' well developed staff grapevines. Much information is consequently either lost or distorted in transmission and there is no record of the communication to which to refer back.

Horizontal communication in the Homes' i.e., between staff in different work units, is particularly weak. We recommend the increased use of written communication in the department and the instigation of more frequent staff meetings within work units and more frequent meetings of managers. We recommend weekly managers' meetings with the administrators and assistants. We do not recommend supplanting the informal communication network. The most effective communication results when managers use informal, oral channels to supplement formal channels.

Recommendation Five: The Minnesota Veterans Homes should develop and implement plans for resolving staff dissatisfaction and improving staff morale.

A Department of Employee Relations employee attitude survey and the Study Team's interviews with supervisors indicate staff morale at the two Homes is low. Minneapolis staff are dissatisfied with compensation, staffing, meetings, employee performance appraisals, training opportunities, job challenge and creativity, communications, and conflict management. Hastings staff are dissatisfied with meetings, compensation, staffing, and job advancement. There obviously are numberous causes and dimensions of the low morale, many of which we discuss elsewhere in this report.

One cause which we do not discuss elsewhere is the rather pervasive feeling among staff that they are unsure of the mission of the Homes and their role in it. In interviews, staff were found to be unsure whether the Homes are to serve younger veterans or older; whether the Homes are nursing homes, retirement homes, half-way houses for the

mentally ill or chemically dependent, or simply residences for veterans; whether the Homes are to provide treatment or just room and board; and whether the Homes are to serve all veterans or only the indigent.

The development of a mission statement and short and long-range plans for the Homes are first steps to removing staff confusion. Secondly, staff position descriptions and overall and individual resident program planning must be tied to the mission statement and long range plans.

Recommendation Six: The Homes' authorized complement is sufficient to operate 150 nursing and 490 domiciliary care beds. The current assignment of staff and staff positions within the Homes, however, must be adjusted to meet program requirements and licensing standards. Forty-five additional positions are needed to operate 250 nursing and 490 domiciliary care beds.

To determine the number and type of staff required by the Minnesota Veterans Homes, the Study Team has applied three sets of staffing standards:

1. Veterans Administration staffing guidelines for domiciliary care in State Veterans Homes. The guidelines are designed for self-standing domiciliary facilities. Because of the Homes' proximity to the Veterans Administration Medical Centers in Minneapolis and St. Cloud and because some staff can be shared by the two Homes, the Study Team has modified the standards slightly.
2. Nursing Care Standards of the Minnesota Department of Health.
3. Nursing Care Staffing Standards adopted by the State of Ohio. These standards are based on detailed, tested time and motion studies of nursing facilities in California, Oregon, and Ohio and have been used by the State of Ohio and others to meet standards of the Joint Commission on Accreditation of Hospitals.

Appendix H is a discussion of the three sets of staffing standards. The Minnesota Veterans Homes currently have an authoritized complement of 247.5 staff: 58 at Hastings and 189.5 at Minneapolis. As of October 16, 1980, there were 53 vacancies at Minneapolis: the Administrator position and 52 nursing positions which are to be filled as residents move into the new nursing facility. There were six vacancies at Hastings.

Table 6 compares current and proposed staffing patterns. The Study Team's recommendations are based on a general analysis of resident needs as identified by the Quality Assurance and Review Team's survey of residents and on the assumption that funding for additional staff is limited in the near future. According to an analysis by the Study Team and the Minnesota Health Department, the Homes' currently have approximately 500 domiciliary and 120 identified nursing care residents. The Study Team has opted to project the staffing needs for the Homes' current population.

The department's current assignment of staff positions reflects its plan to provide only minimal services to 490 domiciliary residents and the provision of intermediate nursing services (ICF-I) to 250 nursing residents. Under the department's plan the Veterans Homes could not meet both VA do miciliary care guidelines for 490 residents and Minnesota Health Department standards for 250 nursing care residents. If the Homes are to meet VA domiciliary guidelines and MHD nursing standards, the present authorized complement is only sufficient to staff 150 nursing and 490 domiciliary beds. An additional 45 personnel would be needed to staff another 100 nursing beds. The only other options available to the Homes are:

1. to reduce medical services and not offer rehabilitative services to domiciliary residents and, thereby, not meet VA care guidelines, or
2. to reduce the number of domiciliary residents.

Under the Study Team's "150/490" plan, administrative staff would be reduced by 2 from current complement; support staff would be reduced by 13.5; clinical and program staff would be increased by 34.5; and residential living staff would be reduced by 19. The Study Team's shift of 19 staff from the residential living unit to clinical and program services provides the staff necessary for the provision of program services in accordance with VA domiciliary guidelines and leaves sufficient staff to meet MHD nursing standards for 150 residents.

Under the Study Team's "250/490" plan, administrative staff would also be reduced by 2 from current complement; support staff would be reduced by 8.5; clinical and program staff would be increased by 40.5; and residential living staff would be increased by 15. Of the 45 additional positions needed to move from the "150/490" to the "250/490" plan, five are support staff, six are clinical and program staff, and thirty-four are nursing staff.

Table 7 is a recommended detailed staffing pattern for 150 nursing and 290 domiciliary beds in Minneapolis and 200 domiciliary beds in Hastings. Table 8 is a recommended

Table 6

COMPARISON OF CURRENT AND PROPOSED STAFFING PATTERNS
MINNESOTA VETERANS HOMES

	Current[1] Staff	Current[1] Authorized Complement	Plan A "150/490" Plan	Plan B "250/490" Plan
Administration Staff	3	4	2	2
Support Services Staff	112.5	115.5	102	107
Administrative	4	4	2	2
Business Office/ Personnel	11	12	8	8
Housekeeping	18.5	18.5	22	25
Engineering	17	17	15	15
Maintenance	24	24	20	20
Food Service	38	40	35	37
Clinical and Program Services Staff	18	20	54.5	60.5
Supervisory/Clerical	0	0	10	10
Therapies	3	3	7	10.5
Activities	4	4	10	10
Social Services	4	6	20	22
Pharmacy	4	4	3.5	4
Records and Admissions	3	3	4	4
Residential Living Unit Staff	55	108	89	123
Domiciliary Units	13	13	31	31
Nursing Unit	42	95	58	92
Total Staff	188.5	247.5	247.5	292.5

[1] Position Control System - Complement Summary Dated 10/16/80

Table 7

STAFFING PATTERN MINNESOTA VETERANS HOMES
150 Nursing Care Beds/490 Domiciliary Care Beds

	Total
Administration	2
Administrator	
Clerk-typist	
Clinical and Program Services	54.5
Assistant Administrator	
Clerk-typists (5)	
Training Director	
Program Director	
Activities Staff (10)	
Therapists or Therapy Assistants (7)	
Medical Records Technicians (2)	
Reimbursement Officer	
Social Work Aide	
Registered Pharmacists (2)	
Pharmacy Technicians (1.5)	
Nursing Director	
Dietitian	
Social Workers (10)	
Chaplains (2)	
Volunteer Coordinator	
Human Service Technicians (2)	
Drivers (5)	
Domiciliary Care Unit - Minneapolis (290 Beds)	17
Group Supervisor	
Clerk-typist	
Hospital Service Assistants (7)	
LPNs or Human Service Technicians (6)	
Registered Nurses (2)	
Domiciliary Care Unit - Hastings (200 Beds)	14
Group Supervisor	
Clerk-typist	
Hospital Service Assistants (5)	
LPNs or Human Service Technicians (4)	
Registered Nurses (3)	
Nursing Care Unit (150 Beds)	58
Registered Nurse IV	
Clerk-typist	
Charge Nurses (Registered Nurses) (3)	
Hospital Service Assistants (3)	
LPNs or Human Service Technicians (45)	
Shift Nurses (Registered Nurses) (5)	
Support Services	102
Assistant Administrator	
Clerk-typist	
Account Supervisor	
Senior Account Clerk	
Cashiers (2)	
Account Clerks (3)	
Stores Clerk	
Executive Housekeeper	
Senior Janitors (4)	
Janitors (17)	
Physical Plant Director	
Stationary Engineer Supervisor	
Chief Power Plant Engineer	
Stationary Engineers (10)	
Plant Maintenance Engineers (2)	
General Maintenenace Worker V	
General Maintenance Workers (12)	
Carpenter Foreman	
Carpenter	
Plumbers (2)	
Painters (2)	
Electrician	
Chief Cooks (2)	
Cook Supervisors (3)	
Baker	
Cooks (8)	
Dining Hall Supervisors (4)	
Food Service Workers (17)	
	247.5

Table 8

STAFFING PATTERN MINNESOTA VETERANS HOMES
250 Nursing Care Beds/490 Domiciliary Care Beds

	Total
Administration	2
Administrator	
Clerk-typist	
Clinical and Program Services	60.5
Assistant Administrator	
Clerk-typists (5)	
Training Director	
Program Director	
Activities Staff (10)	
Therapists or Therapy Assistants (10.5)	
Medical Records Technicians (2)	
Reimbursement Officer	
Social Work Aide	
Registered Pharmacists (2)	
Pharmacy Technicians (2)	
Nursing Director	
Dietitian	
Social Workers (12)	
Chaplains (2)	
Volunteer Coordinator	
Human Service Technicians (2)	
Drivers (5)	
Domiciliary Care Unit - Minneapolis (290 Beds)	17
Group Supervisor	
Clerk-typist	
Hospital Service Assistants (7)	
LPNs or Human Service Technicians (6)	
Registered Nurses (2)	
Domiciliary Care Unit - Hastings (200 Beds)	14
Group Supervisor	
Clerk-typist	
Human Service Assistants (5)	
LPNs or Human Service Technicians (4)	
Registered Nurses (3)	
Nursing Care Unit (250 Beds)	92
Registered Nurse IV	
Clerk-typist	
Charge Nurses (Registered Nurses) (5)	
Hospital Service Assistants (5)	
LPNs or Human Service Technicians (75)	
Shift Nurses (Registered Nurses) (5)	
Support Services	107
Assistant Administrator	
Clerk-typist	
Account Supervisor	
Senior Account Clerk	
Cashiers (2)	
Account Clerks (3)	
Stores Clerk	
Executive Housekeeper	
Senior Janitors (4)	
Janitors (20)	
Physical Plant Director	
Stationary Engineer Supervisor	
Chief Power Plant Engineer	
Stationary Engineers (10)	
Plant Maintenance Engineers (2)	
General Maintenance Worker V	
General Maintenance Workers (12)	
Carpenter Foreman	
Carpenter	
Plumbers (2)	
Painters (2)	
Electrician	
Chief Cooks (2)	
Cook Supervisors (3)	
Baker	
Cooks (8)	
Dining Hall Supervisors (4)	
Food Service Workers (19)	
	292.5

detailed staffing pattern for 250 nursing and 290 domiciliary beds in Minneapolis and 200 domiciliary beds in Hastings. The staffing pattern outlined in Table 7 is that which the Study Team believes necessary to begin operation of the new 250 bed nursing facility. The staffing pattern outlined in Table 8 is that which the Team considers necessary to operate the nursing facility at full capacity.

CHAPTER IV

PROGRAM MANAGEMENT

CHAPTER IV CONTAINS STUDY FINDINGS AND RECOMMENDATIONS UNDER THE GENERAL HEADING OF PROGRAM MANAGEMENT. IT INCLUDES AN ASSESSMENT OF THE QUALITY OF CARE PROVIDED RESIDENTS. IT ASSESSES ADMISSION AND DISCHARGE POLICIES; PROGRAM PLANNING, COORDINATION, AND EVALUATION; HOW RESIDENT NEEDS ARE DETERMINED; AND THE QUALITY OF THE MEDICAL RECORDS. THE CHAPTER ALSO INCLUDES A REVIEW OF THE RESIDENT WORKER PROGRAM AND THE HOMES' ADHERENCE TO THE STATE PATIENT BILL OF RIGHTS.

RECOMMENDATIONS REST ON THE ASSUMPTION THAT THE PRIMARY GOAL OF THE MINNESOTA VETERANS HOMES IS TO INCREASE THE SELF SUFFICIENCY OF RESIDENTS THROUGH CARE AND TREATMENT.

RECOMMENDATIONS ARE BASED ON THE FINDINGS OF THE MINNESOTA HEALTH DEPARTMENT'S QUALITY ASSURANCE AND REVIEW TEAM. ADDITIONAL DATA WERE COLLECTED THROUGH IN-DEPTH INTERVIEWS WITH RESIDENTS, INTERVIEWS WITH HOME STAFF, AND OBSERVATION OF HOME OPERATIONS.

PROGRAM RECOMMENDATIONS

The Study Team believes the primary goal of the Minnesota Veterans Home should be to increase self sufficiency capabilities of each resident. This belief is reflected in the Homes' Mission Statement which says:

> "...the care provided will ensure each member is provided a sheltered environment and an individualized program within which he or she can function or be assisted to function at their highest level of physical, social and mental abilities."

For residents who are provided domiciliary care, this may imply developing and providing programs which relate to educational and vocational skills as well as personal growth. Success measures of this effort should be evaluated by criteria linked to measureable objectives in program plans set for individual residents. One global success measure for domiciliary residents is the number of residents who are able to assume successful community living roles with the support of community-based services.

Nursing care residents will require different programs concentrating on maintaining and improving self-care and mobility skills - both of which are necessary for maintaining independence.

The program recommendatins included in this chapter are based on the Study Team's interviews with residents (summarized as Appendix I), the Minnesota Health Department's Quality Assurance and Review Teams' survey of Minneapolis residents (see Appendix J), and an analysis of admission and discharge records. The program recommendations are consistent with widely accepted models of health care delivery.

It must be strongly emphasized that various facets of the total program recommended for the Homes cannot be isolated or segregated because each of the programs is related to the whole. The actual program established by the Homes will be dynamic and dependent upon the assessment of individual resident needs.

The term "program" is used to described a planned sequence of events which leads to a purposeful outcome for the individual.

- "A planned sequence of events..." requires program planning. The events are a specified amount of staff activity with residents in a given place as indicated by a program plan.

- "That leads to a purposeful outcome..." requires the establishment of behavioral objectives in program planning.

- "...for the individual" requires that the programs be individualized.

An Interdisciplinary Team (IT) is a group of staff, professional and para-professional, responsible for the development, implementation, and evaluation of an individual resident's program plan.

Recommendation One: In addition to providing residential living services, the Homes should provide full-time structured clinical and program services for all residents.

Residential living services include programs which are provided where the person lives (the living unit, room) by staff who are assigned to work there. This program component should be employed universally throughout the nursing care units. While not as heavily staffed, this program component should also be provided in the domiciliary units. Specific responsibilities of the residential living service staff are:

- To participate with the team in individualized assessment, program planning, and evaluation. This is accomplished by attendance at quarterly Interdisciplinary Team meetings.

- To coordinate each resident's program by assuring the resident receives structured services as prescribed by the individualized program plan. This is accomplished, for example, by insuring residents meet medical appointments, etc.

- To assure that each resident's physical maintenance is adequate. This is accomplished by seeing that each resident receives enough to eat and drink, is reasonably clean, appropriately dressed, and takes medications, if required.

- In addition to physical maintenance, to provide dependency reduction programs (i.e. training) in areas of basic self-care skills, such as eating, dressing, and self-medication. In the residence, this training is more likely to take the form of "participatory" maintenance (staff and residents working together) rather than structured training sessions.

- To provide each resident an opportunity to experience

a sense of belonging, identity and personal worth. This is accomplished by a genuine understanding and acceptance of each resident in an atmosphere of mutual respect and by providing opportunity for physical and psychological privacy and the security of possessions.

- With the residents, to have leisure time activities which are enjoyable for all and constructive from the standpoint of resident self-actualization and fulfillment.

Full-time structured clinical and program services refer to program services provided in settings outside of residential units. The services are provided by professional or para-professional activities staff, social workers, therapists, and their assistants. All decisions on program development and provision at the Homes should be based on individual assessments of resident needs.

Recommendation Two: Admission and discharge procedures and policies must be developed and implemented immediately.

The Study Team's review of documentation, records, policies, and procedures yielded little clear information on admission and discharge procedures. Extensive interviews with staff revealed considerable confusion regarding admission criteria and reasons for discharge. Admissions often do not occur systematically or according to any established procedures. Many decisions for admission are made on a unilateral basis and often without adequate medical/social data. Discharge from the facility occurs similarly - that is, non-systematially and without a criterion reference base, despite the fact 183 people were discharged over the last five years.

Several additional recommendations regarding admission and discharge emerge from these findings.

1. A specific set of criteria must be developed against which all applications are measured. The criteria must describe conditions that reflect needs capable of being met by the Minnesota Veterans Homes.
2. A procedure for reviewing admissions must be developed to include a/an:
   - specific definition of the role and responsibility of the admissions committee.
   - procedure for notifying all applicants in writing of the committee's decision in a timely fashion.

- appeal process where the Veterans Advisory Council is named responsible for hearing appeals.
- procedure for maintaining a waiting list that is regularly reviewed and used to fill vacancies.

3. The Admissions Committee should be comprised of staff representing multiple disciplines and be chaired by the Administrator. Representatives from both residential living and clinical and program services must be included.

4. Policies and procedures must be developed that specify criteria for discharging residents. Procedures must specify:

   - development of a discharge plan for every resident prior to discharge.
   - criteria for voluntary discharge of residents admitted for rehabilitation or for short term stays.
   - criteria for involuntary (disciplinary) discharges.
   - an appeal process where the Veterans Advisory Council is named responsible for hearing appeals.

Recommendation Three: The role of patient care meetings in overall program planning at the Homes should be redefined. Patient care meetings should be attended by all managerial staff responsible for resident care. The primary purposes of the meetings should be to adopt individual resident care plans prepared by the interdisciplinary teams, to systematically review changes, problems, and exceptions in the plans, and to review progress of residents before discharge. The meetings must be conducted according to procedures used in most community health care facilities.

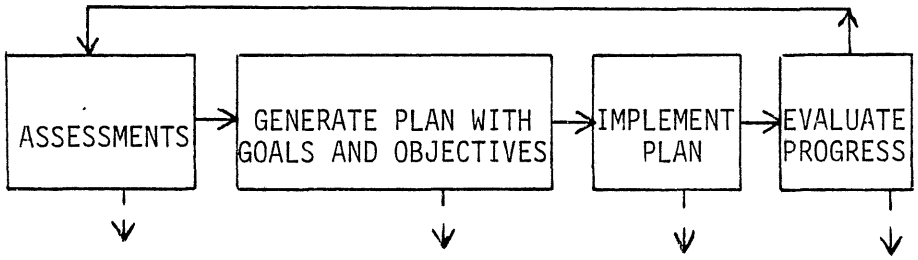
Program planning through the interdisciplinary process is accepted methodology in community health care facilities. While patient care meetings are conducted bi-weekly at Minneapolis and weekly at Hastings, no set procedure is used to conduct business. Decisions are often made without substantiating data, and there is no systematic procedure for reviewing resident progress or problems. When program

decisions are made without a system, there is often failure or inability to communicate changes in the program to staff responsible for implementing the changes. Success for residents is best enhanced when all efforts are clearly defined.

Recommendation Four: The Minnesota Veterans Homes should conduct a formal annual review of each resident's program plan and conduct at least quarterly formal planning sessions for possible revisions.

In accordance with Veterans Administration regulations, an annual assessment of needs and skills should be made of each resident. Using the results of the assessment, the interdisciplinary team develops a plan that specifies necessary objectives for meeting needs and increasing independent living skills. This basic plan is then followed by all staff working with the resident. The Team, consisting of staff from nursing, social work, therapies and resident living staff, meets quarterly for progress review meetings. For residents in the domiciliary units, progress toward possible discharge is carefully reviewed.

The process occurs as diagramed below:



Conducted by therapies (OT, PT, etc.) social workers (behavioral skills).	Developed by team with therapists, medical staff social worker, resident living staff, etc.	Implemented by all staff working with residents.	Quarterly by team

Recommendation Five: The Minnesota Veterans Homes should adopt the American Medical records Association standards for record-keeping.

The Study Team recommends the Homes immediately revise their recordkeeping systems. Resident records must be maintained that accurately reflect needs, service plans, histories, etc. Present health care information recording is outdated and lacks uniformity. This was particularly

evident in patient diagnosis.

It is further recommended that staff work with the Minnesota Department of Health's technical assistance unit to insure thoroughness, reliability, and validity of records. Attention should also be paid to standards relating to the storage and retrieval of resident records.

Recommendation Six: The Minnesota Veterans Homes should contract with physicians who have an expertise in psychiatry and geriatric care to evaluate existing diagnoses and change them as necessary to reflect current accepted practice.

The Minnesota Health Department identified disparities in diagnosis and subsequent treatment. For example, the Minnesota Health Department, in reviewing existing records, found the current physician has diagnosed 87% of the residents at Minneapolis as having some mental disorder. Despite this fact, only 1.3% of the residents receive psychotherapeutic medications. Of more concern is the fact only .01% receive any type of therapeutic service. Re-diagnosis in this instance can succeed in doing one of two things: either document that current diagnoses are inaccurate and drug use and therapeutic services are being used appropriately, or that the diagnoses are accurate, but drugs and therapeutics services are not being used appropriately.

The Minnesota Health Department did not review the medical records of the Hastings residents. Because Hastings shared Minneapolis' contract physician until July, 1980, many of the program problems found at Minneapolis by the Health Department are probably also present at Hastings. The Study Team's interviews with Hastings staff and residents support this contention. Consequently, we believe that this recommendation and the subsequent two recommendations on assessment of resident needs apply to both Homes.

Recommendation Seven: Following the review of existing diagnoses, the Homes should fully and accurately assess the medical needs of all residents. The assessment should utilize resources at the Veterans Administration Medical Centers, Hennepin County Medical Center, and other medical specialists as needed.

According to the Minnesota Health Department, 32% of Minneapolis residents are currently in need of a medical assessment. Based on this significant percentage and on

the problems identified in Recommendation Six above, the Study Team strongly recommends a complete medical and pharmaceutical review of all residents.

Recommendation Eight: In addition to conducting a complete medical assessment, assessments must be conducted for occupational therapy, physical therapy, corrective therapy, social services, and personal interests.

The Minnesota Health Department in its review of resident records in Minneapolis, found that social histories were not present for the majority of residents, activity and/or interest assessments had not been done, and goals could not be identified or resident progress ascertained in the corrective therapy records. Overall, the Minnesota Health Department found "a lack of assessments in all areas and a need for individualized plans of care based on individual needs. It appears that no one is coordinating the services that are being provided."

Until assessments are conducted, it is impossible to determine what programs should be established to meet resident needs.

Recommendation Nine: The Minnesota Veterans Homes must develop a drug management and monitoring program.

The Minnesota Health Department found that while the Homes' pharmacy maintains a drug profile on each resident, no staff person appears to be monitoring and periodically reviewing medications for the majority of residents who are self-medicating. Two-thirds of all residents taking drugs are self-medicators.

Recommendation Ten: The Homes should contract with a dermatologist to provide and maintain a skin care program which includes an educational program to make all residents aware of basic dermatological hygiene.

The Minnesota Health Department identified 55% of the nursing care residents requiring some type of special skin care. Once educational programs have been developed and implemented, routine evaluation by residential living staff will insure adequate maintenance.

Recommendation Eleven: Prior to developing their own rehabilitative and restorative programs, the Homes must explore the use of programs that already exist in the community to serve the identified needs of residents.

For example, 33% of Minneapolis residents are identified as acute or chronic alcoholics or as chemically dependent or chemically abusive. The Minneapolis Home should seek the cooperation of Hennepin County in the use of existing county chemical dependency programs. The Hastings Home is in an ideal position to use Dakota County's chemical dependency programs because the county's detox center is located on the Hastings campus.

The Homes do not actively use the resources of the Hennepin and Dakota County Mental Health Centers, the Veterans Resource Center, the University of Minnesota, and the Veterans Administration Medical Centers and outpatient clinics. The Study Team's discussions with staff of these organizations indicated a willingness to develop cooperative programs and better relations with the Veterans Homes. The use of existing community programs would improve the care of residents by involving them in activities outside the institution and would reduce the need for specialized clinical and program staff at the Homes.

Recommendation Twelve: The Minnesota Veterans Homes should operate their resident work programs in accordance with both federal and state minimum wage laws. The programs should be designed to meet the needs of a broad range of residents and should be funded on a permanent basis.

The current resident work program pays $1.10 per hour. According to information available to the Study Team, this rate, which was established several years ago, is in violation of federal minimum wage laws because no current waiver has been granted. This program is also in violation of state minimum wage laws for which no waiver is available.

The Study Team suggests the Homes explore all available alternatives for using residents, utilizing the expertise which exists in the State's work activities program committee. Further, the Homes need to request specific funding in their budget for a resident work program.

Recommendation Thirteen: The Minnesota Veterans Homes must adhere strictly to the state patient bill of rights (Minn. Statutes 144.651) and Veterans Administration regulations concerning resident councils.

Veterans Administration domiciliary care regulations require the establishment of an elected resident council which regularly communicates with management concerning resident needs and concerns. Veterans Administration nursing care regulations require that residents be permitted to voice grievances and recommend changes in policies and services to staff or outside representatives, with impunity. State law requires all nursing and board and care homes to adhere to the State's patient bill of rights.

The Homes currently have elected resident councils which meet at least monthly. Residents at Minneapolis, in interviews with the Study Team, indicated that they felt the Minneapolis council was dominated by staff and that the management of the Home and department has refused to respond meaningfully to concerns voiced by the council. Furthermore, a number of residents told the Study Team that they feared discharge from the Home if they criticized the Home's staff or management.

To insure the protection of individuals, the Homes must strictly adhere to the state's patient bill of rights, must assure the autonomy of the resident councils, and must guarantee through written policies that residents cannot be discharged for voicing grievances and recommending changes in services and policies.

CHAPTER V

FUTURE DEVELOPMENT

CHAPTER V CONTAINS FINDINGS AND RECOMMENDATIONS ON FUTURE DEVELOPMENT OF THE HOMES. IT INCLUDES AN ANALYSIS OF THE NUMBER OF NURSING AND BOARD AND CARE BEDS NEEDED BY ALL THE STATE'S VETERANS OVER THE NEXT TWENTY YEARS AND AN ASSESSMENT OF THE NUMBER OF BEDS THAT SHOULD BE PROVIDED AT THE MINNESOTA VETERANS HOMES.

DATA FOR THIS CHAPTER WERE COLLECTED FROM RESIDENT AND HOME RECORDS AND THROUGH INTERVIEWS WITH DEPARTMENT AND HOME STAFF. ANALYSIS WAS ALSO BASED ON DATA SUPPLIED BY THE U. S. VETERANS ADMINISTRATION, THE MINNESOTA DEPARTMENT OF HEALTH, THE MINNESOTA BOARD ON AGING, THE OFFICE OF THE STATE DEMOGRAPHER, AND THE U. S. BUREAU OF THE CENSUS.

FUTURE DEVELOPMENT

Recommendation One: The Minnesota Veterans Homes should continue to serve all age groups and to provide both nursing and domiciliary care. In fiscal year 1981 the Homes' licensed capacity should be 150 nursing and 490 board and care beds. In fiscal year 1982 or fiscal year 1983, depending upon the establishment of need and the availability of state funds, the Homes' capacity should be increased to 250 nursing and 490 board and care beds.

Recommendation Two: The Department of Veterans Affairs should develop by January 1, 1983 a detailed long-range plan for meeting the health care needs of the state's veterans through the year 2000. Until the plan has been approved by the Governor and Legislature, the Homes' capacity should remain at 250 nursing and 490 board and care beds. In the plan the department should seriously investigate such alternatives as subsidizing veteran care in private community facilities rather than adding beds at the current Homes or opening new state facilities.

The Minnesota Veterans Homes have a threefold mission: to provide nursing care to eligible veterans and dependents, board and care to eligible veterans and dependents not capable of independent living, and rehabilitative and restorative programs to enable as many of the Homes' residents as possible to return to the community. Under this mission, the Homes' should serve all age groups.

The balance between the three missions should be based on an assessment of the needs of Minnesota's veterans and consideration of all resources in the state available to meet those needs. Existing data indicate that the demand for nursing and board and care beds by veterans will not become critical until the late 1980's or early 1990's. The state, therefore, has at least three to five years before it must decide whether or not to expand the bed capacity of the Department of Veterans Affairs' nursing and domiciliary care programs.

Currently, the Minneapolis campus is licensed to have 181 nursing and 398 board and care (domiciliary) beds, and the Hastings campus is licensed to have 200 board and care beds. With the completion of the new nursing facility in Minneapolis, the licensed bed capacity will be 250 nursing and 290 board and care beds on the Minneapolis campus. At present, only 90 of the nursing beds are set up and staffed, and the combined occupancy rate of board and care beds set up and staffed is 69%. Currently the Homes serve one half of one percent of all veterans aged 65 and over and 300 of the state's estimated 511,000 veterans under age 65 (6 per 10,000 veterans aged 65 and under). At current capacity and occupancy rates, the Homes provide about ten percent of all the beds needed by elderly veterans.

As detailed in previous chapters, the Minnesota Veterans Homes have serious administrative problems and do not meet Minnesota Health Department standards and Veterans Administration guidelines for nursing and domiciliary care. Until management of the Homes is improved, imbalances in staffing are adjusted, standards met, and present programs improved and expanded to meet the needs of current residents, the Study Team cannot recommend any growth in Homes' bed capacity except that required to meet the needs of the 121 current residents identified as needing nursing care. At the latest, this should be accomplished by December 31, 1981. Once the Homes have met standards and the needs of current residents, the Study Team recommends expanding the capacity to 250 nursing and 490 board and care beds. Expansion, however, would require an additional 45 staff.

Expansion beyond the 250/490 level should be requested and approved only on the basis of a detailed assessment of the needs of all veterans and the type of analysis provided in the balance of this chapter. Using updated 1970 census data and Minnesota Health Department statistics, the Study Team has concluded that expansion of State-owned nursing and board and care beds for veterans is not justified either on the basis of cost or the program needs of the state's veterans. A similar analysis using 1980 census data is essential in order to assess the needs of Minnesota veterans and to develop a plan to meet them during the next twenty years.

The department should consider community alternatives. Such alternatives might include subsidizing placement of veterans in community facilities (that is, in community-based non state-owned facilities) and supporting independent living programs. Community facilities provide veterans with a wider range of medical and program services and allow veterans to remain in their own communities near family and friends. Independent living programs like Meals on Wheels, home chore services, and home nursing programs allow veterans to remain in their homes, forestalling institutional care.

In addition, our analysis shows that the primary users of

nursing and board and care beds in the state are and will continue to be, women over age 75. While the number of beds needed by veterans will increase through the year 2000, at no time will veterans constitute more than 17% of all Minnesotans who need nursing and board and care. The State should not invest in buildings which would be left vacant once the demand for beds by the large World War II veteran population decreases after the year 2000. Community beds no longer needed for veterans can be shifted to other individuals, such as elderly women, whose need for beds will continue to increase. State-owned facilities, built with Veterans Administration matching funds, cannot be shifted for 20 years after construction is completed without the State being liable for fiscal penalties.

Assumptions

In order to project the number of nursing and board and care beds required by Minnesota veterans between now and the year 2000, we must consider the number of veterans in the state, their ages and life expentancies, the proportion that will require nursing and board and care, the number of all Minnesotans that will require such care, and the current number of nursing and board and care beds in the state.

Specific demographic and health statistics of Minnesota veterans do not exist as such. Thus, we have necessarily extrapolated statistics from national data compiled by the U.S. Veterans Administration and the Bureau of the Census and from statewide data on all citizens collected by the State Planning Agency, the Minnesota Department of Health, and the Minnesota Board on Aging.

Certain assumptions are necessary in order to develop the projections:

1. The currently legislated eligibility for state and federal veterans benefits will continue.
2. The hospital, medical care, and State Home programs of the U.S. Veterans Administration will continue in their present form. While some type of national health insurance may be enacted, it is not possible to predict its form or impact on the Veterans Administration health care system. These projections are based on a continuation of the present mechanisms of health care financing by the Veterans Administration, the U.S. Department of Health and Human Services, and the State of Minnesota.
3. There will be no technological developments which will significantly prolong life and reduce the incidence of chronic diseases between now and 2000. Even if such technological developments were to be made, it is improbable that they would affect an already aged population within the projected period.
4. There will be no major wars.

5. The socio-economic characteristics of veterans who will apply for long-term care services from the Minnesota Department of Veterans Affairs will not change significantly.

6. The veteran population for the projected period is essentially male. Of the 18.1 million veterans of World War II and the Korean War, only 373,000 (2.1%) were female. Our projections, therefore, will concentrate on the statistics of male veterans. The specific needs of female veterans, however, will be included in the final projections.

7. The availability of community-wide facilities and services, that is to say, those available to both veterans and non-veterans, must be included when determining the total resources available to Minnesota's veteran population.

It is extraordinarily difficult to estimate the number of nursing and board and care beds required by veterans under age 65. Presently the Minnesota Veterans Homes serve one-twentieth of one percent of all veterans in this age group. If that use rate continues through the period, the number of beds needed at the Homes for veterans under 65 will decrease from 300 in 1980 to 225 in 2000. We do not know, however, how many veterans under 65 will be in Veterans Administration hospitals, other state institutions, and community nursing, board and care, and various other treatment and rehabilitation programs. Furthermore, the data on peace-time veterans under age 65 is very sketchy: the Veterans Administration collects extensive data only on war-time veterans since few peace-time veterans are eligible for V.A. health care benefits, and the number of post-Vietnam veterans is constantly expanding.

For these reasons, the following analysis concentrates on projecting the needs of elderly war-time veterans, the heaviest users of medical and related services. It should be noted that between 1980 and 2000, elderly peace-time veterans will constitute less than 1% of all elderly veterans. Where data on peace-time veterans is available, it has been included in the analysis.

Characteristics of Minnesota's Senior Population

According to the state demographer, Minnesota's senior population (that is those 65 years and older) will increase from 445,900 in 1980 to 510,300 in 1995 and then decline to 506,400 in 2000. There are three significant trends projected:

- The rate of growth of Minnesota's senior population will slow. From 1940 to 1975 the state's elderly population grew rapidly and constantly, increasing 108% while total state population grew 41%. It is projected that the elderly population will increase only 15% between 1975 and 1995 and then decline slightly by 2000.

- The ratio of elderly females to elderly males will continue to increase. In 1940 there were 110 elderly males to every 100 elderly females. The Minnesota Department of Health estimates that in 1980 there are 71 elderly men to every 100 elderly women and that in 2000 there will be only 67 elderly men to every 100 elderly women.

- The proportion of senior citizens who are 75 and over and especially the proportion who are 85 and over will continue to increase. Between 1940 and 1980, the proportion of the elderly who were between 75 and 84 years old is estimated to have increased from 28.4% to 32.6%. In the same period, the proportion of the elderly who were 85 and over has increased from 4.3% to 8.6%. By the year 2000, 75 to 84 year olds should constitute 35.7% of the elderly population and those 85 and over should constitute 9.4%.

TABLE 9

ESTIMATED AGE AND SEX BREAKDOWNS FOR
MINNESOTA'S SENIOR POPULATION
1980 TO 2000

	1980	1985	1990	1995	2000
Males					
65-74	119,270	124,415	127,866	127,631	122,131
75-84	57,156	59,460	63,114	65,754	67,551
85 and Over	13,073	12,798	12,649	13.578	14,329
	189,499	196,673	203,629	206,963	204,011
Females					
65-74	149,029	158,447	163,409	162,330	156,028
75-84	91,447	96,588	103,371	109,855	113,088
85 and Over	25,922	28,029	29,029	31,115	33,257
	266,398	283,064	295,809	303,300	302,373
Total					
65-74	268,299	282,862	291,275	289,961	278,159
75-84	148,603	156,048	166,485	175,609	180,639
85 and Over	38,995	40,827	41,678	44,693	47,586
	455,897	479,737	499,438	510,263	506,384

Source: Minnesota Population Projections: 1970 to 2000; Office of the State Demographer, State Planning Agency, November, 1975.

Table 9 projects Minnesota's Senior population from 1980 to 2000. The most rapidly growing elderly group will be females aged 75 and over. It will increase by 25% (28,976) between 1980 and 2000. In contrast, females aged 65 to 74 will increase by 9.6% (14,360) between 1980 and 1990 and then decline by 4.5% (7,381) by 2000. Males aged 75 and over will increase 16.6% (11,651) between 1980 and 2000; and males aged 65-74 will increase by 7.7% (8,596) between 1980 and 1990 and then decline by 4.5% (5,735) between 1990 and 2000.

Following are general characteristics of Minnesota's senior population:

- Women constitute 60% of the state's senior population and a slightly larger proportion of those 75 years and older (64%).

- A majority of elderly Minnesotans (80% in the 1970 census) either live alone or with their immediate family. Of the 107,379 elderly living alone in 1970, 75% of them were females. Approximately 8% of the elderly were living in nursing homes and other health care facilities. This proportion was substantially higher than the national rate of 5%. Approximately 12% of the elderly were living with non-relatives or relatives other than their immediate family.

- Nearly half of the elderly are married. About one-third are widowed and about one tenth are single. The remainder are either divorced, separated, or "married with spouse absent" for reasons other than separation. There are great differences between the marital statuses of men and women. Approximately two-thirds of elderly men are married, whereas only one-third of elderly women are. In the 1970 census, only 16.5% of elderly men were widowed contrasted with 49.5% of elderly women.

- A quarter of all elderly persons in Minnesota have an income below the poverty level. The median income of elderly families in 1976 was $6,290, less than half that of all Minnesota families ($14,730). The income of elderly one-person households was $3,510, two-thirds that of all persons who live alone. Mean income decreases rapidly with age within the elderly population. The mean annual income of elderly females is half that of elderly males.

- The average life expectancy in Minnesota is currently 69.38 for males at birth and 76.8 for females. Minnesota's average life expectancy is the third highest in the nation for males and highest for females.

Size and Characteristics of Minnesota's Senior Veteran Population

According to the U.S. Veterans Administration, there were approximately 479,000 war-time and 80,000 peace-time veterans living in Minnesota as of March 31, 1980. By period of service, the breakdown is:[1]

World War I	12,000
World War II	212,000
Korean Conflict	74,000
Post Korea-Pre Vietnam Era	60,000
Vietnam Conflict	181,000
Post-Vietnam Era	20,000

[1]All data in this analysis reported by period of initial service.

In 1980 the average age of a World War I veteran was 84.4. The average World War II veteran was 59.6, the average Korean veteran was 48.4, and the average Vietnam veteran was 32.1. The average post Korea-pre Vietnam veteran was 41.2, and the average post-Vietnam veteran was 22.7. Table 10 shows the average age of World War II, Korean, and Vietnam veterans from 1976 to 2000.

TABLE 10

AVERAGE AGE OF U.S. WAR-TIME VETERANS BY YEAR

	World War II	Korea	Vietnam
Sept. 1976	56.6	45.2	29.2
Sept. 1977	57.2	45.8	29.8
Sept. 1978	58.2	46.9	30.7
Sept. 1979	59.1	47.9	31.6
March 1980	59.6	48.4	32.1
Sept. 1985	64.6	53.4	37.6
Sept. 1990	69.0	58.7	42.5
Sept. 1995	73.3	63.6	47.3
Sept. 2000	77.8	68.5	52.2

Source: Reports and Statistics Service, Office of the Controller, Veterans Administration

The state's veteran population grew dramatically after World War II. Growth after the Vietnam era has been much slower, and the U.S. Veterans Administration projects a rapid decline in the war-time veteran population as the large group of World War II veterans diminishes. The state's World War I veteran population has decreased 30% since 1977. The World War II and Korean populations have decreased 5.8% and 6.3% respectively. The rate of decline is expected to increase quickly as the veteran population ages.

Because no specific census of the state's veterans has ever been published, we must extrapolate national statistics to estimate the number of elderly veterans in the state. In order to use the national statistics directly, we must assume that Minnesota's veterans are similar in age and demography to the national veteran population, and for certain extrapolations we must assume that the ratio of veterans to the total population is the same in Minnesota as it is at the national level. The latter assumption we know is not true. Minnesota has fewer World War II and Korean veterans per 1,000 population than the nation as a whole and more World War I, Vietnam, and peace-time veterans.

These differences combined with different projections by the U.S. Veterans Administration and the Minnesota State Planning Agency of overall population growth in the state cause us to overestimate the number of elderly veterans in Minnesota (possibly by as much as 15% to 20% for elderly World War II and Korean veterans). While this situation is hardly satisfactory, no better data exist. Therefore, we will make two estimates of the number of elderly veterans in the state and two estimates of the number of nursing and board and care beds required by them. One estimate will be based on a straight extrapolation of national data. The other will reduce the estimates of elderly World War II and Korean veterans by 20%. The two estimates should be

Table 11

ESTIMATES OF MINNESOTA VETERANS AGED 65 AND OLDER

Age Group	High Estimates					Low Estimates[a]				
	1980	1985	1990	1995	2000	1980	1985	1990	1995	2000
65-74	39,500	71,050	97,050	90,900	70,600	31,600	56,840	77,640	72,720	57,680
75 & Over	15,300[b]	16,250[c]	23,350[d]	40,550[d]	55,000[d]	14,640[b]	14,000[c]	18,680[d]	32,440[d]	44,000[d]
Totals	54,800	87,300	120,400	131,450	125,600	46,240	70,840	96,320	105,160	101,680

[a] These estimates are based on a 20% lower projection of elderly World War II and Korean veterans. The 65-74 age group throughout the period will be made up entirely of World War II and Korean veterans.

[b] Estimate includes 12,000 World War I veterans.

[c] Estimate includes 6,000 World War I veterans.

[d] For purposes of analysis, estimates are based on veterans of World War II and Korea.

Source: Extrapolations are based on the proportion of veterans to elderly males in the United States for the years 1980 to 2000 as reported in A Report on the Aging Veteran prepared by the Veterans Administration and submitted to the Committee on Veterans Affairs, U.S. Senate on January 5, 1978. Estimates of the state's elderly male population were taken from Minnesota Population Projections: 1970 - 2000 prepared by the State Demographer in November, 1975.

treated as the upper and lower limits of a range. We would expect the actual number of elderly veterans during the period and the nursing and board and care beds needed by them to fall somewhere between our two estimates.

The number of elderly veterans in Minnesota will increase through 1995 and, like the state's senior population as a whole, decline slightly by the year 2000. See Table 11.

The number of veterans aged 75 and over is expected to increase steadily from 1980 to 2000, except perhaps for a period in the mid 1980's. Growth during that period will depend upon the death rate of the state's World War I veterans. As of 1980, 60% of these veterans are aged 80 to 84 and a third are aged 85 and over. The death rate of the younger group is nearly 10% per year; the death rate of the older group is approximately 17% per year. Consequently, during the mid 1980's there may be a brief decline in the number of veterans aged 75 and over.

The number of veterans aged 65 to 74 will increase rapidly between 1980 and 1990, but then decline by the year 2000 to 1985 levels. In contrast, veterans aged 75 and over will increase most rapidly from the late 1980's to 2000. Both trends reflect the aging of the World War II veteran population and parallel trends of Minnesota's senior population as a whole.

According to the U.S. Veterans Administration, there are no significant social, economic, or demographic differences between veteran and non-veteran males in the country. We will thus assume that the general characteristics of Minnesota's senior population describe the state's elderly veterans as well. The majority of these veterans, we would project, are married and living with their spouse, reside outside the metropolitan area, are aged 65 to 74, and have incomes below the state median income for all Minnesotans.

Nursing and Board and Care Beds Required by the State's Elderly Veteran Population

The Minnesota Health Department annually calculates the use rate of nursing and board and care homes by the state's elderly. The most recent calculations are for 1978. See Table 12.

Use rates differ substantially by age and by sex. Women aged 75 and over are the largest users (198.5 per 1,000 population). The other groups in descending order are men aged 75 and over (129.9 per 1,000 population), women aged 65 to 74 (24.6 per 1,000), and men aged 65 to 74 (22.4 per 1,000).

By using 1978 use rates and state demographer population projections, we can estimate roughly the number of nursing and board and care beds required in the state in the next twenty years. See Table 13.

TABLE 12

1978 USE RATES FOR MINNESOTA'S SENIOR POPULATION
NURSING AND BOARD AND CARE BEDS

Age and Sex	1978 Nursing Home Residents[1] No.	%	1978 Elderly Population[2] No.	%	1978 Use Rate Per 1,000 Population
65-74					
Male	2,722	6.9	121,390	26.2	22.4
Female	3,723	9.5	151,506	32.7	24.6
75+					
Male	9,265	23.5	71,351	15.4	129.9
Female	23,632	60.1	119,073	25.7	198.5
65+					
Total	39,342	100.0	463,320	100.0	84.9

[1]Nursing and board and care home patients--one day census.

[2]State Demographer's preliminary elderly estimate--1978--divided according to the percentage projected to be in age-sex groups for 1980.

Source: Office of Health Statistics, Minnesota Department of Health

In 1978 Minnesota had 46,490 licensed nursing home and board and care beds, of which 44,651 were actually set up and staffed. The 39,541 staffed nursing care beds had an occupancy rate of 93.2%; the 6,110 staffed board and care beds had an occupancy rate of 92.4%. See Table 14. If 1978 use rates persist, the state will need to build an additional 4,900 beds between 1978 and 2000 (assuming 100% occupancy). If we assume 93% occupancy, 8,800 new beds would be required by the year 2000.

The same calculations can be used to project the number of nursing and board and care beds needed specifically by elderly veterans. See Table 15.

The total number of beds required by elderly veterans will increase substantially between 1980 and 2000 as the large World War II veteran population reaches age 75. Using our high estimates, the number of beds needed by elderly veterans will increase from 7% of the total number of beds needed by all population segments in 1980 to just over 15% in 2000. The largest user of nursing and board and care beds in the state throughout the period, however, will remain non-veteran women aged 75 and over (approximately 55% of the total number of beds). In fact, almost two-thirds of the beds needed will be for non-veteran women aged 65 and over. The remaining 14% will be for non-veteran elderly men and people under age 65. See Chart 4

TABLE 13

NURSING AND BOARD AND CARE BEDS REQUIRED IN MINNESOTA
1980 TO 2000

Age Groups	1980	1985	1990	1995	2000
65-74					
Males	2,671	2,787	2,864	2,859	2,736
Females	3,666	3,898	4,020	3,993	3,838
75 & Over					
Males	9,123	9,386	9,842	10,305	10,636
Females	23,298	24,736	26,281	27,982	29,049
Total for those 65 & Over	38,758	40,807	43,007	45,139	46,259
Beds for those under 65[a]	4,306	4,534	4,778	5,015	5,139
Total Beds	43,064	45,341	47,785	50,154	51,398

[a]According to Minnesota Health Department data, 10% of all nursing care and board and care residents are under age 65.

Source: Calculations based on data provided by the Office of Health Statistics, Minnesota Department of Health and on population projections found in Minnesota Population Projections: 1970-2000, Office of the State Demographer.

Growth in the demand for beds between 1980 and 2000 will be concentrated among women aged 75 and over. Seventy percent of the additional beds needed in the state by the year 2000 will be needed by this segment of the population. Ten percent will be needed by females aged 65 to 74 and people under age 65. Only 20% of the additional beds needed will be for elderly males.

During the period, the proportion of veterans among elderly males needing nursing and board and care beds will double from 25% to 50%. However, the overall ratio of males to females needing beds will not change significantly. Seventy percent of all nursing and board and care beds in the state will continue to be occupied by elderly females. The increased need for beds by veterans will be largely offset by the decreased need for beds by non-veteran males.

The greatest surge in demand for beds for elderly veterans will occur after 1985, particularly after 1990. The need for nursing and board and care beds should continue to grow after 2000 as the majority of World War II veterans turn 85 and the majority of Korean veterans turn 75. It should begin to decline around 2010 as these large populations decline. There will be no significant demand for beds by peace-time and Vietnam veterans until 2020.

Table 14

MINNESOTA DEPARTMENT OF HEALTH

DATA YEAR 1978 — HEALTH FACILITIES INFORMATION SYSTEM

STATE-TOTAL — SUMMARY TABLE I - SELECTED STATISTICS BY FACILITY SIZE — 09/07/79

Bed Size	Number of Facilities	Number of Licensed Beds*	Beds Set Up and Staffed*	Admissions	Patient Days	Number of Discharges**	Discharge Patient Days	Average Size***	Average Daily Census	% *** Occupancy	Average Length of Stay
Nursing Homes											
1-24	21	375	375	2964	96830	2944	63435	18	265.3	70.7	23.6
25-49	63	2499	2459	2870	835803	2709	665314	39	2289.9	94.1	245.6
50-99	206	14638	14593	8304	5039143	7772	4092719	71	13805.9	94.6	526.6
100-199	122	16231	16065	9250	5546457	9127	4255358	132	15195.8	94.6	478.1
200 +	23	6283	6049	3309	1925302	2889	1478163	263	5274.8	87.2	511.7
TOTAL	435	40026	39541	26697	13443535	25441	10554989	91	36831.6	93.2	422.9
Board and Care Homes											
1-24	62	881	839	302	295934	403	204108	14	767.8	91.5	506.9
25-49	41	1401	1332	473	445346	465	293896	32	1220.1	94.1	650.2
50-99	25	1591	1526	505	546387	370	350115	61	1497.0	93.1	946.3
100-199	11	1383	1311	568	386794	478	331454	108	1059.7	88.9	693.4
200 +	4	1208	1102	582	349885	505	117132	276	958.6	87.0	231.9
TOTAL	143	6464	6110	2430	2024346	2221	1296705	42	5503.1	92.4	587.3

* No Bassinets ** Deaths Included *** Based on Beds Set Up and Staffed

Source: Office of Health Statistics, Minnesota Department of Health.

Table 15

NURSING AND BOARD AND CARE BEDS REQUIRED BY ELDERLY MINNESOTA VETERANS
1980 to 2000

	High Estimates					Low Estimates				
Age Group	1980	1985	1990	1995	2000	1980	1985	1990	1995	2000
65-74	900	1600	2200	2000	1600	700	1275	1750	1625	1300
75 & Over	2000	2100	3000	5300	7200	1900	1825	2450	4275	5775
Totals	2900	3700	5200	7300	8800	2600	3100	4200	5900	7075

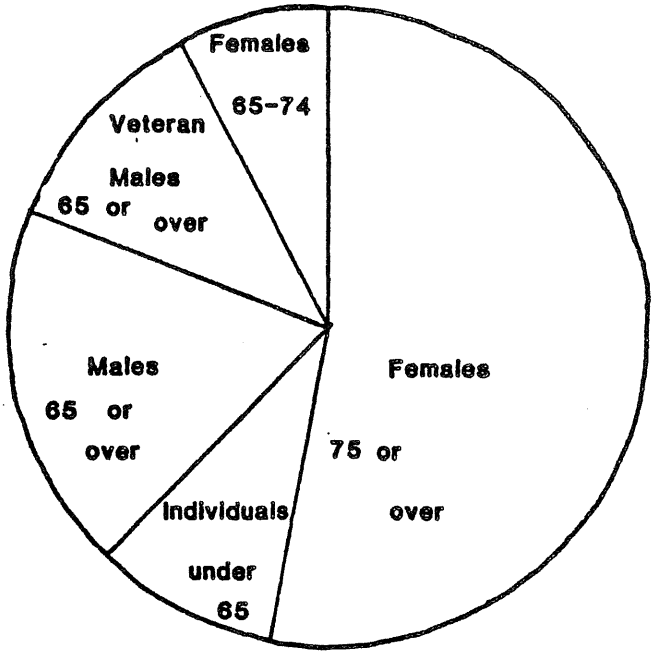
Source: Calculations are based on veteran population projections made in Table 6 and use rates found in Table 7. They assume that 2.1% of World War II and Korean veterans are women (which is the national average according to the United States Veterans Administration). We projected the following use rates:

Females 75 and over (198.5 per 1000 population)
Males 75 and over (129.9 per 1000 population)
Females 65 to 74 (24.6 per 1000 population)
Males 65 to 74 (22.4 per 1000 population)

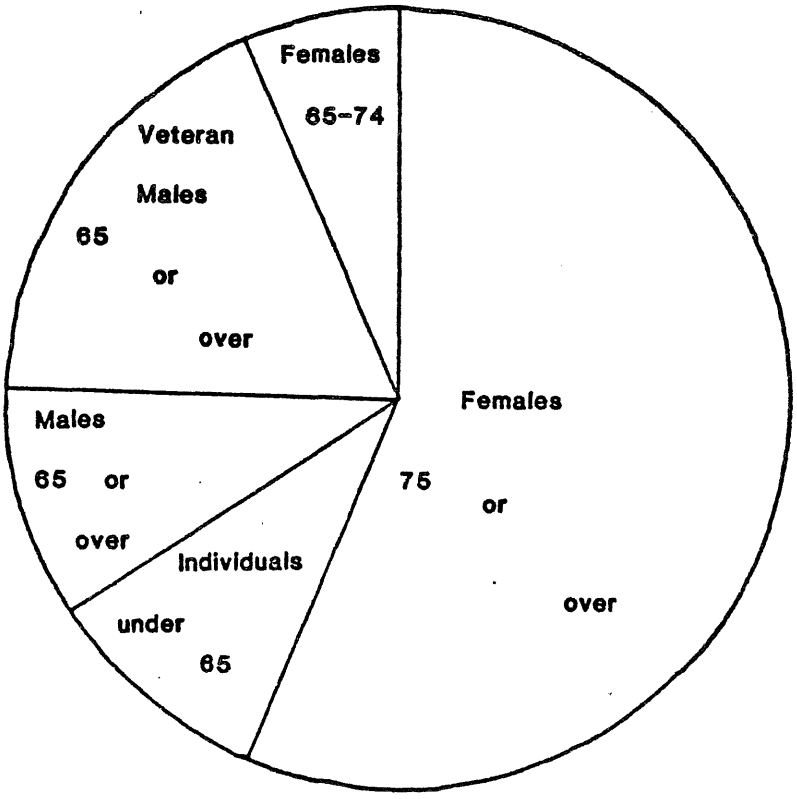
CHART FOUR

COMPARISON OF NURSING AND BOARD AND CARE BED USE
1980 - 2000

1980



2000



Nursing and Board and Care Beds Needed at the Minnesota Veterans Homes

So far, we have been discussing the number of nursing and board and care beds required by all veterans in the state. We now turn to the question of how many of these beds should be provided by the state at the Minnesota Veterans Homes.

In determining the number of beds to be provided, the department, the Governor, and the Legislature must first define the role of the Homes in the overall health care system of the state.

Presently most of the state's elderly veterans requiring care are served by the state's community-based health care system and not by the health care programs of the State Department of Veterans Affairs. The community-based system offers several advantages. The system has enough beds currently and for the next several years to meet the needs of all veterans and non-veterans requiring care. Furthermore, per patient costs for nursing and board and care have been, on average, less expensive than those at the Minnesota Veterans Homes. The community system gives residents a greater choice of facilities, allowing them to choose one located in their community and one that best fits their needs.

Finally, from the state's perspective, the community system provides greater flexibility to meet increases and shifts in demand for nursing and board and care beds. New beds can be added faster by the community system, and beds no longer needed by veterans can be readily shifted to use by non-veterans. This latter point is particularly important because the demand for beds by non-veterans (especially women over age 75) will continue to increase after the year 2000 while the demand by veterans will decline.

The next several years should be spent by the department to improve the management of the current programs, to collect and analyze data on the needs of Minnesota veterans, and to develop a long-range plan for meeting the health care needs of the state's veterans through the year 2000. The department should base its recommendations on a special analysis of 1980 census data and should consider undertaking a major needs assessment survey of the state's veteran population. Health care professionals, particularly health care planners, should be used to develop alternative long-range plans for consideration by the department, the veterans community, the Governor, and the Legislature.

On the basis of current data, the Study Team believes that the department should continue to rely on the state's community care system as the primary provider of nursing and board and care for veterans. It should consider subsidizing placement of veterans in community nursing and board and care facilities and supporting independent living programs rather than significantly expanding the capacity of the present veterans homes or building new state facilities. Under this plan, veterans would be offered a wider choice of facilities and the state would not invest in buildings which would be vacated once the demand for beds by World War II

veterans passes. The Homes should be seen as one of a whole set of facilities and programs available to veterans. The Homes should redefine their roles accordingly, placing special emphasis on providing services not readily available to veterans in the community.

Recommendation Three: Until the Department submits its detailed long-range plan for meeting the health care needs of the state's veterans through the year 2000, no further state funds should be allocated for capital improvements.

In the previous analysis the Study Team has attempted to provide a framework within which to develop future capital plans. Table 16 is an analysis of building appropriations from 1969 to 1980. Since 1969, $13,272,834 has been expended, committed, or projected for capital improvements to the Minnesota Veterans Homes.

There were three major projects during the period: 1) construction of a 100 bed residential restorative facility completed in 1972 for $1,217,792, 2) construction of a 250 bed nursing care facility to be completed in 1980 for $7,089,178, and 3) remodeling of the Hastings Veterans Home currently underway for $1,968,200. Overall during this period the state has appropriated $5,377,712 for capital improvements and major repairs; the federal government has provided $7,895,122 in matching funds.

See Tables 17 and 18 for a list of major buildings on the Minneapolis and Hastings campuses, their present conditions, and the Department's future capital plans.

Of the 15 major buildings on the Minneapolis Campus, nine were built before 1905. One extensively remodeled building (Building 9) which is licensed for nursing but used for domiciliary care was built in 1936. The Chapel-Auditorium building was completed in 1958. The current 100 bed nursing care facility was built in 1972 and the new 250 bed nursing facility will be completed this year. The Commissioner of Veterans Affairs plans to abandon eight of the nine buildings built before 1905 and to replace these older domiciliary buildings with new nursing care buildings. He also plans to convert two other domiciliary buildings (Buildings 9 and 16) to nursing care within the next three years.[2] Under these plans only one building on the Minneapolis Campus will be left to house domiciliary residents.

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[2]Under the Commissioner's plans, Building 16 is to be converted from nursing to domiciliary care for the next two to three years and then reconverted to nursing care.

Table 16

MINNESOTA VETERANS HOMES
BUILDING APPROPRIATIONS

Year Funds Appropriated	Project - Minneapolis Home	Year Completed	State	Federal	Total
1961/1963/ 1969	Paint understructure of bridge, landscaping, and resurfacing streets and parking lots.	1969	$ 46,500		
1971	Construct and equip a 100 bed residential center (Building 16).	1971	1,217,792		
1971	Install controls, flow meters, and hot water heater in power plant and repair plaster and moisture damage in infirmary (Building 9).	1972	24,300		
1971	Connect to Minneapolis water system and demolish old water tower.	1972	85,000		
1973	Replace windows and install two elevators in the infirmary (Building 9).	1979	100,000	$ 285,714	$ 385,714
1976	Fire protection, air conditioning, and bathroom modernization (Building 9).	1979	66,150	189,000	225,150
1976	Fire protection, utility room, and central baths (Building 16).	1979	40,000	114,286	154,286
1976	Construct and equip 250 bed nursing care facility (Building 17).	1980	1,925,000	3,560,000	5,485,000
1978	Supplemental appropriation for new 250 bed nursing care facility (Building 17).	1980	267,750	765,000	1,032,750
1978	Replace boilers (under plans).		457,800	850,200*	1,308,000
1978	Connect Building 6 to Building 17.		52,500	97,500*	150,000
1978	Convert to new voltage system (under plans).		64,750	120,250*	185,000
1978	Renovate utility tunnels (under plans).		118,650	220,350*	339,000
1978	Construct sewer lift station (under plans).		22,650	42,064*	64,714
1980	Equipment for new nursing care facility (Building 17).	1980	200,000	371,428	571,428
	Total		$4,648,842	$6,615,729	$11,264,571
	Project - Hastings Home				
1978	Remodel old state hospital for use as Veterans Home facility (under construction).		$ 688,870	$1,279,330	$ 1,968,200
	GRAND TOTAL		$5,377,712	$7,895,122	$13,272,834

* Federal funds pending.

Table 17

MINNEAPOLIS VETERANS HOME

Building Number	Built	Use	Condition	Department of Veterans Affairs Plans
1	1888	Domiciliary Residence	*Currently meets Veterans Affairs and Minnesota Department of Health life and safety standards, but in need of interior and exterior repairs and remodeling.	To abandon Buildings 1-5. Question of whether the buildings will be torn down or will be designated national historic sites by the Minnesota Historical and the U.S. Department of Interior.
2	1888	Domiciliary Residence	*	
3	1891	Domiciliary Residence	*	
4	1891	Domiciliary Residence	*	
5	1895	Domiciliary Residence	*	
6	1905	Domiciliary Residence	*	Continue as Domiciliary Residence in near future. Long-range plans are not yet determined.
7	1902	Dining Room and Kitchen	*	To abandon building 10/80. Question of whether building will be torn down or used as a storage building.
9	1936	Domiciliary Residence and Home's Medical Clinic	Extensive remodeling done recently. Licensed for nursing care.	Continue use as a Domiciliary Residence. Move some Administrative offices onto ground floor 11/80. Possibl return to nursing care use in the next two to three year
10	1892	Headquarters Building	Minor repairs needed.	Turn building over to Minnesota Historical Society
11	1950	Maintenance and Transportation	Minor repairs needed.	Continue present use.
12	1891	Former Laundry Building; Currently not in use.	Major repairs needed to be able to return to active use.	Tear down building.
14	1937	Power Plant	Need to replace current boilers	Continue present use.
15	1958	Auditorium - Chapel Building	Minor repairs needed.	Continue present use.
16	1972	Nursing Care Facility	Minor repairs and remodeling needed.	Turn into Domiciliary Residence for two to three years; then return to nursing care use.
17	1980	Nursing Care Facility	Construction completed 10/80.	Use as Nursing Care Facility, Administrative Office, and Central Dining Facility.

Table 18

HASTINGS VETERANS HOME

Building Number	Built	Use	Condition	Department of Veterans Affairs Plans
23	1916-18	Domiciliary Residence and Program Offices	Undergoing extensive remodeling and repairs.	Continue present use.
Addition to 23	1951			
24	1951	Administrative Offices	Minor repairs needed.	Continue present use.
25	1919	Domiciliary Residence	Minor repairs needed.	Continue present use.
1	1909	Leased to Dakota County	Minor repairs needed for current use.	Continue present use.
2	1911	Not currently in use.	Major remodeling and repairs needed for domiciliary use.	Undecided.
4	1915	Not currently in use.	Major remodeling and repairs needed for domiciliary use.	Undecided.

Of the six residential buildings on the Hastings Campus, only three are currently used by the Veterans Home. One building is leased to the Dakota County Detoxification Center and two are currently vacant. The Study Team is not aware of any long-range capital plans for the Hastings Campus.

The committment of resources in the past decade to expand the physical plant and undertake other capital improvements is a visable measure of the committment Minnesota citizens have for veterans of the state. The Study Team believes, however, that expenditures of this magnitude should be part of a planned, long term approach consistent with the philosophy of the state and emerging practices of care, treatment, and rehabilitation of residents.

CHAPTER VI

CONCLUSIONS

CONCLUSIONS

The Minnesota Veterans Homes have serious administrative problems, particularly managing their financial and personnel resources. Of even more importance are the problems regarding resident care. The Homes do not provide care which meets Minnesota Health Department standards and Veterans Administration guidelines. These problems have existed for many years. The Minneapolis Home, in particular, has been the subject of many critical reports.

In the past decade a number of improvements have been made. The Homes have increased and improved medical and related rehabilatative services and have come directly under the responsibilities and operating authorities of the Departments of Veterans Affairs, Administration, Finance, and Employee Relations. In the past six months, the Department of Veterans Affairs has improved the fiscal operations of the Homes, bringing them into line with state procedures. The improvements made over the last decade, however, have not been sufficient. The Homes are costly and poorly managed and better care is provided in most community facilities.

Solutions to the numerous problems identified by this study and by the Legislative Auditor and the Minnesota Health Department can be implemented within the Homes' current authorities and budgets and with the Homes' current complement. Only if the Homes expand beyond their present bed capacities would additional funds and staff be needed.

The Study Team has carefully and extensively analyzed existing data on current and future health care needs of the state's veterans. It is unmistakable that in the next twenty years, as World War II veterans turn 75, there will be a large increase in their need for nursing and other services. This increase, however, must be put into perspective. The largest user of nursing and board and care beds (two-thirds of all such beds) is and will continue to be elderly non-veteran women over age 64. The number of beds needed by veterans will only increase from 7% of all beds in 1980 to just over 15% in the year 2000 and will be offset by the decreased need for beds by non-veteran men. The need, therefore, for more state-owned beds for veterans must be seriously questioned.

As now constituted, the Veterans Homes provide institutional care, separating veterans from family and friends and segregating them from the rest of the community. Over the last decade there have been two significant, almost revolutionary, trends in the care of the elderly. First, community health care facilities have been developed. In these facilities, care is personalized and is provided in the community where the person lived and near family and friends. Second, programs have been developed to help the elderly to live independently - to stay in their own homes. In Minnesota, Meals on Wheels, specialized transportation programs, home nursing services, and senior citizens centers have been established to support the continued independent living of the state's elderly and to forestall institutional care.

The Department of Veterans Affairs must seriously reconsider the role of the Homes and decide how to shift the philosophy of care. There remains a need for the state's two Veterans Homes. The Homes should continue to serve veterans of all ages and to provide both nursing and domiciliary care. The issue facing the department is not whether the Homes should continue to exist. It is how to provide better care at the Homes and how community based facilities and programs can be more extensively used in providing that care. The role of the Homes should be to serve those not served by the community. A secondary issue is expansion of the department's health care program, specifically, whether or not to construct new facilities. The Study Team believes that the dollars which would be spent on building new state facilities would be better spent tying into existing community facilities and programs. Doing so would be less expensive than building new facilities and, more importantly, would provide better care to the state's veterans.

APPENDICES

STATE OF MINNESOTA
DEPARTMENT OF VETERANS AFFAIRS
VETERANS SERVICE BUILDING
SAINT PAUL, MINN. 55155

OFFICE OF THE
COMMISSIONER
(612) 296-2783

REPLY TO: (612) 296-2783

March 17, 1980

Mr. James J. Hiniker, Jr., Commissioner
Department of Administration
Administration Building
50 Sherburne Avenue
St. Paul, Minnesota 55155

Dear Commissioner Hiniker:

I have been concerned about the organization and responsibilities of this Department and accordingly have requested additional personnel to improve our delivery system of services and care as mandated by the Minnesota Legislature.

It appears we will be receiving some of these personnel in this legislative session and, therefore, I would request your department to perform a management study of the Department of Veterans Affairs and I would request the initial study be made with the Minnesota Veterans Home, Minneapolis Campus. This particular division has been in need of personnel in the past and is presently expanding its nursing care facility to include a new 250 bed nursing care unit to be completed in July of this year.

With the above as my desire, I would appreciate an early scheduling of this study.

Sincerely,

DONALD M. MILLER
Commissioner

DMM/vk

INTERVIEW WITH _____ DATE _____

INTERVIEWER _____

1. What is your position?

   Working title:

   Job Classification

2. Would you tell me what you do on your job?

3. How long have you been working in your current position?

   How long have you worked for the Veterans Home?

4. Whom do you supervise?

   A. How many people do you supervise?

   B. What positions?

   C. What activities?

5. Who is your boss? (Who tells you what tasks to do and when to do them?)

6. How do you receive instructions on what to do from your boss?

7. How do you know if you are doing a good job? (By what means do you know?)

8. What are the good things about your job? (What do you like about your job?)

   A.

   B.

   C.

9. What are the bad things about your job? (What do you like about your job?)

   A.

   B.

   C.

10. What ideas do you have about improving your job?

A.

B.

C.

11. How effectively do people work together?

A. In this home?

B. Between the two homes?

C. Between Central Office and this home

12. How effective are the communications among staff?

A. In this home?

B. Between the two homes?

C. Between the Central Office and this home?

13. How effective are the communications between staff and residents in this home?

14. I'm interested in identifying the major activities of your unit, the staff assigned to each, and approximately how much time is devoted to each activity. USE UNIT ACTIVITY ANALYSIS FORM TO COLLECT DATA.

15. How do you give instructions to your employees on what to do?

16. Do you have current position descriptions for yourself and for your staff? May I have copies of them?

17. EMPLOYEE EVALUATIONS?

    A. Do you use the Employees Performance Appraisal system (PEAR's) in your unit? _____

    B. If not, how do you evaluate your employees?

    C. How often do you evaluate your employees?

    D. May I see copies of the most recent PEAR's or evaluations?

18. A. Do you have written policies and procedures for your unit?

B. May I have copies of them?

C. Are you drafting any new policies or procedures? _____

D. What are they?

19. I'm interested in the interaction you and your staff have with other units and staff inside the home and outside? USE UNIT INTERACTION ANALYSIS FORM TO COLLECT DATA.

A. Which units in this home do you work with the most?

B. Which units in the other Veterans Home do you work with the most?

C. Which staff in Central Office do you work with the most?

D. Do you work with staff at the Veterans Hospital (Minneapolis and St. Cloud? _____

Whom?

E. Do you have much contact with staff in other state agencies? _____. Whom?

20. A. What mechanism do you have in your unit to identify services needed/level of care required?

B. What have you found out? What level of care/services are needed?

21. Are you familiar with the recent Legislative Audit Report or the latest Health Department survey?

What was the gist of the survey/report for your unit?

What deficiencies were identified?

Have they been corrected? Why or Why not?

STATE OF MINNESOTA
DEPARTMENT OF ADMINISTRATION
SAINT PAUL 55155

MANAGEMENT ANALYSIS DIVISION
5-80

MINNESOTA VETERANS HOMES SURVEY

(1-2) ___ CARD NUMBER

(3) ___ INTERVIEWER (TLB=1/KRR=2/SGK=3/PRS=4)

(4) ___ FACILITY (MPLS=1 HASTINGS=2)

(5-6) ___ BUILDING NUMBER

(7) ___ LEVEL OF CARE (DOM=1/INTERMED=2/NHC=3)

(8-11) ____ HOME ID NUMBER

(12) WHEN DID YOU FIRST COME TO LIVE HERE AT THE HOME?

1 1980
2 1979
3 1975-1978
4 1970-1974
5 1964-1969
6 BEFORE 1964

WHO REFERRED YOU TO THE HOME?

(13) ___ VETERANS SERVICE OFFICER

(14) ___ V.A. HOSPITAL STAFF

(15) ___ VETS SERVICE ORGANIZATION

(16) ___ FRIEND

(17) ___ FAMILY MEMBER

(18) ___ OTHER INDIVIDUAL

(19) ___ SELF

(20) ___ OTHER SOCIAL AGENCY _____

(21) ___ OTHER GOVERNMENT AGENCY _____

(22) WHERE DID YOU LIVE BEFORE COMING HERE THE FIRST TIME?

1 BY SELF
2 WITH OTHER RELATIVE
3 IN A NURSING HOME
4 OTHER _____
5 WITH SPOUSE/CHILD(REN)
6 WITH SOMEONE NOT A RELATIVE
7 IN A HOSPITAL

WHAT THING(S) DO YOU MISS NOW, THAT YOU COULD DO BEFORE YOU FIRST CAME TO THE HOME? (23-25)

WHICH OF THESE THINGS WOULD YOU STILL WANT TO DO? (26-28)

DO YOU THINK THESE SHOULD BE OFFERED BY THE HOME? (29-31)

HOW OFTEN DO YOU TAKE PART IN SCHEDULED ACTIVITIES? (Other than meals)

		THERE ARE NONE	FREQ.	OCCAS.	NOT INTERESTED
(32)	8am-5pm M-F....	1	2	3	4
(33)	5pm-10pm M-F...	1	2	3	4
(34)	WEEKENDS.....	1	2	3	4

(35) WERE YOU EVER HOSPITALIZED BEFORE YOU CAME TO THE HOME?

1 YES 0 NO

(36) IF SO, HOW MANY TIMES IN THE 2 YEARS JUST BEFORE YOU CAME TO THE HOME?

1 ONCE
2 TWICE
3 THREE TO FIVE TIMES
4 MORE THAN FIVE TIMES

WHO VISITS YOU, WHOM DO YOU WRITE TO, OR WHOM DO YOU GO TO SEE OUTSIDE THE HOME?

(37) ___ SPOUSE ONLY
(38) ___ CHILD(REN) ONLY
(39) ___ OTHER RELATIVE(S)
(40) ___ OTHER _____

(41) ___ SPOUSE/CHILD(REN)
(42) ___ PARENT(S)
(43) ___ FRIEND(S)
(44) ___ PERSON FROM SERVICE ORGANIZATION OR AUXILIARY
(45) ___ NONE

IF YOU HAD THE OPPORTUNITY, WOULD YOU LIKE TO LIVE SOMEPLACE ELSE? IF SO, WHERE? (46-47)

1 YES _____ 0 NO

_____

(48) WHICH WARS DID YOU SERVE IN?

0 SPANISH AMERICAN
1 WORLD WAR I
2 WORLD WAR II
3 KOREAN WAR
4 VIET NAM WAR
5 OTHER
6 NOT APPLICABLE

ARE YOU CURRENTLY EMPLOYED?

	(49) ON	(50) OFF
REGULAR/FULL-TIME	1	1
REGULAR/PART-TIME	2	2
ODD JOBS/OCCASIONAL	3	3
NOT EMPLOYED	4	4
NOT INTERESTED	5	5

DO YOU WANT TO BE EMPLOYED?

	(51) ON	(52) OFF
REGULAR/FULL-TIME	1	1
REGULAR/PART-TIME	2	2
ODD JOBS/OCCASIONAL	3	3
NOT EMPLOYED	4	4
NOT INTERESTED	5	5

HOW FREQUENTLY DO YOU USE THE FOLLOWING MEDICAL SERVICES?

		DAILY	WKLY	MNTHLY	OCCAS	NEVER
(53)	DR. MOONEY/CLINIC AT BUILDING 9	1	2	3	4	5
(54)	VA CLINIC IN BUILDING 18	1	2	3	4	5
(55)	VA HOSPITAL-MPLS IN-PATIENT	1	2	3	4	5
(56)	VA HOSPITAL-ST. CLOUD IN-PATIENT	1	2	3	4	5
(57)	HENNEPIN COUNTY MEDICAL CENTER	1	2	3	4	5
(58)	HOME'S DENTIST	1	2	3	4	5
(59)	HOME'S EYE DOCTOR	1	2	3	4	5
(60)	HOME'S PODIATRIST	1	2	3	4	5
(61)	YOUR OWN PRIVATE MD/DDS/OPTH/ETC.	1	2	3	4	5

(62) ARE YOU A SELF-MEDICATOR?

1 YES 0 NO

(63) DO YOU GO FOR THERAPY TO BUILDING 16?

1 YES 0 NO 2 NOT AWARE OF

HAD YOU BEEN IN A DETOX/TREATMENT PROGRAM BEFORE YOU FIRST CAME TO THE HOME? (64-65)

0 NO YES - HOW MANY TIMES? _____

HAVE YOU BEEN IN A DETOX/TREATMENT PROGRAM SINCE COMING TO THE HOME? (66-67)

0 NO YES - HOW MANY TIMES? _____

WHICH OF THE FOLLOWING SERVICES DO YOU FEEL SHOULD BE IMPROVED AT THE HOME? (Rank order 1-10)

(68) ____ LAUNDRY SERVICE
(69) ____ DEPOSIT/WITHDRAWAL $
(70) ____ FOOD SERVICE ON GROUNDS
(71) ____ OWN/PRIVATE BATHROOM
(72) ____ ACTIVITIES OFF-GROUNDS
(73) ____ RUNNER FOR ERRANDS
(74) ____ FOOD BROUGHT TO ROOM
(75) ____ SECURITY/SAFETY
(76) ____ ACTIVITIES ON-GROUNDS
(77) ____ TRANSPORTATION OFF-GROUNDS
(78) ____ NONE
(79) ____ OTHER _____

_____

(1-2) __ __ CARD NUMBER

(3-7) DUPLICATE

(8-11) __ __ __ __ HOME ID NUMBER

(12) DO YOU LEAVE THE GROUNDS BY YOURSELF?

0 NO 1 YES

(13) ___ HOW FREQUENTLY?

(14-16) WHERE DO YOU GO?

WHEN YOU GO, HOW DO YOU GO?

(17) ___ MTC BUS FROM MPLS HOME
(18) ___ ON CALL MTC BUS/HASTINGS BUS
(19) ___ ANY MTC BUS
(20) ___ OWN CAR
(21) ___ SOMEONE ELSE'S CAR: WHEN SOMEONE VISITS ME
(22) ___ SOMEONE ELSE'S CAR: I CALL
(23) ___ ON FOOT: CONVENIENT MEANS
(24) ___ ON FOOT: MEDICAL REQUIREMENT
(25) ___ OTHER PUBLIC TRANSPORTATION
(26) ___ USE HOME'S TRANSPORTATION, WHEN AVAILABLE

CURRENT SOURCES OF INCOME? (rank largest 3)

(27) ___ VETERANS ADMINISTRATION
(28) ___ SOCIAL SECURITY
(29) ___ SSI
(30) ___ EARNINGS
(31) ___ PRIVATE PENSION
(32) ___ SAVINGS
(33) ___ CHILD(ERN)(NOT A PASS THROUGH OF ABOVE)
(34) ___ OTHER _____

WHERE DO YOU KEEP YOUR MONEY? (Interviewer use 36)

(35)	(36)	
1	1	USES COMMERICAL BANK ACCOUNT
2	2	USES CASHIER: NO RESTRICTIONS
3	3	USES CASHIER: SOME RESTRICTIONS
4	4	USES CASHIER: OFFICIAL CONTROL
5	5	KEEPS CASH/UNCASHED CHECKS ON SELF

MEMBER'S PERCEPTION OF OWN NEEDS? (Rank 1st 3)

(37) ___ MEDICAL SERVICES
(38) ___ PSYCHOLOGICAL/COUNSELING SERVICES
(39) ___ PERSONAL SKILLS TRAINING
(40) ___ VOCATIONAL SERVICES
(41) ___ MAID SERVICE
(42) ___ LEISURE TIME ACTIVITIES
(43) ___ DENTAL SERVICES
(44) ___ OTHER (SOCIAL SERVICE NEEDS)
(45) ___ EDUCATIONAL SERVICES
(46) ___ LEGAL SERVICES
(47) ___ RELIGIOUS TIES/ACTIVITIES
(48) ___ OFF-GROUNDS TRANSPORTATION
(49) ___ MEMBER SEES NO NEEDS

WHAT IS THE MOST DIFFICULT THING YOU HAVE TO DEAL WITH EVERY DAY? *(50-52)*

(76) INTERVIEWER'S IMPRESSION OF HOW MEMBER FELT ABOUT BEING INTERVIEWED?

1 PLEASED

2 COOPERATIVE, BUT NEUTRAL

3 RELUCTANT NEAR END

4 REFUSED TO SUPPLY INFORMATION

5 NOT ABLE TO SUPPLY INFORMATION

INTERVIEW IS OVER

INTERVIEWER'S IMPRESSION OF PHYSICAL/HEALTH STATUS?

		NONE EVIDENT	SOME PROBLEM	SERIOUS PROBLEM
(53)	HEARING	1	2	3
(54)	VISION	1	2	3
(55)	SPEECH	1	2	3
(56)	MOBILITY	1	2	3

SUMMARY STATEMENT OF MEMBER'S MAIN PROBLEM?

		NONE EVIDENT	SOME PROBLEM	SERIOUS PROBLEM
(57)	MENTAL ILLNESS	1	2	3
(58)	PHYSICAL HANDICAP	1	2	3
(59)	INFIRMITY OF OLD AGE	1	2	3
(60)	ALCOHOL/DRUG ASUSE	1	2	3
(61)	SOCIAL ISOLATION	1	2	3
(62)	CAN'T COPE	1	2	3
(63)	NO MAJOR PROBLEM	1	2	3
(64)	OTHER _____	1	2	3

ESITMATED LEVEL OF FUNCTIONING SKILLS?

		NOT OBS	ADE-QUATE	MINOR	SER-IOUS
(65)	PERSONAL HYGIENE/GRMING .	1	2	3	4
(66)	EATING SKILLS	1	2	3	4
(67)	CARE OF OWN LIVING SPACE .	1	2	3	4
(68)	MGMT OF OWN MONEY	1	2	3	4
(69)	MGMT OF OWN MEDICATIONS .	1	2	3	4

INTERVIEWER'S IMPRESSION OF MEMBER IN INTERVIEW?
(if no indication, check "no evidence")

		NO EVID-ENCE	MINOR PROBLEM	SERIOUS PROBLEM
(70)	KEEPS FORGETTING & IS CONFUSED	1	2	3
(71)	SUSPECTS OR FEARS IMAGINARY THINGS	1	2	3
(72)	OVERACTIVE & MAY HURT OR UPSET OTHERS	1	2	3
(73)	QUIETLY DEPRESSED & DISCOURAGED	1	2	3
(74)	PRODUCES A LOT OF STRANGE BEHAVIOR	1	2	3
(75)	THREATENS TO KILL, SEEMS DANGEROUS	1	2	3

QUALITY ASSURANCE AND REVIEW PROGRAM
MINNESOTA DEPARTMENT OF HEALTH
INDIVIDUAL REVIEW FORM
1980

USE BLACK INK ONLY!!

[1]

COMPLETE PART I ONLY

PART I GENERAL INFORMATION

Label - Facility Name
Address
(2-3-4-5-) (6)
(Facility & Dist. Codes)

ROOM No. _____

M.A. No. [7 ... 22]

NAME [24 last - print 39]

[40 first - print 48] [49 m.i.] [50 sex]

[51 year birth]

LEVEL OF CARE: 1. SNF 2. ICF 3. ICF-MR 4. PSYCHIATRIC HOSPITAL [23]

Month/Year of First Admission [55 57]

RESPONSIBLE PHYSICIAN [59 last 74] [75 initials]

ADMITTED FROM: 1. Home; 2. Hospital; 3. State MI-MR Facility; 4. Other Long Term Care Facility [77]

CURRENT/ACTIVE DIAGNOSIS (Include Severity of MR)

1. _____ [78]
2. _____ [82]
3. _____ [86]
4. _____ [90]
5. _____ [94]
6. _____ [98]

SUMMARY OF GENERAL CONDITION: 1. Improving; 2. Stable; 3. Unstable 4. Declining; 5. Terminal; 6. No Record [107]

[2] [1]

PART II
INDIVIDUAL DEPENDENCIES AND POTENTIAL FOR RESTORATION (PR: 1. Slight; 2. Moderate; 3. Good)

	Depen.	Pot. for Rest
1. DRESSING: 0.Independent; 1.Independent with programming or supervision; 2.Aid of another person; 3.Must be dressed; 4.Never dressed	[23]	[24]
2. GROOMING: (Care of teeth, dentures; combing hair, shaving, make up) 0.Independent; 1.Independent with programming or supervision; 2.Aid in 2 or 3 areas; 3.Aid in all areas	[25]	[26]
3. BATHING: 0.Independent; 1.Independent with programming; 2.Supervision only; 3.Aid to get in and out of tub; 4.Aid in washing; 5.Bathed completely	[27]	[28]
4. EATING: 0.Independent; 1.Independent with programming; 2.Slight help to cut meat, arrange food; 3.Feeds self with help or supervision of another person; 4.Completely fed	[29]	[30]
5. BED MOBILITY: 0.Independent; 1.Occasional help to sit up; 2.Always helped to sit up; 3.Must be turned and positioned	[31]	[32]
6. TRANSFERRING: 0.Independent; 1.Needs guidance only; 2.Aid of one person; 3.Needs two persons or mechanical device; 4.Bedfast	[33]	[34]
7. WALKING: 0.Independent; 1.Independent with device; 2.Aid of one person; 3.Aid of two persons; 4.Does not walk	[35]	[36]
8. WHEELING: 0.Independent; 1.Help with elevator/doorsills; 2.Must be wheeled	[37]	[38]
9. COMMUNICATION: 0.Normal speech; 1.Speech impairment but can be understood; 2.Language barrier/uses gestures/written; 3.Inappropriate content, echolalia, garbled sounds; 4.Refuses or unable to speak	[39]	[40]
10. HEARING: 0.Normal; 1. Normal with hearing aid; 2.Impairment; 3.Does not hear; 4.Unknown	[41]	[42]
11. VISION: 0.No impairment; 1.Impairment corrected with glasses; 2.Impairment; 3.Blind; 4.Unknown	[43]	[44]
12. ORIENTATION: 0.Oriented; 1.Minor forgetfulness; 2.Partial/intermittent periods of disorientation; 3.Totally disoriented: Does not know time, place, identity; 4.Comatose; 5.Unknown	[45]	[46]
13. BEHAVIOR: 0.No problem; 1.Observation for potential problem behavior; 2.Uncooperative, wanders, withdrawn, crying, hallucinates; 3.Disruptive/runs away; 4.Some of above plus assaultive	[47]	[48]
14. TOILETING: 0.Independent; 1.Needs help to toilet, no incontinence; 2.Occasional accident; 3.Nocturnal incontinence only; 4.Incontinent bladder; 5.Incontinent bowel; 6.Incontinent bowel and bladder or not trained	[49]	[50]
15. SELF PRESERVATION SKILLS: 0.Independent; 1.Minimal supervision; 2.Mentally unable; 3.Physically unable; 4.Both 2 & 3	[51]	[52]

PART III TREATMENT PROGRAMS

INDIVIDUAL CARE REQUIREMENTS:

1. MEDICATIONS
   a. 1. Number of oral medications [53]
      2. Total number of doses administered daily [55]
   b. 1. Number of injectable medications ordered [57]
      2. Number of injections per week [58]
   c. 1. Number of other medications [60]
      2. Average number of applications per day [62]
2. NUMBER OF CLINICAL MONITORING PROCEDURES PER DAY [64]
3. THERAPEUTIC DIET: 1. Yes; 2. No [66]

HE-01138-01

PART III CONTINUED

4. SPECIAL TREATMENTS

a. Tube Feeding: *1. Self administration w/o help; 2. Self administration with help; 3. Given by staff* [67]

b. Oxygen and Respiratory Therapy: *1. Self administered; 2. Given two or three times weekly; 3. Given daily; 4. Suctioning* [68]

c. Tracheotomy Care: *1. Routine care with occasional suctioning; 2. Special care, dressings, frequent daily suctioning* [69]

d. Retention Catheter: *1. Routine care includes changing; 2. Special care irrigations* [70]

e. Ostomy: *1. Self care; 2. Routine care. irrigations by staff; 3. Special care skin problems, teaching self care* [71]

f. Dressings: *(Does not include ace bandage/ted stockings) 1. Simple dressings daily; 2. Large dressings daily; 3. Large dressings or extensive dressings more than twice daily* [72]

g. Skin Care: *1. Special measures to maintain health of skin, foot soaks, heat lamp; 2. Dermatitis, stasis ulcer, abrasions and other lesions; 3. Decubitus ulcer* [73]

h. Rehabilitation Procedures-ROM/Excercise, Ambulation, ADL, Transfers: *1. One of above; 2. Two of above; 3. Three of above; 4. All of above or prosthetics and supportive device.* [74]

i. Toileting: *(Bladder) 1. Routine program of taking to toilet; 2. Written individualized program* [75]

j. Toileting: *(Bowel) 1. Routine program, take to toilet/suppository; 2. Written individualized program* [76]

5. SPECIAL PROGRAMS

a. Speech Therapy: *1. Directed by therapist; 2. Plus reinforced by nursing/staff* [77]

b. Physical Therapy: *1. Directed by therapist; 2. Plus reinforced by nursing/staff* [78]

c. Occupational Therapy: *1. Directed by therapist; 2. Plus reinforced by nursing/staff* [79]

d. Social Service: *1. Social service by S.W.; 2. Reinforced by staff* [80]

e. Psychological/Behavioral Services: *1. Counseling/behavior mod. by trained person; 2. Reinforced by staff* [81]

f. Psychotherapy: *1. Programmed by psychiatrist; 2. Plus reinforced by nursing/staff* [82]

g. Activity Program: *1. Programmed by the director; 2. Plus reinforced by nursing/staff* [83]

h. Reality Orientation or Remotivation Program: *1. Twenty-four hour by staff; 2. Structured program* [84]

6. PROGRAM PLAN FOR M.R.

a. CURRENT INDIVIDUALIZED PROGRAM

1. Sensori-motor - Stimulation/development [85]

2. Physical mobility/dexterity [86]

3. Self-care development [87]

4. Language/communication [88]

5. Social behavior/self direction [89]

6. Community access/work [90]

b. PROGRAMS

1. Day activity [91]

2. School [92]

3. Work/skill training [93]

4. Competitive work [94]

PART IV - BEHAVIOR ADDENDUM

A. CODE APPROPRIATE CATEGORY

1. Has major mental illness diagnosis
2. MMI diagnosis and behavior problem
3. No MMI diagnosis - psychotropic drug use
4. Behavior problem only
5. MR and MMI diagnosis

[95]

C. PSYCHOTHERAPEUTIC DRUG USE

Anti-psychotic tranquilizers
1. Ordered - not used
2. Administered

[96]

Anti-anxiety tranquilizers
1. Ordered - not used
2. Administered

[97]

Anti-depressants
1. Ordered - not used
2. Administered

[98]

Sedatives/hypnotics
1. Ordered - not used
2. Administered

[99]

B. BEHAVIOR DESCRIPTION

0. No behavior problem
1. Irritable, grouchy but functions socially
2. Lethargic, drowsy
3. Passive, withdrawn or wanders
4. Disturbs others
5. Aggressive verbally/threatens/steals
6. Physically tries to harm self or others or both

[100]

D. THERAPEUTIC SERVICES

1. Psychotherapy [101]

2. ECT [102]

3. Day programs [103]

4. Community support groups [104]

5. Psychological counseling [105]

6. Sheltered workshop [106]

[ ] 3

PART V REVIEW TEAM SUMMARY AND RECOMMENDATIONS

A. ASSESSMENT INDICATES THAT THIS PERSON NEEDS:

1. Skilled Care 2. Intermediate Care 3. ICF-MR 4. Psychiatric Care 5. Acute Hospital [ ] 23

B. POSSIBLE ALTERNATIVE LIVING:

1. Less restrictive alternatives (MR) 2. Semi-independent living
3. Independent living with home care services [ ] 24

C. INDIVIDUAL COMPONENTS ASSESSMENTS AND PLANS

01. Medical Services [ ] 25
02. Nursing [ ] 26
03. Speech, Hearing, Vision [ ] 27
04. Dental [ ] 28
05. Psychological Services [ ] 29
06. Social Services [ ] 30
07. Activity Assessment [ ] 31
08. Direct Care Staff [ ] 32
09. Dietary [ ] 33
10. Rehabilitation/Special Services (O.T., P.T.) [ ] 34
11. Program of Care [ ] 35
12. Developmental Services - IPP [ ] 36

D. PROGRAM OF CARE IMPLEMENTATION

21. Medical Services [ ] 37
22. Nursing [ ] 38
23. Speech, Hearing, Vision [ ] 39
24. Dental [ ] 40
25. Psychological Services [ ] 41
26. Social Services [ ] 42
27. Activity Assessment [ ] 43
28. Direct Care Staff [ ] 44
29. Dietary [ ] 45
30. Rehabilitation/Special Services (O.T., P.T.) [ ] 46
31. Program of Care [ ] 47
32. Developmental Services [ ] 48
33. IPP [ ] 49
34. Active treatment by trained staff [ ] 50
35. On-going review [ ] 51
36. Appropriate environment [ ] 52
37. Advocacy [ ] 53
38. Specialist consultation [ ] 54

Explanations: _____

_____

_____

_____

_____

_____ R.N. _____ S.S.W. _____ M.D.

DATE [ ][ ] [ ][ ] 198[ ] 55 57 59

ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT Minnesota Veterans Home-Minneapolis **Office Memorandum**

TO : Donald Miller, Commissioner
Department of Veterans Affairs

DATE: 10-28-80

FROM : Francis W. Singer
Admin. Mgt. Director FWS

SUBJECT: Comments on "Management Audit of the Minnesota Veterans Homes" Report.

I received a copy of this report late afternoon of Monday, October 27, 1980. To provide comments as were requested by the cover memorandom will be restricted to those areas where we have been progressing prior to the receipt of this report.

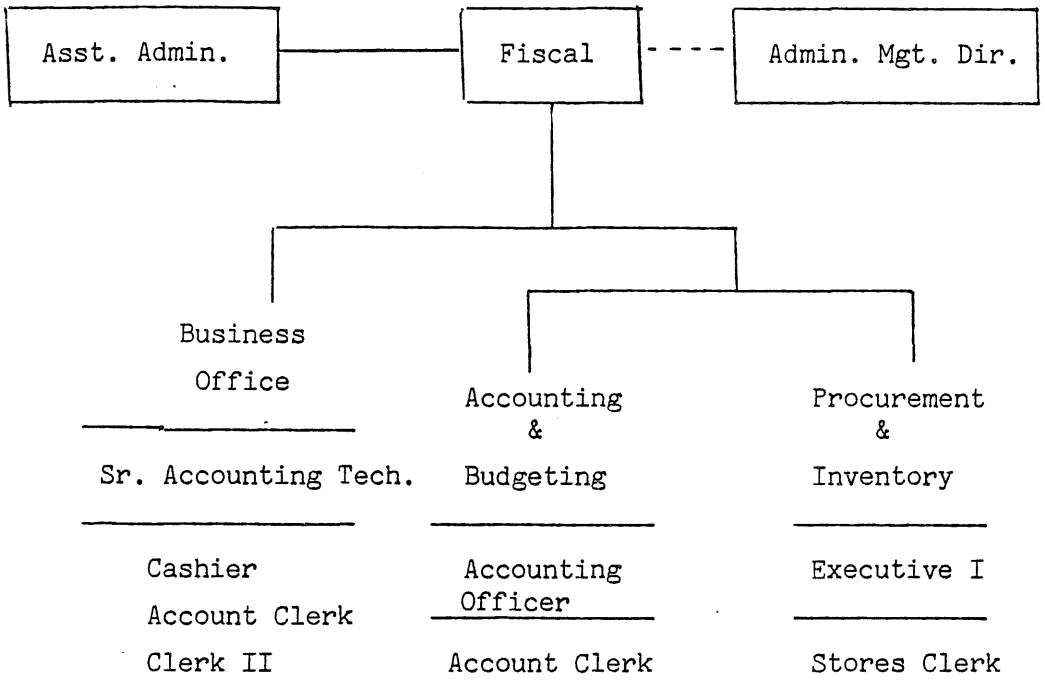
I came aboard on August 4, 1980 and was taken to the various agencies which make up the Department of Veterans Affairs. I met the people in charge and had a brief opportunity to meet the people in the various fiscal units.

The first couple of weeks I was employed by the Department, I reviewed the program structure, statewide accounting reports and attempted to evaluate the operations of Veterans Affairs in light of the Legislative Audit Report and my position description.

Since that time and currently the majority of time has been given to the operations at the Minneapolis Veterans Home realizing that adjustments to current operational procedures will be applicable at Hastings and the Central Office.

My first concern was to restructure the fiscal unit to provide for specific areas of responsibility which would meet the specific needs.

The following is an organizational chart as it now appears for Minneapolis:



Relating to this structure, position descriptions are being prepared for each position outlining the principal responsibilities, tasks and performance measurement guides.

To initiate corrections of the deficiencies of the Legislative Audit report, I begin with the Accounting and Budgeting Activity. On August 8th I reviewed the then current operations of this activity with the Accounting Officer and the Account Clerk. At that time and following, we provide for internal records of encumbrances, establish a system for recording payments, a file maintenance system, procedures for auditing transactions and assigned specific duties to each employee, eg. The Account Clerk issues and records Department Field Orders, the Accounting Officer receives the invoices for payment and approves after verifying receipt of material, the Account Clerk codes prepares and enters the batch for payment.

A policy and procedure dealing with the request for payment for contract services has been established to assure that dual payments are

not made to the vendor nor that payments are made that do not comply with the schedule provided by the contract.

Other policy and procedure guides are being considered and drafted for all aspects of the Accounting and Budgeting Activity.

The next area that I entered was the Business Office Activity. Here, again, I found the need to provide the employees with specific direction to accomplish the correction of the Legislative Audit Report listed deficiencies.

On September 22, with the assistance of the Accounting Officer, I made a cash count to determine whether a balance could be established and what activities were being conducted by this unit.

The Senior Accounting Technician position was assigned to provide the immediate supervision required by the employees and the activities. With this employee and the employees of the Business Office, the deficiencies were reviewed, discussed and reporting forms were prepared.

Since October 13, when we begin using the new forms (Daily Cash Statement and Daily Transaction Log) the Business Office has continually balanced.

Recognizing the types of errors that appeared on the prior forms, I have directed the Senior Accounting Technician to reconstruct from the past records to the new forms all transactions since July 1, 1980. It is my strong belief that the errors that have been reported have had no effect on the daily cash nor the member's accounts but only affected the balance portion of the daily report.

The Senior Accounting Technician was further directed to provide written justification/explanation to justify my belief.

As the employees of this unit and I have discovered areas needing training, sessions have been held which have resulted in an understanding of their specific duties and my understanding of individual work loads.

Each employee has an understanding that the changes that are being

made will reflect in theposition descriptions.

As is the case with the Accounting and Budgeting Activity, policies and procedures are being prepared and reviewed for each aspect of the Business Office.

Many areas of deficiencies that were listed in the Legislative Audit Report key off the areas presently being corrected and will be addressed in a priority manner.

The third area I placed on the organizational chart, Procurement and Inventory, will be supervised by the Executive I position. This position will be filled beginning November 19. In addition to the two areas listed, Procurement and Inventory, this position will be involved with Forms and Records Management.

The need for more immediate involvement in the Inventory area resulted from the completion and equipping of the new building at Minneapolis. Cooperating with the Fixed Asset Inventory System, the equipment received has been marked and last Friday, an Auditor appeared to inspect the process. After his review, I was informed of his complete satisfaction of the process.

Policies and procedures are currently being written for the process of a complete inventory of the Minneapolis Campus and the method of disposal of excess property. Representatives of the Fixed Asset Inventory System have been contacted and have agreed to provide instructions to the employees involved in the on-site inventory and the disposal of surplus property.

Recognizing that Department Field Orders were not being used as directed by the Department of Administration, a memo was directed to the Activity Managers on October 8, 1980 calling to their attention the abuse of this authority. With the memo, each was provided with a copy of the procedures to be used.

To comply with the requirements of maintaining records showing receipts and disbursements from and to the designated contributions account, the Deposit Form has now listed the amount of contribution, contributor and purpose if provided.

The Deposit Form also provides for a Source of Funds breakdown of Receipts. Beginning November 1, the receipts for the Canteen, Coffee Shop and Shop-n-round will be deposited to separate codings. The receipts for VA reimbursements and member payments will be coded separately between domiciliary and nursing care beginning December 1.

On September 30th, a meeting of all activity managers was held at the Minneapolis Veterans Home. Each manager was provided with copies of various printouts and explanation of each printout was provided. This meeting resulted from prior meetings with the Assistant Administrators of the Home at which time we discussed selection of Activity Managers and their responsibilities. Similiar discussions were held at the Central Office and Hastings. The assignment of Activity Managers and provision of fiscal information on a monthly basis will create an informational system of available resources for the Activity Manager and reflect needs to the Assistant Administrators who together will determine programs to be carried out.

I regret that my comments cannot be in greater detail. I further regret that I cannot comment on each item in the report that relates to my area of responsibility. I am aware of the existence of the deficiencies listed. I assure you that with the assistance of the present staff and those yet to be hired the corrections will be made.

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT Of Administration

Office Memorandum

TO : Kathryn R. Roberts, Director
Management Analysis Division

DATE: August 14, 1980

FROM : Warren D. Madigan, Auditor
Management Analysis Division

PHONE: (612)296-6621

SUBJECT: Dental Service Invoices - MN Veterans Home

Per your instructions I have made an examination of invoices for dental services provided to residents of the Minnesota Veterans Home - Minneapolis.

Invoices paid during the period July 1, 1973 through June 30, 1975 and July 1, 1976 through June 30, 1979 were reviewed for compliance with MN Department of Public Welfare fee schedules. Invoices for the period July 1, 1975 through June 30, 1976 were not available and consequently could not be examined.

The purpose of this review was to determine the extent of overpayments stated in reports by the Legislative Auditor's Staff.

FINDINGS:

The examination of invoices disclosed a total of 596 discrepancies; 594 overpayments and 2 duplicate invoices. Amounts of overpayment and the period in which they occured are listed below.

July 1, 1973 - June 30, 1974	$ 854.00
July 1, 1974 - June 30, 1975	$ 787.00
July 1, 1975 - June 30, 1976	not available
July 1, 1976 - June 30, 1977	$ 557.00
July 1, 1977 - June 30, 1978	$3,647.00
July 1, 1978 - June 30, 1979	$1,397.00
TOTAL	$7,242.00

It is the opinion of the writer that these overpayments were caused by two primary reasons.

a) Non-compliance by the consultants with contracts and fees set forth in Department of Public Welfare schedules.
b) Failure by the MN Veterans Home to monitor invoices and payments for services.

At the time of the review, there were no written policies and procedures in effect and MVH accounting personnel had only recently received a copy of the dental fee schedule.

There was no evidence to indicate that invoices for dental services were reviewed prior to delivery to the accounting unit for payment.

Although a procedure relative to securing dental work for residents was issued April 11, 1979, it does not contain a requirement to review invoices for compliance with fee schedules as required in the consultants' contract.

MVH has been paying statements which reflect outstanding balances with no explanation of treatment rendered to the patient. None of the statements reviewed appeared to have been questioned as none have notations or references that would indicate that they had.

RECOMMENDATIONS:

1. That the Department of Veteran Affairs take positive action to recover overpayments through voluntary reimbursement, or by legal means if necessary.

2. That written policies and procedures be prepared and that they contain specific responsibilities for monitoring compliance with DPW fee schedules and consultant contracts.

3. That invoices be reviewed, and payment approved by an individual with a working knowledge of the services provided; this may require assistance from medical staff personnel.

4. That invoices be reviewed and processed for payment within three days except for those which require clarification or additional information.

5. That dental consultant contracts contain the requirement to use American Dental Association Codes of Dental Procedures on invoices to identify treatment provided. This would enable the reviewer to correctly identify the procedure and to verify charges accurately and quickly.

6. That the present practice of making payments on vendor's statements be discontinued immediately - payment should be made on original invoices only and then only after that invoice has been compared against the fee schedule.

ATTACHMENTS:

1. MVH Procedures for Securing Dental Work for Residents, April 11, 1979.

2. Duplicate Payments - Richard Kirchoff and Lyle McGillivary

3. Analysis of Dental Charges (18 pages)

4. DPW Dental Fee Schedules

cc: Terry Bock

WDM/lmn

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT of Administration

Office Memorandum

TO : Kathryn R. Roberts, Director
Management Analysis Division

DATE: September 16, 1980

FROM : Warren D. Madigan, Internal Auditor
Management Analysis Division

PHONE: 296-6621

SUBJECT: Optometrist/Optician Invoices - Minnesota Veterans Home

An examination has been made of invoices for optometry and optician services provided residents of the Minnesota Veterans Home (MVH) during the period July 1, 1973, through June 30, 1979. The purpose of this audit was to measure compliance with Minnesota Department of Public Welfare (DPW) fee schedules and to determine the extent of overpayments stated in the Legislative Auditor's reports.

FINDINGS:

1. A total of 95 variances with DPW fee schedules was disclosed during the reviewal. Amounts of overpayments, time period, and recipient are as follows:

Period	MN Eye Clinic	Midway Opticians
July 1, 1973 - June 30, 1974	$ 604.85	Not Available
July 1, 1974 - June 30, 1975	1,180.50	Not Available
July 1, 1975 - June 30, 1976	1,151.75	$ 46.05
July 1, 1976 - June 30, 1977	829.35	108.55
July 1, 1977 - June 30, 1978	1,259.40	205.20
July 1, 1978 - June 30, 1979	945.60	240.30
TOTALS:	$5,971.45	$600.10

The overcharges listed to the Minnesota Eye Clinic are attributable primarily to "services rendered" charges. This charge apparently stems from an agreement made in September, 1971, wherein the Minnesota Veterans Home was to pay the Minnesota Eye Clinic a per capita of $6.00 plus a fee of $150.00 for each group of eight residents examined or $24.75 per examination, which exceeds fee schedule limitations of $19.55 up to January 31, 1979, and $22.00 thereafter. Minnesota Veterans Home accounting personnel were aware of the "services rendered" charges; however, none recalled having seen documentation. It appears the charges came into being due to residents failing to show up for examinations.

2. Payments made to the Minnesota Eye Clinic have been based on statements which identify the patient by name, but not treatment provided. Some statements indicated "exam", "service rendered", "#1", "#2", "#4", etc., and there was no apparent correlation between codes used in the statements and DPW fee schedules.

3. Statements submitted by the Minnesota Eye Clinic for January and February, 1979, were paid March 12, 1979, and were paid again June 4, 1979. It appears to have occurred through failure to effect payment only from the original invoice. In this instance, the vendors had repeatedly submitted statements for overdue payments which in reality had been paid nearly three months previously and no apparent effort was made to determine if payment had actually been made.

4. Glasses prescribed by the Minnesota Eye Clinic have been purchased from Midway Opticians during the period covered by this review. No contractual agreement was found to exist between the Minnesota Veterans Home and Midway Opticians, nor was any evidence found that such an agreement existed during the period July 1, 1973, and June 30, 1979. Additionally, there was no evidence to indicate that Midway Opticians has ever been on a Procurement Division price contract for prescription glasses.

5. At the time of the review, it was revealed that Midway Opticians procures the lenses and frames from Soderberg Optical Service, Incorporated. Midway Opticians submits the Soderberg invoice to Minnesota Veterans Home for payment to Midway Opticians. This is not an acceptable accounting procedure.

6. On January 8, 1979, Minnesota Veterans Home was billed $110.00 for glasses for Richard Means; on January 15, 1979, an invoice for $50.00 was submitted for lenses for the same individual. In a similar situation, William Schaeffer was provided glasses on June 5, 1978, for $114.00; on August 11, 1978, and again on April 19, 1989, he was provided lenses at $50.00 for each occasion.

   In neither instance was there any indication as to why these changes were necessary in such a short period of time.

7. Soderberg, Inc., invoice #415857, dated May 22, 1977, relative to Marie Wilnes indicates charges were changed at least twice; the amount paid ($58.60) does not agree with figures shown on the invoice.

8. Soderberg, Inc., invoice #1002750, dated May 4, 1979, that pertains to Adolph Verpy does not reflect the amount charged for frames. A payment of $11.00 was made to Midway Opticians on SWA transaction 060679-05446.

9. During the period July 1, 1973, through June 30, 1977, all payments for optometry and optician services were made from automatic encumbrances. These actions were contrary to procedures established by the statewide accounting system.

RECOMMENDATIONS:

1. Action should be taken by the Department of Veterans Affairs to recover overpayments.

2. Maintain a log of residents who request appointments for eye examinations and insure they keep the appointments.

3. Establish a system to monitor vendor invoices for compliance with DPW fee schedules.

4. Discontinue payment of invoices other than those of the vendor providing the service.

5. Request clarification of invoices, or other requests for payment, which are not clearly stated before approving payment.

6. Insure that contracts are processed in accordance with policies and procedures established by the Office of Contract Management, Department of Administration.

7. Prepare written policies and procedures that assign specific responsibilities for providing optometry and optician services to the residents.

ATTACHMENTS:

1. Analysis of Payments for Optometry Services

2. Analysis of Payments to Midway Opticians

3. Duplicate Payments for January and February, 1979

4. Invoices - Richard Means, 1/8/79 and 1/15/79

5. Invoice - Marie Wilnes, 5/27/77

6. Invoice - Adolph Verpy, 5/4/79

7. DPW Optometry/Optician Fee Schedules

WDM:lo

cc: Terry Bock

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT of Administration

Office Memorandum

TO : Kathryn R. Roberts, Director
Management Analysis Division

DATE: October 13, 1980

Warren D. Madigan

FROM : Warren D. Madigan
Interanl Auditor
Management Analysis Division

PHONE: 296-6621

SUBJECT: Podiatry Service Invoices - Minnesota Veterans Home

A review has been made of invoices for podiatry services provided residents of the Minnesota Veterans Home (MVH) for the periods July 1, 1973, through June 30, 1977, and July 1, 1978, through June 30, 1979. Invoices for the period July 1, 1977, through June 30, 1978, were not available and therefore were not examined.

The purpose of this review was to determine compliance with contracts for the audit periods and with Department of Public Welfare (DPW) fee schedules.

FINDINGS:

1. At the time of this review there were no written policies and procedures for the internal processing of disbursements.

2. Statements submitted by the contractor did not identify residents, nor the treatment rendered. Only the date and number of hours were shown on the monthly statements.

3. Although the contracts required podiatry services be performed as prescribed and recommended by the MVH physician, there was no evidence to indicate this was done.

4. Requests for surgical authorizations and post operative reports submitted by the contract podiatrist were approved by the MVH administrator after surgery had been performed.

5. Compensation for services rendered pursuant to the contract were at the rate of $25.00 per hour. The contracts contained no provision for additional compensation. However, separate statements were submitted for surgical procedures.

6. Payments for surgery were made from automatic encumbrances which circumvented terms of the contracts relating to the rate of compensation for services rendered.

7. Because of the method of billing for surgical services, there was no apparent relationship with the DPW fee schedule.

RECOMMENDATIONS:

1. Internal controls for the disbursement of funds be established and they assign specific responsibilities for monitoring professional service contracts and compliance with DPW fee schedules. These procedures would include the institution of a log of residents who request or are referred for treatment.

2. Invoices should identify the patient, describe treatment provided, indicate the AMA procedure code, and total time involved.

3. All requests for payment should be reviewed by the Minnesota Veterans Home medical staff prior to processing the disbursement. This would assist the accounting section in identification of the procedure and verification of charges.

4. The Minnesota Veterans Home physician should review and approve all requests for surgical authorization and coordinate with the accounting section to ensure availability of funds.

5. All disbursements are in conformance with terms of the contract as to compensation for services rendered.

6. No payments for medical services be made from automatic encumbrances. Medical services are to be encumbered under object code 162.

7. Future contracts for mdeical services contain a provision that compensation rates will conform with DPW fee schedules.

ATTACHMENTS:

1. Monthly Statements, January and April, 1974

2. Operative Report and Request for Surgery (Johnson)

3. Operative Report and Request for Surgery (Anderson)

4. Statement, January 31, 1974 (Alexander and Graftar)

5. Operative Report and Request for Surgery (Olson)

6. Contract for F.Y. 1974 (59000-00021)

7. Contract for F.Y. 1976 (59000-00713)

8. Contract for F.Y. 1980 (75200-01099)

WDM:mmat

cc: Terry Bock

MISSION STATEMENT

MINNESOTA VETERANS HOMES

TO PROVIDE NECESSARY NURSING AND DOMICILIARY CARE FOR THE VETERAN AND ELIGIBLE DEPENDENT POPULATIONS OF THE STATE OF MINNESOTA WHEN SUCH CARE IN A COMMUNITY SETTING IS NOT WITHIN THE ECONOMIC MEANS OF THE VETERAN OR ELIGIBLE DEPENDENT. THE CARE PROVIDED WILL INSURE THAT EACH MEMBER HAS A SHELTERED ENVIRONMENT AND AN INDIVIDUALIZED PROGRAM WITHIN WHICH HE OR SHE CAN FUNCTION OR BE ASSISTED TO FUNCTION AT THEIR HIGHEST LEVEL OF PHYSICAL, SOCIAL AND MENTAL ABILITIES. THE CARE WILL BE PROVIDED IN A HUMANE AND DIGNIFIED MANNER WHICH AT ALL TIMES MAINTAINS THE RIGHTS OF EACH MEMBER TO BE FULLY INVOLVED IN DETERMINING THEIR OWN NEEDS AND THE PROGRAMS PROVIDED TO MEET THOSE NEEDS.

APPENDIX H

Staffing Guidelines

To determine the number and type of staff required by the Minnesota Veterans Homes, the Study Team has applied three sets of staffing standards:

1. Veterans Administration staffing guidelines for domiciliary care in State Veterans Homes.

2. Nursing Care Standards of the Minnesota Department of Health.

3. Nursing Care Staffing Standards adopted by the State of Ohio. These standards are based on detailed, tested time and motion studies of nursing facilities in California, Oregon, and Ohio and have been used by the State of Ohio and others to meet standards of the Joint Commission on Accreditation of Hospitals.

Table 1 is the Veterans Administration staffing guidelines for domiciliary care in State Veterans Homes. The guidelines were given to the Study Team by the Director of the State Veterans Home Program, U.S. Veterans Administration. Nursing care standards of the Minnesota Department of Health can be found in Minnesota Code of Agency Regulations 7MCAR Section 1.044 through 1.056 (MHD 44 through 56). A copy of the nursing care staffing standards adopted by the State of Ohio is available upon request from the Study Team.

The Study Team's staffing recommendations are based on a general analysis of resident needs as identified by the Quality Assurance and Review Team's survey of residents. All staffing standards, including those used in this report, provide only generalized guidelines in determining the number and type of staff needed by a facility. The exact number and type of staff required must be determined by detailed, in-depth assessments of residents by staff and an assessment of the physical pecularities of the facility. The number and type of staff required by a facility changes with changes in residents and resident needs.

Table 2 outlines staffing requirements of the Minnesota Veterans Homes for 490 domiciliary beds. The Study Team recommends 12 fewer staff than the V.A. guidelines would require: 4.9 FTE fewer psychologists, 1.0 FTE fewer rehabilitation staff, and 6.1 fewer dental staff. The Study Team believes these services can be contracted for or provided by the Veterans Administration Medical Centers and other community agencies.

Table 3 outlines staffing requirements of the Minnesota Veterans Homes for both 150 and 250 nursing care beds. The Study Team recommends fewer psychologists and registered nurses than the State of Ohio standards would suggest because the Team believes these services can be contracted for or provided by outside agencies. Fewer physicians,

pharmacists, and maintenance personnel are needed because of economies of scale which occur by operating the nursing program in conjunction with the domiciliary programs. Fewer medical records staff are needed because the Study Team believes that actual maintenance of records should be done by staff assigned to the living units. Fewer personnel staff are needed because most of the personnel work can be done by Central Office staff. Overall, the Study Team recommends 23 fewer FTE positions than the Ohio standards to staff 250 beds. The Team's recommendations meet all Minnesota Health Department licensing standards.

Table 4 summarizes the staffing recommendations.

Table 1

UNITED STATES VETERANS ADMINISTRATION
DOMICILIARY STAFFING GUIDELINES

	100 Beds	200 Beds
Domiciliary Administration		
*Chief Domiciliary Operations	1.0	1.0
*Executive Assistant (Asst. Chief)	1.0	1.0
Domiciliary Assistants	3.0	6.0
Secretary/Clerk/Steno	1.0	2.0
Medical Administration	1.5	3.0
Subtotal	7.5	13.0
Direct Care		
Physicians	1.0	2.0
Nurses (including supervisor)	1.0	2.0
LPN/NA	2.0	4.0
Psychology	1.0	2.0
Social Work	1.5	3.0
RMS (Rehabilitation)	2.0	4.0
Recreation	1.0	2.0
Dietetics	5.75	11.5
Dental	1.25	2.5
Chaplain	.25	.5
Subtotal	16.75	33.5
Support		
Pharmacy	.50	1.0
Building Management	2.50	5.0
Engineering	2.0	4.0
Support Staff (X-ray, Lab., etc.)	1.75	3.5
Subtotal	6.75	13.5
Total	31.0	60.0

*Chief, Domiciliary Operations and Executive Assistant (Assistant Chief) will be responsible for administrative and program functions. One position each will be required regardless of the number of beds.

Table 2

DOMICILIARY STAFFING REQUIREMENTS
MINNESOTA VETERANS HOMES

	Veterans Administration Guidelines for 490 Beds	490 Dom Beds
Domiciliary Administration	29.0 FTE	29.0 FTE
Includes:		
Chief Domiciliary Operations	1.0	1.0
Executive Assistant (Asst. Chief)	1.0	1.0
Domiciliary Assistants	14.7	14.7
Secretary/Clerk/Steno	4.9	4.9
Medical Administration	7.4	7.4
Direct Care	82.0 FTE	70.0 FTE
Includes:		
Physicians	4.9	4.9
Nurses	4.9	4.9
LPN/NA	9.8	9.8
Psychology	4.9	-0-
Social Work	7.3	7.3
Rehabilitation	9.8	8.8
Recreation	4.9	4.9
Dietetics	28.2	28.2
Dental	6.1	-0-
Chaplain	1.2	1.2
Support	33.0 FTE	33.0 FTE
Pharmacy	2.5	2.5
Building Management	12.2	12.2
Engineering	9.8	9.8
Support Staff (X-ray, Lab, etc.)	8.5	8.5
Total	144.0 FTE	132.0 FTE

Table 3

NURSING STAFFING REQUIREMENTS
MINNESOTA VETERANS HOMES

	Ohio Standards for 250 Beds	150 Nursing Beds	250 Nursing Beds
Social Workers	2.8 FTE	2.0 FTE	3.0 FTE
Physicians	2.7 FTE	-0-	-0-
Interchangeable Staff	2.7 FTE	5.0 FTE	5.5 FTE
Psychologists	3.5 FTE	-0-	-0-
Rehabilitation	8.5 FTE	5.0 FTE	7.5 FTE
Dietary Staff	8.7 FTE	7.0 FTE	8.0 FTE
Housekeeping	11.5 FTE	9.0 FTE	10.5 FTE
Personnel	3.0 FTE	-0-	-0-
Chaplains	1.0 FTE	1.0 FTE	1.0 FTE
Administrative Offices	10.0 FTE	10.0 FTE	10.0 FTE
Central Stores	3.0 FTE	2.0 FTE	2.0 FTE
Nursing - RN	17.0 FTE	9.0 FTE	11.0 FTE
LPN HST	75.0 FTE	45.0 FTE	75.0 FTE
Business Office	4.0 FTE	4.0 FTE	4.0 FTE
Pharmacy	3.0 FTE	1.0 FTE	1.0 FTE
Medical Records	5.5 FTE	1.5 FTE	2.0 FTE
Maintenance	20.0 FTE	14.0 FTE	14.0 FTE
Power Plant	6.0 FTE	6.0 FTE	6.0 FTE
Total	187.9 FTE	121.5 FTE	160.5 FTE

Table 4

STAFFING REQUIREMENTS
MINNESOTA VETERANS HOMES

	Veterans Administration Guidelines Ohio Standards for 250 NCB/490 DCB	150 NCB/ 490 DCB	250 NCB/ 490 DCB
Domiciliary Care	144.0 FTE	132.0 FTE	132.0 FTE
Nursing Care	187.9 FTE	121.5 FTE	160.5 FTE
Total	331.9 FTE	253.5 FTE	292.5 FTE

APPENDIX I

Resident Characteristics
Minnesota Veterans Homes - 1980

Appendix I is comprised of three parts. Part One describes the residents of the Minnesota Veterans Homes in 1980. The source of this information was the resident files at the Homes as of June, 1980. From those files were abstracted the building in which the person was housed, the age in 1980, sex, marital status, monthly income, county from which admitted, number of readmisssions in the file, the branch of military service, and the first conflict during which the resident served. Similar data were collected by the EBS management team in 1968. Where possible, historical comparisons of resident characteristics are included.

A sample of 132 residents was drawn from the Minneapolis facility. These people were interviewed in some depth by the Study Team. The interview schedule is found as Appendix C. Part Two describes the characteristics of those 132 residents. They are similar in their overall characteristics to the population of the two facilities and can be presumed representative of the total population current as of June, 1980.

A sample of 25 residents was also interviewed at the Hastings facility. No significant differences emerged between the residents interviewed at Minneapolis and at Hastings. The data on Hastings residents, which is not reported here because of the small sample size, is available upon request.

Part Three describes characteristics of residents discharged from the Minnesota Veterans Homes during the years 1960 to 1980, and of residents who died in the Homes during the years 1965 to 1980. The source of this information was resident files at the Homes.

Overall Resident Population

Table 1 shows the age distribution of Minnesota Veterans Homes residents in 1968 and 1980. A little more than half of the residents (54%) in 1980 were aged 55-74. The total age span in 1980 is from under 25 to over 95. The proportion of residents under age 55 has increased between 1968 and 1980, while the proportion of residents aged 75 and over has declined. Significant, however, is the slight increase in the proportion of residents over age 84.

Table 1

AGE DISTRIBUTION OF MVH RESIDENTS

	1968		1980	
Age	N	%	N	%
17-24			2	.3
25-34			14	2.4
35-44			22	3.8
45-54	30*	8.5*	80	14.0
55-64	76	21.5	180	31.5
65-74	133	37.5	130	22.7
75-84	93	26.3	85	14.9
85+	22	6.2	57	9.8
N/A**	-	-	2	.2
Total	354	100%	572	100%

*Reflects all individuals 54 and under. In 1980, 20.6% of all residents were aged 54 and under.

**N/A means either non-applicable or data not available.

Table 2 gives the male/female distribution of Minnesota Veterans Homes residents in 1968 and 1980. It is interesting to note the sharp decrease of female residents.

Table 2

SEX DISTRIBUTION IN 1968 AND 1980

	1968		1980	
Sex	N	%	N	%
Female	64	18.1	21	3.7
Male	290	81.9	551	96.3
Total	354	100%	572	100%

Table 3 presents the breakdown of residents by their marital status. Less than 6% of the residents were currently married in 1980. The largest percentage, 43%, had never been married. Nearly 30% (28.9%) were divorced, and 15% were widowed. The proportion of divorced residents increased slightly between 1968 and 1980.

Table 3

MARITAL STATUS OF MVH RESIDENTS AT APPLICATION

	1968		1980	
	N	%	N	%
Married	25	7.1	32	5.6
Widowed	83	23.4	88	15.4
Separated	18	5.1	38	6.6
Divorced	68	19.2	164	28.7
Single	157	49.1	246	43.0
N/A	4	1.1	4	.7
Total	354	100%	572	100%

Table 4 is a cross tabulation of resident age by level of care. Sixty percent of all residents aged 75 and over and 17% of all residents aged 65 to 74 reside in the Homes' nursing care unit. Forty percent of all residents over age 84 live in the Homes' domiciliary units. The Minneapolis domiciliary unit has a slightly larger proportion of residents under age 45 and of residents over age 74 than Hastings.

Table 4

AGE OF MVH RESIDENTS BY LEVEL OF CARE - 1980

Age	Minneapolis Domiciliary	Nursing Care	Hastings Domiciliary	Row Total
17-24	2	0	0	2
25-34	12	1	1	14
35-44	17	0	5	22
45-54	53	1	26	80
55-64	117	6	57	180
65-74	80	22	28	130
75-84	45	28	12	85
85+	21	32	4	59
N/A	-	-	2	-
Total	347	90	135	572

Table 5 shows that almost 60% of the Homes' residents were admitted from the seven-county metropolitan area. This figure is slightly lower than that (65%) reported in 1968 by EBS. Current residents have been admitted from 71 of Minnesota's 87 counties, and a slightly disproportionate number come from the metropolitan area. Part of this disparity arises from the fact that a Veterans Administration Medical Center is located in Minneapolis and is the Homes' single largest source of medical referrals.

Table 5

COUNTY OF ADMISSION

	1968		1980	
	N	%	N	%
Metro Area	288	65	328	57.4
Outstate	155	35	225	39.3
N/A	-	-	19	3.3
Total	443*	100%	572	100%

*This represents county of admission of all members of the Homes between January 1, 1967 and June 1, 1968.

In an attempt to further define the current Minnesota Veterans Homes population, readmission data were collected. About 16% of all residents in 1968 had been readmitted more than one time. In 1980, 21% had been admitted more than once.

Table 6

RE-ADMISSIONS

Number of	1968		1980	
Readmissions	N	%	N	%
0	297	83.9	452	79
1	57*	16.1*	80	14
2			23	4
More than 2			17	3
Total	354	100%	572	100%

*Reflects all individuals with more than one admission. In 1980, 21% of all residents had more than one admission.

Table 7 reports residents' first period of military service. In 1980, two-thirds of the residents are World War II veterans. As expected, the World War I population decreased sharply between 1968 and 1980. The number and proportion of non-veterans has also decreased markedly.

Table 7

PERIOD OF FIRST MILITARY SERVICE

	1968		1980	
Period	N	%	N	%
Spanish-American	6	1.7	0	0
World War I	165	46.6	98	17.1
World War II	119	33.6	373	65.2

Table 7 (continued)

Period	1968 N	1968 %	1980 N	1980 %
Korea	1	.3	49	8.6
Vietnam	0	0	17	3.0
Peace-time	*	*	18	3.1
Non-Veteran	63	17.8	17	3.0
Total	354	100%	572	100%

*Peace-time veterans, except for extraordinary circumstances, were not eligible for addmission until 1980.

Table 8 shows the branch of service of Minnesota Veterans Homes residents in 1980. Service data was not collected by EBS in 1968.

Table 8

BRANCH OF SERVICE - 1980

Branch	N	%
Army	420	73.4
Navy	84	14.7
Marines	22	3.8
Air Force	13	2.3
Coast Guard	1	.2
Non-Veterans	17	3.0
N/A	15	2.6
Total	572	100%

Table 9 depicts the monthly income of residents as of June, 1980. Almost 45% of all residents have monthly incomes between $201 and $400. Thirty percent have incomes over $400, and almost 15% have no income. The range of monthly incomes is from none to $1,317. The residents' two primary sources of income are Social Security and Veterans Administration payments. Strictly comparable data on resident income is not available for 1968 due to inflation. EBS did report that 12.7% of all residents in 1968 had no income, which is roughly comparable to the figure reported for 1980.

Table 9

TOTAL MONTHLY INCOME - 1980

Range	N	%
None	81	14.2
$1 - $200	74	13.0
$201 - $400	250	43.7
$401 - $600	70	12.2

Table 9 (continued)

Range	N	%
$601 - $800	51	8.9
$801 - $1,000	38	6.6
More than $1,000	8	1.4
Total	572	100%

Table 10 shows total monthly income by level of care. There are significant differences between the income of individuals receiving nursing care and those receiving domiciliary care. Two-thirds of all residents receiving nursing care have total monthly incomes of over $600 compared to only 7.5% of all residents in domiciliary care. No significant income differences exist between the Minneapolis and Hastings domiciliary units except for a slightly larger percentage of residents in Hastings who have no income. Increased Veterans Administration compensation (formerly aid and attendance payments) for nursing care residents and age differences explain income differences between nursing and domiciliary residents. Ninety-one percent of all nursing care residents are over age 64 and thereby entitled to maximum Social Security and Veterans Administration benefits, compared to only 39.4% of all domiciliary residents (see Table 4).

Table 10

TOTAL MONTHLY INCOME BY LEVEL OF CARE - 1980

Range	Minneapolis Domiciliary	Nursing Care	Hastings Domiciliary
None	53	1	27
$1 - $200	53	4	17
$201 - $400	171	12	67
$401 - $600	42	12	16
$601 - $800	15	30	6
$801 - $1,000	11	26	1
More than $1,000	2	5	1
Total	347	90	135

Twelve percent of all residents have outside "guardians" who either make or monitor payments of maintenance charges to the Homes. These individuals and organizations are not necessarily legally designated guardians.

Residents in Department of Administration Sample

This part describes the characteristics of the 132 residents interviewed at Minneapolis. The residents were chosen at random and can be presumed to be representative of the Home's total population as of June, 1980. A sample of 25 residents of Hastings was also interviewed. No significant differences between the two groups of residents

were noted. Conclusions about Minneapolis residents, we believe, can be generalized to all residents, including those at Hastings.

A number of questions asked residents permitted more than one response. Consequently, the N's reported for certain questions will differ from the base N of 132. All percentages are based on the number of responses to a specific question.

Residents were asked to identify who referred them to the Home. See Table 11. Thirty-eight percent of the residents said they had been referred to the Home by Veterans Administration Medical Center staff in Minneapolis and St. Cloud. The nearly 20% who reported a "self-referral" may have interpreted the question as "who decided they should come to the Homes" rather than "who referred them."

Table 11

"WHO REFERRED YOU TO THE HOMES?"

Response	N	%
Veterans Administration Medical Center Staff	50	37.3
Self-referral	25	18.7
Veterans Service Officers	16	11.9
Veterans Service Organizations	6	4.5
Family Members	15	11.2
Friends and Other Individuals	7	5.2
Social Service and Other Governmental Agencies	15	11.2
Total	134	100%

When asked where the resident had lived immediately prior to admission to the Home, nearly half (48.5%) stated they had been living by themselves. Ten percent had lived with their families, 25% with other relatives, 5% with other persons, and 6% came directly from a hospital. No responses were given by 5.3% of the sample.

In addition to basic background information, the interview included many questions regarding resident activities or program participation. Following are results from those questions.

When asked what the residents miss that they had, or could do before coming to the Home, the responses were widely scattered. It is interesting that 37% said they missed nothing. Of the 8% who said they missed sports, most missed fishing or sports in general. Of other activities missed, residents mentioned cooking, gardening, photography, and teaching Sunday school. Nine percent stated they missed being employed: 7 missed the work itself; 5 missed the money.

As it related to their surroundings, 2 residents missed "good food" and one resident each missed peace and quiet and having a private bathroom. Four percent reported they missed privacy, 3% independence,

3% owning a car, and 2.3% owning their own home. One person mentioned missing "being young" and one reported the Home to be "just like the service."

Eight percent said that they missed specific people. Friends were missed by 5 residents, family members by 3, wives by 2, and one resident missed "youngsters."

Next, the residents were asked to identify the extent they participated in daytime and evening activities. Following are the results.

Table 12

"HOW OFTEN DO YOU TAKE PART IN SCHEDULED ACTIVITIES?"

Time Period	Responses "There are None"	Frequently	Occasionally	Not Interested
8am-5pm M-F	12 (9.1%)	30 (22.7%)	32 (24.2%)	54 (40.9%)
5pm-10pm M-F	1 (0.8%)	50 (37.9%)	35 (26.5%)	42 (31.8%)
Weekends	28 (21.2%)	28 (21.2%)	22 (16.7%)	50 (37.9%)

Note: Percentages given are based upon 132 interviews, and disregard the 4 residents who did not respond to each question.

The Study Team was also interested in the extent to which residents had regular contacts with persons they knew outside the Home. Five of the 132 residents visited their spouses and children, while 25, or 20%, visited only their children. (The term "visited" inplies any regular contact between a resident and someone outside the Home. It includes telephone conversations, letters, and being visited at the Home.) Fifty-nine percent of the residents visited other relatives, mostly brothers and sisters; 5% visited parents; 44% visited friends; 5% visited other persons. Twenty residents, or 16% of the respondents, said they had no visitors and visited no one.

In an attempt to determine whether the residents were satisfied with their living conditions, they were asked, "If you had the opportunity, would you like to live somewhere else?" Forty-four residents, or 33% of the respondents, said they would move to another residence from the Home if they had the opportunity. Fifty-one percent of the residents said they would prefer not to move. Fifteen percent did not answer the question.

Residents were asked to respond to two questions regarding their employment status. First, were they currently employed, and if not, did they want to be. Tables 13 and 14 present the results of those questions.

Table 13

"ARE YOU CURRENTLY EMPLOYED?"

Response	N	%
On Campus		
Employed	37	28.0
Physically Unable	50	37.9
Not Employed	44	33.3
N/A	1	.8
Total On Campus	132	100%
Off Campus		
Employed	2	1.5
Physically Unable	51	38.6
Not Employed	78	59.1
N/A	1	.8
Total Off Campus	132	100%

Table 14

"DO YOU WANT TO BE EMPLOYED?"

Response	N	%
On Campus		
Yes	10	7.6
Already Employed	37	28.0
Physically Unable	50	37.9
Not Interested	32	24.2
N/A	3	2.3
Total On Campus	132	100%
Off Campus		
Yes	11	8.3
Already Employed	2	1.5
Physically Unable	51	38.6
Not Interested	65	49.3
N/A	3	2.3
Total Off Campus	132	100%

The Study Team asked the residents to identify how often they used available medical services. See Table 15. The Home's physician was seen monthly by 39% and occasionally by 45% of the residents. One resident reported seeing the Home's physician daily and 10 reported seeing him weekly. The Home's contract dentist was seen monthly by 1.7% of the residents and occasionally by 37.7%. The Home's podiatrist was seen weekly by 1.6% of the residents, monthly by 7.4%, and occasionally by 41.8%. The Home's eye doctor was seen occasionally by 38.5% of the residents. Six percent of the residents reported that they had never seen the Home's physician, 60.7% had

never seen the Home's dentist, 49.2% had never seen the Home's podiatrist, and 61.5% had never seen the Home's eye doctor. Almost 10% of the residents reported seeing a private physician at least occasionally, and 5.7% reported using the Hennepin County Medical Center for medical services other than the Home's required annual chest X-ray.

The Veterans Administration Medical Center outpatient clinic in Minneapolis was used at least monthly by 9.8% of the residents and occasionally by 34.7%. Sixty percent of the residents reported having been admitted as inpatients at the Minneapolis Veterans Administration Medical Center while they were residents of the Home. Only 4.2% reported having been inpatients at the St. Cloud Veterans Administration Medical Center since their admission.

Table 15

"HOW FREQUENTLY DO YOU USE THE FOLLOWING MEDICAL SERVICES?"

Service	Daily	Weekly	Monthly	Occas.	Never	Row* Total
Homes' Physician	1	10	48	55	8	122
Homes' Dentist			2	46	74	122
Homes' Podiatrist		2	9	51	60	122
Homes' Eye Doctor				47	75	122
Private Physician			1	11	110	122
Hennepin County Medical Center			1	6	115	122
VAMC Outpatient	4	4	4	42	67	121
VAMC Inpatient - Minneapolis				70	49	119
VAMC Inpatient - St. Cloud				5	115	120

*Row totals vary due to the number of residents not responding to the question.

The residents were also asked if they used the Home's corrective therapy services. Twenty-nine percent said they used the services, 65% said they did not, and 6% said they did not know the services were offered.

The Study Team asked each respondent if they had been in a detoxification program prior to or since being admitted to the Home. Twenty-five residents (20%) reported they had been in a detoxification program prior to entering the Home. Seven residents (5.7%) said that they had been in a detoxification program while residents of the Home.

The residents were also asked about how often and under what circumstances they left the grounds. Eighty-five percent of respondents said they did so. Forty-five residents, or 37% of the respondents, said they leave at least once a week and another 26% said they go off campus once a month. Only 15% reported never leaving the grounds.

Of the 104 who reported leaving the grounds, the destinations were as follows (up to three answers could be given by a single resident): to visit relatives and friends, 48%; shopping, 17%; errands, 9%; restaurants, 6%; taverns, 3%; recreation, 24%; and "downtown", 26%. Twenty-four percent did not specify their destination.

The residents who left campus were asked what means of transportation they used: the MTC bus which stops at the Home, 56%; a visitor's car, 33%; any other MTC bus, 31%; on foot, 19%; taxi, 17%; someone with a car whom the resident calls, 16%; transportation owned by the Home, 8%; and other public transportation, 6%.

The Study Team asked residents to report the sources of their income. For most residents, the largest source of income is either Veterans Administration or Social Security benefits. Less than 5% report private pensions as their largest source of income. Earnings and savings are not significant sources of income.

Following, a question was posed which asked where the residents' money was kept and the extent to which they manage their money. Records at the Home were also checked against the same question. Thirty-nine percent of the residents said they used the Home's cashier without restriction; the Home records reported this to be the case with 90%. Another 10% reported they used the cashier with some restrictions, and 5% said they used the cashier who controlled their money; the Home records indicated that in 6% of the cases, the cashier exercised control over the residents' money. Sixteen percent of the residents said they kept cash, and another 31% said they used commercial bank accounts. The Home records reported only one using a commercial bank account. Table 16 presents the findings in tabular form.

Table 16

"WHERE DO YOU KEEP YOUR MONEY?"

	Resident Response		Cashiers' Response	
	N	%	N	%
Commercial Bank Account	38	28.8	1	.8
Cashier - No Restrictions	48	36.4	119	90.2
Cashier - Some Restrictions	12	9.1	-	-
Cashier - Control	6	4.5	8	6.0
Keeps Cash	20	15.2	-	-
N/A	8	6.0	4	3.0
Total	132	100%	132	100%

Finally, the residents were asked their own perceptions of personal needs. The responses were as follows.

Table 17

PERSONAL NEEDS

Need	N	%
Medical Services	65	49.2
Psychological Counseling	13	9.8
Personal Skills Training	2	1.5
Vocational Services	8	6.1
Maid Service	10	7.6
Leisure Time (Recreation)	25	18.9
Dental Services	20	15.2
Other Social Services	10	7.6
Educational Services	6	4.5
Legal Services	9	6.8
Religious Ties/Activities	20	15.2
Off-Grounds Transportation	11	8.3
No Needs	28	21.2

The fact that 49.2% listed medical services as a personal need, under circumstances where medical services are provided and in response to a question that explicitly asked about needs not now being met, is a striking fact and worthy of further exploration. The second ranked need, for leisure time activities, is also worthy of attention. The needs reported for dental services and for religious ties and activities (both 15.2%) are also large enough to warrant attention in the Homes' programming.

It is also significant that one-fourth of the respondents stated that they had no needs of the kinds covered by the list.

Upon completion of the interview, the Study Team recorded their impressions of the resident using a structured format. The Study Team's observations and opinions are of a lay character, rather than expert opinion, and were recorded in order to gain some general picture of the population and with no intent to base any individual action or judgement upon them.

Physical Status: The Study Team noted 33 cases (25% of the interviewees) in which there was some noticeable problem with hearing. A serious problem was noted in 8% of the cases. Vision was noted to constitute some noticeable problem in 19% of the cases and a serious problem in 3%. Speech constituted a noticeable problem in 10% of the cases and appeared to be a serious problem in 5%. Physical mobility was impaired to an extent that could be noticed in 29% of the interviewees and appeared to be a serious problem for 9%.

Functioning: The Study Team was asked to make an estimate, based upon the observations during the interview and its surroundings, of the residents' level of functioning in four areas of behavior.

Personal hygiene and grooming was rated as adequate for 61% of the residents. Thirteen percent were observed to have minor deficiencies, and 3% serious deficiencies. This skill area was not observed in 22% of the cases.

Eating skills were appraised as: adequate, 67%; minor problem, 7%; and serious problem, 2%. No observation of this was made in 25% of the cases.

Skill in the care of the resident's own living space was rated as: adequate, 52%; minor deficiency, 11%; and serious deficiency, 7%. In 30% of the cases, this area was not observed.

In the management of their own money, the residents were rated as adequate in 61% of the cases. A minor problem was evident in 5%, and a serious problem appeared to be present in 8%. In 25% of the cases, no observation was made.

Residents' Feelings About Being Interviewed: Finally, the Team recorded its impression of how the resident felt about being interviewed. In 51% of the cases, the residents were rated as being pleased to have been interviewed. Thirty-three percent of the residents were rated as cooperative. One resident showed reluctance to be interviewed near the end of the session, and three (2%) refused to participate in the interview. In 17 cases (12.9%), residents were unable to provide all information requested, and staff were asked to supply missing information. Only factual information, substantiated by resident records or two staff people, was included. The Study Team purposefully created the category of "staff response" so that these cases could be readily identified and any bias easily detected. No bias was found.

Deaths and Discharges

A sample of records at the Minnesota Veterans Homes was drawn from those residents discharged during the years 1960 to 1980, and another sample was drawn from the records of those residents who died during the years 1965 to 1980.

The discharge files were sampled by drawing every sixth record. Since 410 files were drawn in this manner, the total number of discharges during those 20 years exceeded 2,460. The files of those who had died while on the rolls of the Homes were sampled by drawing every tenth record.

It must not be supposed that the numbers given above are truly representative of the proportion of deaths to discharges, except in the formal sense. It is very likely that some of the people who were discharged, particularly if they were very elderly, were discharged to acute care or to other situations in which they shortly died; they would not be counted among those who had died while on the rolls.

The following section describes the characteristics of residents who were discharged during the period 1960 to 1980.

Table 18

SEX DISTRIBUTION OF DISCHARGEES

	N	%
Female	116	28.3
Male	294	71.7
Total	410	100%

The number of residents discharged has increased markedly in the last 5-½ years. While the size of the institution has increased 40% between 1960 and 1980, the number of discharges in a five-year period, as reflected in the sample, has increased 522%. These data indicate a significantly less stable population in the last 5-½ years than previously.

Table 19

YEAR OF DISCHARGE

Period	N	%
1960 to 1964	35	8.5
1965 to 1969	99	24.1
1970 to 1974	92	22.4
1975 to 1980	183	44.6
Unknown	1	.2
Total	410	100%

The age of residents at time of discharge ranges from 20 to 101. Average age is between 60 and 69. As expected, a higher proportion of younger residents at the Homes are discharged than older residents. Analysis of resident files indicates that "disciplinary" problems are the primary reasons listed why residents, particularly residents under age 70, are discharged.

Table 20

AGE AT DISCHARGE

Age	N	%
20-29	40	9.8
30-39	13	3.2
40-49	44	10.7
50-59	72	17.6
60-69	95	23.2
70-79	81	19.8
80-89	52	12.7
90-99	10	2.4
100-110	2	.5
Unknown	1	.1
Total	410	100%

Seventy-one percent of dischargees had been admitted from the seven metropolitan counties, and 54% from Hennepin County. This is a higher metropolitan representation than was true of the general population during the years when they were admitted, and especially so in the case of Hennepin County. Metropolitan admissions seem to have been about 150% of what would have been representative. Furthermore, this distribution varies significantly from the metropolitan representation of the Homes' current population.

Table 21

COUNTIES FROM WHICH THE DISCHARGEES
HAD BEEN ADMITTED TO MINNESOTA VETERANS HOMES

County Admitted From	N	%
Metropolitan Area		
Anoka County	12	2.9
Carver County	2	.5
Dakota County	5	1.2
Hennepin County	221	53.9
Ramsey County	46	11.2
Scott County	2	.5
Washington County	3	.7
Metropolitan Total	291	70.9
Outstate Counties	110	26.9
Unknown/Non-Minnesota Counties	9	2.2
Total	410	100%

The vast majority (82%) of the dischargees had been admitted to the Homes only once. The remaining 18% had been admitted more than once; a few (9) had been readmitted more than twice.

Table 22

NUMBER OF RE-ADMISSIONS

Number of Readmissions	N	%
0	337	82.2
1	52	12.7
2	11	2.7
More than 2	9	2.2
Unknown	1	.2
Total	410	100%

This section describes the characteristics of those residents of the Minnesota Veterans Homes who died in the Homes during the sixteen year period of 1965 to 1980. A sample was drawn by pulling the files of every tenth resident who died during that period. Since 108 files were drawn in this manner, the total number of deaths in the Homes during 1965 to June, 1980 exceeded 1,080.

Table 23

SEX DISTRIBUTION OF RESIDENTS WHO DIED

Sex	N	%
Female	13	12.0
Male	95	88.0
Total	108	100%

Table 24

MARITAL STATUS OF RESIDENTS WHO DIED

Marital Status	N	%
Married	6	5.6
Widowed	29	26.8
Divorced	23	21.3
Separated	5	4.6
Single	45	41.7
Total	108	100%

The population of those who died, like the population of those who were discharged, is dominated by people not currently married.

Table 25

AGE AT DEATH

Age at Death	N	%
40-49	1	.9
50-59	9	8.3
60-69	25	23.2
70-79	35	32.4
80-89	28	25.9
90-99	10	9.3
Total	108	100%

It will be noted, while ten of the sampled residents were in their nineties when they died, 81% of the deaths occurred for residents who were between the ages of 60 and 89. One person was under age 50. Causes of death were not systematically recorded in the files available to the Study Team.

Summary

The records of discharges and deaths present a picture of the recent population of the Homes and, to some extent, their changing characteristics over the past 16 to 21 years.

The populations that seem to be represented in these samples are: men without households, and widows of veterans. Though there are many individual exceptions, this is the basic pattern.

A higher turnover rate seems to have characterized the Homes in the past decade, with more multiple readmissions and shorter stays. This is consistent with a change of the facility's role from "old soldiers' home" to a care facility in the past decade.

SUMMARY OF FINDINGS

MINNESOTA VETERANS HOME

The summary is based on the review of residents at the Minnesota Veterans Home in June, 1980, by the Quality Assurance and Review Program of the Minnesota Department of Health.

The review was conducted utilizing the same methodology used in the annual review of 30,000 Title XIX recipients in 650 long term care facilities. The review team members were registered nurses and social workers assigned to the metro area. The review consisted of an examination of the medical record to determine care needs and the provision of services, a resident interview and verification of care needs with a knowledgeable staff person.

A total of 421 residents in 8 buildings were reviewed. A summary of findings by Building is attached.

Problem areas that were identified through the review and suggested interventions are discussed by service area.

I. Social Services: (59 recommendations)

Social service involvement is not reflected in the majority of resident records. Recommendations relate to:

- social histories not present in majority of medical records
- better coordination needed with day program
- insufficient involvement on day to day basis especially residents in Building 16
- need for involvement with younger residents related to job opportunities, housing, financial security, GI Benefits, etc.
- 1:1 contact needed for those with specific problems
- better admission, transfer and discharge planning involving resident
- mechanism for resident complaints and grievances

II. Activities: (89 recommendations)

The review identified needs for structured activities for many residents in the Board and Care buildings. There is an overall lack of planned activities for these residents. Recommendations relate to:

II. Activities: (Continued)

- activity and/or interest assessments not present
- need for small group activities such as sensory stimulation, reality orientation, remotivation, in Building 16
- more community interaction for residents

III. Corective Therapy: (48 recommendations)

The Corrective Therapy Department does not utilize specific treatment goals as usually seen in a rehabilitation service department. Recommendations relate to:

- goals not identified
- unable to determine progress from medical record
- need for individualized orders for frequency, duration, modality, etc.
- utilization of staff time
- perceived by some as recreation rather than therapeutic

IV. Medical Services: (148 recommendations)

The role of the on campus physician is not well defined. It is unclear if the physician is viewed as the "primary physician" or as "Medical Director". The roles are not the same. Medical services are not always coordinated with VAMC clinics or hospital. Recommendations relate to:

- current medical status and diagnosis not present
- progress notes and physicals often incomplete
- lab work not on chart especially for diabetics, anemias, etc.
- corrective therapy orders not individualized
- referrals to hospital often don't communicate findings to nurses and clinic, or if sent, often delayed in receiving
- diet orders not specific
- vision and hearing referrals not followed up
- no procedure for monitoring diabetics, those on psycho-therapeutic drugs and self-administered medications, hypertensive patients, etc.

IV. Medical Services: (Continued)

- Diagnoses found in medical record do not always substantiate reason for medication and/or treatment
- medication start dates and current medication listing not available in medical record
- medication orders not reviewed on a regular basis

V. Nursing Service: (62 recommendations)

Nursing service personnel provide many non-nursing functions such as social worker, counselor, transport service, etc. in addition to regular nursing duties. Recommendations relate to:

- need for specific nursing assessments and nursing care plans reflective of resident needs
- monitoring system for medications of self-administered medications
- need for monitoring of diabetics, anemias, cardiacs, etc.
- insufficient staff and dissatisfaction with scheduling
- need for follow through of nursing problems

VI. Dietary Department: (31 recommendations)

Recommendations relate to:

- need for nutritional assessments
- little attention paid to or monitoring of special diets
- pattern of weight gain

VII. Resident Interviews:

- many state dissatisfaction with medical care - especially wait for vision, dental, and hearing assessments
- lack of something to do - both activities and work
- complaints of low pay for work done
- interest in continued programs for those with chemical dependency background
- need for more support services for many, such as, social services, remotivation, sensory stimulation, etc.

VIII. Administration:

There appears to be no organized system for communicating policies, procedures, job descriptions and authority level both from the management level and the department level. The role of the Veterans Home Clinic and clientele served is not clear.

XIX. Pharmacy:

The Pharmacy maintains a profile on each resident but no one appears to be monitoring or periodically reviewing medications for the majority who are on self-administration.

X. General Observations:

Many residents in the out buildings were not known to any staff members, that is, their name, health status, needs, and where they work.

Overall the recommendations reflect a lack of assessments in all areas and a need for individualized plans of care based on individual needs. It appears that no one is coordinating the services that are being provided.

There appears to be insufficient staff to conduct the individual assessment, design individualized plans, and provide the services identified by the review.

QUALITY ASSURANCE AND REVIEW PROGRAM
SUMMARY INFORMATION: VETERANS HOME
JULY 10, 1980

RECOMMENDATIONS MADE BY BUILDING

AREA	BUILDING 1		BUILDING 2		BUILDING 3		BUILDING 4		BUILDING 5		BUILDING 6		BUILDING 9		BUILDING 16		TOTAL	
	Assess	Impl	Assess	Impl	Assess	Impl	Assess	Impl	Assess	Impl	Assess	Impl	Assess	Impl	Assess	Impl	Assess	Impl
MEDICAL SERVICES	8	2	12	1	16	3	6	2	13	1	18	--	14	2	46	4	133	15
NURSING	4	--	6	1	--	1	--	--	1	1	7	4	2	1	17	17	37	25
SPEECH,HEARING,VISION	2	--	3	--	2	3	2	--	2	--	--	--	1	1	16	--	28	4
SOCIAL SERVICES	2	2	3	--	5	4	2	2	3	2	4	1	4	1	24	--	47	12
ACTIVITIES	1	--	9	--	1	--	4	--	1	--	5	--	3	--	47	18	71	18
DIETARY	3	--	11	--	--	--	1	--	1	1	2	--	4	--	9	--	31	--
CORRECTIVL THERAPY	--	--	1	--	--	--	--	--	--	--	--	--	2	1	25	19	28	20
PROGRAM OF CARE	2	--	7	--	4	--	4	--	--	--	--	--	1	--	8	3	26	--
CHEMICAL DEPENDENCY	1	--	--	--	2	--	1	--	4	--	5	5	--	--	--	--	13	5
TOTALS BY BUILDING	23	4	52	2	30	11	20	4	25	5	41	10	31	6	192	61	414	99

* Column 1 is Assessment/Plan
Column 2 is Implementation

QUALITY ASSURANCE AND REVIEW PROGRAM
SUMMARY INFORMATION: VETERANS HOME
JULY 10, 1980

	TYPE		L.O.C. RECOMMENDATIONS					PROG. STRENGTH.		AGE DISTRIBUTION							
	NSG. HOME	B&C	SNF	ICF	BD & ~~LCBC~~. Care	PSYCH.	ALTER. LIVING	IND. ASSESS.	PROG. IMPLE.	15-24	25-44	45-64	65-69	70-74	75-79	80-84	>84	OMITS
BUILDING 1		24		2	22			8	2			15	1	5	2	1		0
BUILDING 2		40	1	6	32		1	53	2		5	17	9	4	1	3	1	2
BUILDING 3		29		2	27			34	11		8	15	1	3	2			2
BUILDING 4		21			20		1*	21	4	1	2	17		1				5
BUILDING 5		31			30		1	26	5		4	24	3					0
BUILDING 6		127	3	18	106			43	11		1	24	32	17	11	21	21	7
BUILDING 9		65		6	58	1**		32	7		11	29	11	4		4	6	2
BUILDING 16	84		45	38	0		1	195	61		1	5	8	11	9	13	37	4
TOTAL	84	337	49	72	295	1	4	412	103	1	32	146	65	45	25	42	65	22

* FOSTER HOME
** POSSIBLE