
Staff Update

Veterans' Home at Rocky Hill: Residential Services

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Legislative Program Review
and Investigations Committee

Connecticut General Assembly

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VETERANS' HOME AT ROCKY HILL: RESIDENTIAL SERVICES

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Veterans' Home at Rocky Hill: Residential Services

Background

In May 2014, the program review committee voted to authorize a study of the Connecticut State Veterans' Home. The study is evaluating the Home's operations and effectiveness.

The Home offers 24-hour nursing care (similar to a nursing home) as well as domiciliary care to those who served in the Armed Forces. Domiciliary care consists of shelter, food, and services that aim to prepare residents to successfully rejoin the wider community. The Home charges domiciliary residents \$200 monthly, which can be waived. Nursing care residents must use public insurance (e.g., Medicaid) and self-support to pay for their stays. Free respite services also may be provided to families caring for veterans themselves.

Most domiciliary care residents live in the main Residential Facility (often called "the Domicile" or "the Dom"). Others participate in a residential substance use treatment program with separate housing, live somewhat independently in apartments, or reside in one of several single-family houses across the street from the main Home campus. The nursing care residents live in a separate building, the Health Care Facility.

The Home is the centerpiece of the state Department of Veterans' Affairs (DVA). The Connecticut Veterans' Home was the first of its kind. It was founded in 1864 and moved from Darien to its current Rocky Hill location in 1940.

To complete this update, program review committee staff: interviewed Home and DVA personnel; met with the Home's resident council; observed certain Home staff meetings; reviewed a variety of documents and websites; analyzed data provided by Home and DVA managers; communicated with some other state agency staff, as well as with a person from the federal Department of Veterans Affairs (VA); and interviewed a limited number of veteran and homeless advocates.

Main Points

The Home's nursing care facility is nearly full, while multiple domiciliary care residences have substantial vacancies. The domiciliary care occupancy rate has fallen recently, from 83 percent in 2009 to 53 percent as of June 2014. As of July 31, the largest domiciliary components – the main Residential Facility and the residential substance use treatment program – were both just over half-occupied. Across domiciliary care options, 240 of the 456 beds available to veterans were full. In contrast, the 124-bed nursing facility has a short waitlist.

The Home's domiciliary care population overall is older, dealing with a variety of health or ability challenges, and somewhat likely to live there long-term. Two-thirds of the residents are 60 or above. Health challenges include cognitive impairment (31 percent of residents), heart ailments or signs of it (87 percent), psychiatric diagnosis (87 percent), and impaired ambulation (17 percent). Nearly half the Home's veterans (47 percent) have lived there more than five years.

Domiciliary care residents can receive a variety of services, and must abide by a rules and discipline system. Among several other services, there is a medical clinic as well as education and job search assistance. The Home has rules that must be followed, partly due to the substantial number of residents living in large shared rooms.

The budget and staff levels have dropped. In real terms, the Home's budget fell 25.6 percent over the last ten fiscal years. In FY 14, the DVA generated revenues of \$23 million and spent \$28.8 million. Nearly all this revenue flows to the state's General Fund. The Home's effective staffing level fell 17 percent from FYs 08-14, to 313.

Aside from the newer nursing facility, the campus's buildings and infrastructure are aged; several designed as residences are not used that way. Nearly all the buildings were constructed in the 1930s, and a 2005 assessment found most to be in some level of poor condition. Two duplexes, three houses, and two apartment buildings (aside from the old hospital building) are used as offices and storage.

Next Steps

PRI staff will continue research. Staff anticipates surveying residents, meeting with advocates for and non-Home personnel who serve veterans, interviewing Home staff, and learning about other states' homes.

Several potential issues, listed below, will be considered, and staff will analyze data and records to assess services.

1. Domiciliary care: Mission/model of care, occupancy rate, residents' aging in place, therapeutic work program for residents
2. Nursing care: Respite care availability
3. Overall: Resource level and balance, facilities use and conditions, information technology and management, resident transportation, and connections with the federal VA

Acronyms

| | |
|-----------------|---|
| AA/NA | Alcoholics Anonymous/Narcotics Anonymous |
| APRN | Advance Practice Registered Nurse |
| ARRA | American Recovery and Reinvestment Act |
| AWOL | Absent Without Leave |
| BEST | Bureau of Enterprise Systems and Technology |
| CADC | Certified Alcohol/Drug Counselor |
| CDH | Chronic Disease Hospital |
| CMS | Centers for Medicare and Medicaid Services |
| CY | Calendar Year |
| DCP | Department of Consumer Protection |
| DMHAS | Department of Mental Health and Addiction Services |
| DPH | Department of Public Health |
| DSH | Disproportionate Share Hospital |
| DSS | Department of Social Services |
| DVA | (State) Department of Veterans' Affairs |
| EHR | Electronic Health Records |
| FY | Fiscal Year |
| HCF | Health Care Facility |
| HUD-VASH | U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing |
| ID | Identification |
| IGWF | Institutional General Welfare Fund |
| IT | Information Technology |
| ITP | Interdisciplinary Treatment Plan |
| MAP | Medication Assistance Program |
| NASVH | National Association of State Veterans Homes |
| OE | Other Expenses |
| OSC | Office of the State Comptroller |

| | |
|-------------|---|
| PL | Patriots' Landing |
| PRI | Program Review and Investigations Committee |
| PS | Personal Services |
| PT | Physical Therapy |
| REP | Recovery Education Program |
| RF | Residential Facility |
| RIM | Recovery in Motion |
| RPP | Residential Plus Program |
| RSP | Recovery Support Program |
| RT | Recreation Therapy |
| SSVF | Supportive Services for Veteran Families |
| VA | (Federal) Department of Veterans Affairs |
| VIP | Veterans Improvement Program |

Introduction

In May 2014, the Legislative Program Review and Investigations Committee (PRI) voted to evaluate the Connecticut State Veterans' Home's operations and effectiveness. The comprehensive assessment includes the Home's admissions, complaint, and discipline processes, among many other aspects. This interim document describes the Home's operations. It also discusses areas the PRI staff intends to further explore over the next two months in developing proposed findings and recommendations.

Background

Located in Rocky Hill, the Veterans' Home (i.e., the Home) has two categories of residential care for Armed Services veterans. First, domiciliary care provides room, board, and various rehabilitative services. There are multiple domiciliary care buildings: the main Residential Facility (often called "the Domicile" or "the Dom"); residential substance use treatment; apartments for veterans with full-time employment outside the Home; and a handful of single family houses. Second, 24-hour nursing care is offered in a nursing home setting. All states have at least one veterans home, though the precise components vary (e.g., whether domiciliary care is offered).

The Home is operated by the state Department of Veterans' Affairs (DVA). The department's main administrative office is located on the Home's grounds. The Home is funded by the state and federal governments, its residents, and private donors.

Methods

This update was developed from the study's research to date, which consists of:

- nearly two dozen interviews with DVA and Veterans' Home managers and staff;
- a meeting with the Home's Veterans' Council, made up of domiciliary care residents;
- review of: relevant statutes and state regulations; the Home's resident admission application, website, and domiciliary care policy and procedures manual; the website of the National Association of State Veterans Homes; and the website of the federal Department of Veterans Affairs (VA);
- observation of admissions team meetings, one each for domiciliary care and nursing care, and of the DVA's 2014 Stand Down event;¹

¹ Stand Down is a daylong annual event in Connecticut; similar events are held nationwide throughout the year. Nonprofit organizations, state agencies, and federal agencies connect and provide needed services to veterans who

- conversations with a limited number of homeless and veterans’ advocates; and
- communication with personnel at the state Departments of Public Health and Consumer Protection, as well as federal VA staff.

In addition, several data requests have been issued to the Home and DVA. Some of the requests have been answered, but due to time constraints, much of the information received has not been incorporated into this update. Included is preliminary data analysis of expenditures and revenues, staffing levels, occupancy rates, and resident characteristics.

Over the next few months, program review committee staff will continue to gather and analyze information, as detailed in Chapter VII. Staff expect to focus on hearing from more Home residents and unionized staff, and on interviewing advocates, relevant nonprofit providers, and government personnel outside the Home.

Program review committee staff also will keep abreast of multiple other efforts involving the Home. One involves a working group, led by the Lieutenant Governor, which is considering how the Home can best serve veterans given its campus and programs. It is composed of veterans and activists for them, an advocate for ending homelessness, and staff of nonprofits, the federal VA, and the state executive branch. The DVA’s board of trustees has been invited to participate. The working group’s first meeting is scheduled for early October. The other effort is a consultant’s study of the campus and facilities, funded by \$500,000 in state bonds, which also might be starting soon. Simultaneously, veteran homelessness at large has been a focus of a working group started in April 2013 and led by the CT Heroes Project, under the umbrella of the Partnership for Strong Communities’ campaign to end homelessness.

Report Organization

Chapter II provides an overview of the Veterans’ Home, briefly explaining its types of care, admissions requirements, history, governance, oversight, and information technology. Chapter III presents preliminary analysis of the DVA and Home budget (expenditures and revenues), as well as staffing. The Home’s facilities, grounds, infrastructure, fleet, and resources are described in Chapter IV. Chapters V and VI explain the Home’s domiciliary and nursing care, respectively; in addition, preliminary analyses of capacity, occupancy, and resident characteristics are included. Chapter VII describes committee staff’s future research plans and points to several areas that will be explored for the next report.

Appendix A contains a campus map. The map, from 1996, has some outdated building names and usages; see Appendix B for current information. Appendix B also gives some information on building condition and capacity. Appendix C describes multiple services for Home nursing and domiciliary care residents not discussed in the main body of the report (e.g., security, food services).

attend. The services range from dentistry to a traffic “court”. Some donated goods are also distributed by collecting nonprofits.

Nearly all photographs in the report were taken by PRI staff with the permission of DVA personnel. A few photographs used were from other sources (a consultant's study of the facilities' condition, and a DVA brochure), and these instances are noted.

Veterans' Home Overview

The Connecticut State Veterans' Home offers two major types of residential care for veterans: domiciliary and 24-hour nursing (mainly long-term care). Each has distinct missions and buildings, but they share a 90-acre hillside campus in Rocky Hill. This chapter briefly describes the Home's:

- domiciliary and nursing care;
- basic eligibility requirements for admission;
- history;
- governance;
- organization;
- oversight; and
- information technology.

The Rocky Hill Home is one of the 149 state veterans' home facilities spread across all 50 states, the District of Columbia, and Puerto Rico. Among them, 140 offer nursing home-like care, 54 provide domiciliary care, and two have adult day programs.^{1,2}

Domiciliary care. The collective mission of the Home's domiciliary care is: "...to facilitate rehabilitation in all its residents to the greatest extent possible and at the fastest rate possible. The ultimate goal is to return as many residents as possible to society as productive citizens, capable of independent living."³ Domiciliary care is provided in a collection of buildings and settings, described in Chapter V and outlined below in Figure II-1. As the figure indicates, the largest setting is the main Residential Facility. It is made up of multiple connected buildings and often called "the Domicile" or "the Dom."

Nearly all domiciliary care residents have access to a range of social, rehabilitative, and health care services. They may eat three meals every day in the common dining hall at no cost beyond the program fee. The exception is the West Street houses' residents, who receive social services through a contracted nonprofit provider. They are expected to take care of their own healthcare and food needs.

¹ "2014 State Veterans Homes – VA Survey Deficiency Overview," Presentation by JoAnne Delanko and Valerie Parker, VA Office of GEC Operations, at the 2014 National Association of State Veterans Homes (NASVH) summer conference (July 27-August 1) in Charleston, South Carolina. Accessed on August 26, 2014 via: <http://www.nasvh.org/Conferences/conferenceLinks.cfm>.

² Domiciliary care offers shelter, food, outpatient medical care, and rehabilitative programs to help veterans unable to support themselves, attain maximal functioning. Adult day programs offer group care for people who need some assistance but not full-time nursing care. ("State Veterans Home (SVH) Per Diem Payment Program," Veterans Health Administration Handbook 1601SH.01, U.S. Department of Veterans Affairs, August 2011. Accessed September 10, 2014 at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2442.)

³ Connecticut State Department of Veterans' Affairs, "Residential Facility Programs and Services Policy & Procedures Manual," October 1, 2013.

There is no fee for the first three months of domiciliary care. Thereafter, it may be waived upon application, as discussed in Chapter III.

Figure II-1.

Veterans' Home Domiciliary Care

| | |
|--|--|
| <p style="text-align: center;">Main Residential Facility</p>  <ul style="list-style-type: none">• General population• 362 capacity• Multi-person rooms | <p style="text-align: center;">Fellowship House</p>  <ul style="list-style-type: none">• Residential substance use treatment• 75 capacity• Single-person rooms |
| <p style="text-align: center;">STAR Accommodations</p>  <ul style="list-style-type: none">• Working full-time off-campus and seeking to move into the community• 12 capacity*• 5 apartments with private rooms | <p style="text-align: center;">West Street Houses</p>  <ul style="list-style-type: none">• Families and single women**• 7 veteran capacity, plus family members• 5 single-family three-bedroom houses |

Notes

*Full capacity is 15 but one of the apartments is being used as American Legion offices.

**Single women may also live in the other residential options, except for Fellowship House.

Sources: Department of Veterans' Affairs for West Street Houses picture; Friar Associates Inc. 2005 Master Plan for the department's grounds, for the Fellowship House picture; PRI staff.

24-hour nursing care. Around-the-clock nursing care is given to veterans living in the



Sgt. John L. Levitow Veterans Health Center, referred to as the Health Care Facility (HCF) (sometimes called the “Hospital” or “Health Care Center”). The HCF has a maximum capacity of 124 residents (pictured at left).⁴ Most patients are long-term HCF residents, although usually there are a few domiciliary care veterans who are recuperating from injury or surgery. In addition, the HCF can provide respite for veterans’ family caregivers. The HCF’s care is similar to a skilled

nursing facility (i.e., a traditional nursing home), although it differs in some key respects, as explained in Chapter VI.

Eligibility

A person is eligible for admission to the Veterans’ Home when the following statutory requirements are met:

1. active service in the Armed Forces;⁵ and
2. an “honorable discharge” or “released under honorable conditions.”⁶

There also are admissions criteria specific to domiciliary and nursing care, as explained in Chapters V and VI.

History

Over its 150 years, the State Veterans’ Home has made multiple transitions in populations served, government funding, and name. The Home opened in 1864 as Fitch’s Home for Soldiers and Their Orphans, located in Darien. It was built and funded by town resident Benjamin Fitch to care for veterans, and for children who were left without parents due to the Civil War. The Home was the first of its kind in the country. In 1865, the Home’s Board of Trustees voted to transition the home to serving only orphans. Sometime in the 1880s, the Home reversed course and moved to house exclusively veterans, a policy that continues today (with the West Street houses as an exception).

The Home gradually became recognized and subsidized by government at all levels. In 1867, Darien began financially supporting it. State government funding was limited until the early 1880s, although the Home was legally incorporated by the state in 1874. By 1887, the State assumed responsibility, with governance continuing to rest in a trustees’ board. The following

⁴ The facility was built with a capacity of 125. One room is now used as a sensory room for dementia unit residents.

⁵ “Armed forces” consists of the U.S. Army, Navy, Marine Corps, Coast Guard, Air Force, and the Connecticut National Guard. Reserves are included, as is service with wartime allies. “Active service” is defined by U.S. Code (“active duty”) as full-time duty except for training, cadet service, or training service during which the person was injured.

⁶ C.G.S. Sec. 27-108(a), with reference to C.G.S. Sec. 27-103(a). C.G.S. Sec. 27-108 (b), which addresses veterans who are entitled to Armed Forces retirement pay, seems to require Connecticut residency for those veterans.

year, the federal government began subsidizing state homes across the country. The Home expanded and was renovated over the next four decades, particularly after the federal government boosted its level of financial support in 1930 upon the federal VA's establishment.⁷

The Home moved to its current Rocky Hill location in 1940 and the new Health Care Facility opened in 2008 as a replacement for the aged hospital.⁸ Nearly all other Home operations reside in the original late-1930s buildings. The West Street houses and some of the other buildings initially were residences for Home staff. The West Street houses were vacant for some years and recently renovated.⁹ In 2004, the campus's name changed from the Veterans' Home and Hospital to simply the Veterans' Home.

Governance

The State Veterans' Home is governed by multiple entities and documents.

State law. The Connecticut General Statutes and State Regulations authorize the Home's programs, define eligibility criteria, set out certain procedures (e.g., admissions) and programs, establish rules and discipline, and regulate various other aspects of the Home. Some of the Home's regulations, mainly addressing resident conduct, recently were repealed by Public Act 14-187.

State DVA. The DVA works to carry out those laws in its operation and day-to-day management. The commissioner's office and the administrative offices – such as the Business Office – guide activities. The commissioner is specifically empowered by statute to set the Home's rules, enforce discipline, and ensure safety and health.¹⁰

Board of Trustees. The 17-member Board of Trustees also plays a role in governing the Home. The board, established in statute, is composed of ten members appointed by the Governor and six selected by legislative leaders, as well as the DVA commissioner. The appointed members are to be familiar with health care, business management, social services, or law, with “a demonstrated interest in veteran concerns.” Veterans must be a majority, with representation from World War II, the Korean conflict, and the Vietnam period.

The board is required to meet quarterly, as well as whenever convened by the commissioner, and needs a quorum to do so. The board must:

- advise and assist the commissioner;
- review and approve, before adoption, regulations involving admissions, discharge and transfer procedures, fee schedules, and family member participation in Home programs; and

⁷ “New Member Orientation,” Presentation by Eric Jordan, NASVH Vice President, at the 2014 NASVH summer conference (July 27-August 1) in Charleston, South Carolina. Accessed on August 26, 2014 via: <http://www.nasvh.org/Conferences/conferenceLinks.cfm>.

⁸ Lower floors of the old hospital building are still used for administrative activities (e.g., mail room).

⁹ The historical information regarding the Veterans' Home was drawn mainly from the DVA's website and a 1981 PRI report on the state's Veterans Home and Hospital Commission, which was the Board of Trustees' predecessor.

¹⁰ Connecticut General Statutes (C.G.S.) Sec. 27-106

- annually report to the Governor and the legislature’s Public Safety committee on activities and recommendations for improving and starting new services.¹¹

The board has, at times, been less active than statute requires. The last annual report was issued in 2008, and it met only twice in 2012. The number of appointed trustees made it difficult for the board to reach a quorum in many of those years, according to DVA staff. A recent State Auditors’ report cited the DVA for failing to ensure meetings were held in six of the 12 quarters from the audit’s period (Fiscal Years 2011 through 2013).¹²

Organization

The Connecticut Veterans’ Home has been the central part of the Department of Veterans’ Affairs since 1988, one year after the DVA was formed. The DVA operates the Home and its administrative offices are located there, in a single building.

Veterans’ Home administration. The DVA’s centralized fiscal, human resources, and planning staff perform those functions for the Home. Domiciliary care and the Health Care Facility each have an on-site lead manager (called “administrators” in this report) and assorted staff. Certain functions, such as buildings and grounds, serve the entire Home campus.

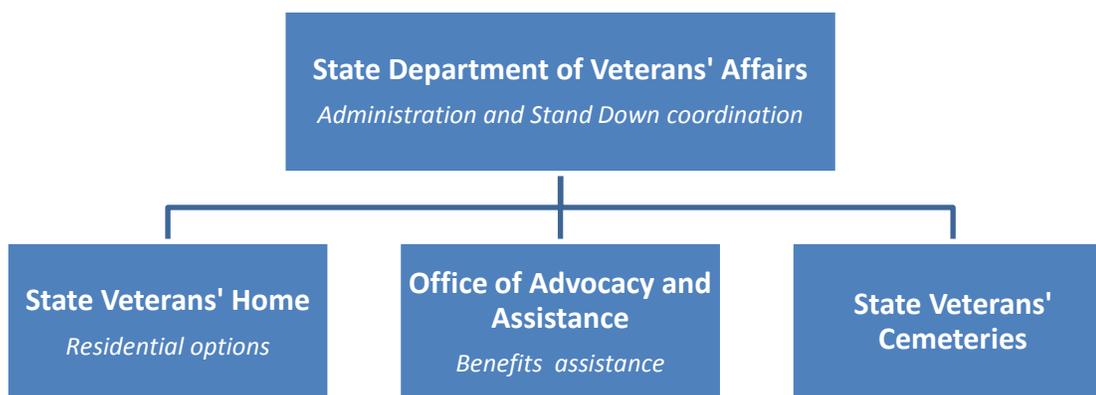
Other DVA services. The department has three additional significant services, as Figure II-2 illustrates. Unlike the federal Department of Veterans Affairs, the state DVA does not provide primary medical care or financial benefits to the general population of Connecticut veterans.

Office of Advocacy and Assistance. This office is staffed by an administrator as well as five Veteran Service Officers, each with supplementary personnel. The service officers and their staff are distributed across Connecticut’s five congressional districts. They help Connecticut veterans obtain and advocate for government benefits, services, and nursing home admission. They also offer counsel on education, health, medical, and rehabilitation opportunities.

¹¹ C.G.S. Sec. 27-102n

¹² “Auditors’ Report; Department of Veterans’ Affairs for the Fiscal Years Ended June 30, 2011, 2012 and 2013,” State of Connecticut Auditors of Public Accounts, September 15, 2014. Accessed on release date at: http://cga.ct.gov/apa/reports/Veterans%20Affairs,%20Department%20of_20140915_FY2011,2012,2013.pdf.

Figure II-2. DVA Responsibilities



Source: PRI staff.

State Veterans' Cemeteries. The DVA operates three cemeteries for Connecticut veterans and their spouses who choose to be buried there.¹³ The Colonel Raymond F. Gates cemetery is open to veterans who died while residing at the Home and is located across the street from it.¹⁴ A contracted private funeral home provides funeral services for those veterans. The Connecticut State Veterans Cemetery in Middletown is available to the general veteran population, while the Spring Grove Veterans Cemetery in Darien is full. The Middletown and Rocky Hill grounds are maintained by the Veterans' Home's staff.

Stand Down. The DVA hosts and organizes an annual single-day Stand Down event. Stand Downs, held throughout the country at various times, give basic services, donated goods, benefits counseling, and community referrals to veterans. They involve participation from the DVA, the federal VA, other government entities, and community organizations.

Separate from Federal Veterans Affairs services. The federal Department of Veterans Affairs (VA) contributes funding to and oversees certain state DVA activities (largely, the Home). It also administers a variety of services, most of which are different from the state DVA services; specifically, it:

- provides eligible veterans with a wide range of medical and behavioral health care, at two major campuses (West Haven and Newington) and six outpatient clinics throughout the state;
- financially supports community providers of emergency and transitional housing;
- financially supports community providers focused on keeping veteran families in housing or finding them housing and then offering supportive services to ensure

¹³ The eligibility criteria are found at: http://www.ct.gov/ctva/lib/ctva/Cemetery_Brochure_rev_4.pdf and C.G.S. Sec. 27-122b.

¹⁴ This cemetery used to be open to the general public but is no longer.

housing success, through the Supportive Services for Veteran Families (SSVF) program;

- operates three residential programs with a combined capacity of 32, at its West Haven campus;¹⁵
- offers a special housing voucher program that also provides permanent social supports, in collaboration with the federal Department of Housing and Urban Development (HUD);
- hosts housing at the Newington campus, with social supports for some residents from a contracted nonprofit;¹⁶
- conducts outreach to homeless veterans and, like the state DVA, issues referrals to appropriate housing providers;
- administers veteran benefits programs and offers vocational counseling; and
- gives veteran and family readjustment assistance at four Vet Centers throughout the state.

Oversight

Various aspects of the Veterans' Home are inspected by the federal VA, the state Department of Public Health (DPH), and the state Department of Consumer Protection (DCP). Each oversight body's standards and the Home's inspection results will be explored in the next report.

Federal VA. The federal VA inspects all state veterans homes annually. Federal financial support is contingent on a satisfactory inspection. Nursing and domiciliary services – as well as facilities – must comply with certain standards. For the last few years, the inspections have been carried out by a contracted company, Ascillon Corporation.

Department of Public Health. DPH inspects the Health Care Facility and laboratory components of the Home every two years. The HCF inspection is done for dual purposes: 1) renewal of the facility's chronic disease hospital licensure, which includes the pharmacy component; and 2) certification for Centers for Medicare and Medicaid Services (CMS) reimbursement. The laboratory examination enables that operation to be a licensed clinical laboratory and hold a federal Clinical Laboratory Improvement Amendments certification, which is necessary for CMS reimbursement of lab work.

¹⁵ The programs are: 1) a residential treatment program for veterans with Post-Traumatic Stress Disorder; 2) a residential program for mostly homeless veterans who are in a day treatment behavioral health recovery program; and 3) transitional housing for veterans coming out of the first two programs, who engage in compensated work therapy and pay rent. The estimated average lengths of stay for the programs are three months, four weeks, and five months, respectively, according to federal VA staff.

¹⁶ The housing, known as Victory Gardens, is a mix of special housing vouchers (mentioned in this series of bullets), subsidized housing, and market value housing.

Department of Consumer Protection. DCP inspects the pharmacy, located within the Health Care Facility, every seven years, which is the current schedule for hospital pharmacies. The pharmacy holds a controlled substance registration with DCP and the federal Drug Enforcement Administration. DCP does not license the pharmacy because it is a hospital (not retail) pharmacy, and therefore it falls under the DPH hospital license.

Information Technology and Use of Technology

Service. The DVA had its own information technology (IT) staff until recently. Effective July 1, 2013, the four staff (and one vacancy) moved to the Department of Administrative Services' Bureau of Enterprise Systems and Technology (BEST) unit, which assumed responsibility for DVA's information technology services. The BEST unit handles IT equipment and services for the State's executive branch agencies. The DVA liaison for IT services is the planning director.

Resident electronic records. The Veterans' Home's electronic record system for resident information is called the Patient Care System. It was developed by the Home's IT staff many years ago and, according to Home staff, cannot be altered. It contains a limited amount of resident demographic information that is difficult to extract for analysis, as well as a medications ordering and tracking component used by the Pharmacy and the Home's medical staff.



All other information related to residents' care – such as occasional progress notes from social workers or other rehabilitative staff – is placed into hard copy “medical records.” Records for domiciliary care residents are kept in the domiciliary clinic (B Clinic – records shown at left) while those for HCF residents are kept at that facility. When a domiciliary care resident has a short stay in the HCF to recuperate from illness or injury, a separate HCF medical record is created. Some DVA staff use Microsoft Word or Access to keep their own informal records to help them track and serve residents. Discipline records are stored separately.

The Veterans' Home has begun the process of moving to electronic health records (EHRs), which the federal government required all healthcare providers to have done by January 1, 2014.¹⁷ Adopting EHRs is critical for the Home because otherwise it could see a slightly smaller Medicare reimbursement, beginning at a one percent reduction in 2015 and rising to three percent by 2017.¹⁸ The Home receives Medicare reimbursement for up to 100 days when

¹⁷ This requirement was part of the American Recovery and Reinvestment Act (ARRA) of 2009, which was commonly called “the stimulus act.”

¹⁸ The reduction will rise gradually to five percent in 2019 if 25 percent or more of providers have not yet complied. There is a hardship exemption request form, which may be used for five years. (“Are there penalties for providers who don't switch to electronic health records (EHR)?” www.HealthIT.gov. Accessed September 10, 2014 at:

Medicare-enrolled veterans move from a hospital to the HCF, regardless of whether the veteran is a new or returning resident.¹⁹ Although the Home's Medicare reimbursements are a small part of the DVA budget (\$27,000 in Fiscal Year 2014), the DVA planning director has been working with a consultant to implement an EHR system. The goal is to create a basic system in time to avoid the Medicare reimbursement penalty, and a comprehensive system involving all aspects of care (e.g., social work, vocational rehabilitation) later in 2015.

The Home's nursing and medical staff has limited access to view and print residents' federal VA medical records. They cannot enter anything into the VA's system. The federal VA healthcare system has a rigorous process for acquiring and maintaining access to its records.

<http://www.healthit.gov/providers-professionals/faqs/are-there-penalties-providers-who-don%E2%80%99t-switch-electronic-health-record>

¹⁹ There is a Medicare copay for each day after the 20th day at the Home. ("Medicare Coverage of Skilled Nursing Facility Care," Centers for Medicare and Medicaid Services. Accessed September 10, 2014 at: <http://www.medicare.gov/Pubs/pdf/10153.pdf>)

Budget and Staff Resources

The budget and staff resources of the Department of Veterans' Affairs (DVA) primarily support the Veterans' Home. All but one of the key budget areas within the department – the Office of Advocacy and Assistance – are directly related to the overall operation of the Home, and the domiciliary and nursing care it provides veterans.

This chapter examines budget (expenditure and revenue) and staffing data provided by the DVA for the ten-year period of Fiscal Years (FYs) 2005-14. Since all but roughly three percent of the department's funding is dedicated to the operation of the Veterans' Home, the information below is based on the department's budget, unless otherwise specified.¹ In addition, the terms "Department of Veterans' Affairs" and "Veterans' Home" are used interchangeably to mean all residential services and programs at the Home. (Note: All expenditure and revenue data in this chapter have been adjusted for inflation using FY 14 dollars.)

BUDGET

Similar to other state agencies, the DVA budget is biennial. During the budget development process, the department's central Business Office asks unit managers for their budget and staffing requests. Once the managers' requests are submitted, the Home's final budget is developed through the DVA Business Office, with the commissioner's approval.

The Business Office reviews program expenditures at periodic intervals throughout the fiscal year. A comparison of budgeted amounts with actual expenditures is made quarterly, and program managers are notified of any substantive differences between original budgets and expenditures. If deficits occur during the year, unit managers are asked to make any necessary adjustments to their programs to ensure expenditures remain in-line with original budgets prior to year's end.

According to the department, it has maintained a balanced budget in each of the last nine fiscal years. Ten years ago, though, it was necessary for the agency to make a deficiency request of the legislature due to a pending budgetary shortfall of almost \$2 million for the fiscal year. The Home was experiencing unexpected costs in several areas, including an increase in average resident populations,² unplanned emergencies, and a policy change that no longer allowed charitable donations to be used for operations costs – thus shifting some of the Home's costs to the General Fund. In addition, Home personnel told committee staff the shortage was creating

¹ For FY 14, the Office of Advocacy and Assistance budget was \$935,865 of the Department of Veterans' Affairs total budget of \$28,799,121, which is 3.2 percent.

² In 2004, the legislature expanded the eligibility for admissions to the Veterans' Home to by eliminating war service as a criterion for admission to the Home, thus making eligible all veterans who were honorably discharged from active armed forces service. According to DVA, the change expanded the number of veterans eligible for admission to the Home by approximately 30,000. The resulting impact on admissions to the Home at that time is unclear, but the change may have played a part in increased admissions experienced by the Home when it requested a deficiency appropriation.

inefficiencies – it was late paying bills, resulting in some vendors not offering discounts for bulk purchases or refusing to supply the department altogether. There also was no supply point established. The Home was receiving just-in-time shipments, not allowing it to create any type of inventory, negatively impacting overall operations. The Home noted in its deficiency funding request to the legislature that short of freezing admissions as a cost savings measure, increased General Funds were needed. Through a combination of additional funding and cost shifting, the agency was able to offset its budgetary deficiency.

For budgeting purposes, the Veterans' Home is organized into four administrative and program-based functions:

- *Office of the Commissioner*: Includes centralized management and fiscal and human resource administration of the Veterans' Home, along with multiple campus-wide services: safety and security, facilities (grounds, maintenance, utilities), and food services. The commissioner office's budget also funds the Home's Veteran Therapeutic Worker (i.e., Veteran Worker) program.
- *Residential and Rehabilitation Services*: Consists primarily of funding for operating the Home's main Residential Facility and smaller residential buildings spread throughout the campus and used for specific purposes. Those facilities are substance use rehabilitation program housing for veterans in recovery, residential apartments on campus for veterans working full-time off campus, and five standalone houses known as the West Street houses (also referred to as Patriots' Landing) used for homeless or near homeless veterans and their families. The Home's broader social work, substance use treatment, and vocational rehabilitation programs also are funded through the Residential and Rehabilitation Services budget.
- *Health Care Facility (HCF)*: Funds 24-hour nursing care for veterans in a 124-bed³ facility, the HCF's clinic for domiciliary care residents (B Clinic), the HCF on-site clinic with selected healthcare specialties, the Home's pharmacy, and the Home's respite program for veterans with family caregivers.
- *Office of Advocacy and Assistance*: Not directly linked with residential services, the Office assists veterans statewide in finding and obtaining federal Department of Veterans Affairs (VA) benefits.⁴

Expenditures

The Department of Veterans' Affairs receives its funding from several sources. The bulk of the department's expenditures are paid by a state General Fund appropriation. The department also receives federal funding and state capital funding. In addition, it uses program fees collected

³ The Health Care Facility was built with 125 beds. One single-bed room is now being used as a sensory room for residents with dementia, lowering the number of beds to 124.

⁴ Committee staff has yet to meet with OAA personnel, but will do so as the study continues.

from residents are maintained in a separate fund and used for their cost of care, as discussed below. A snapshot of committee staff’s preliminary analysis of DVA expenditure data shows for FY 14:

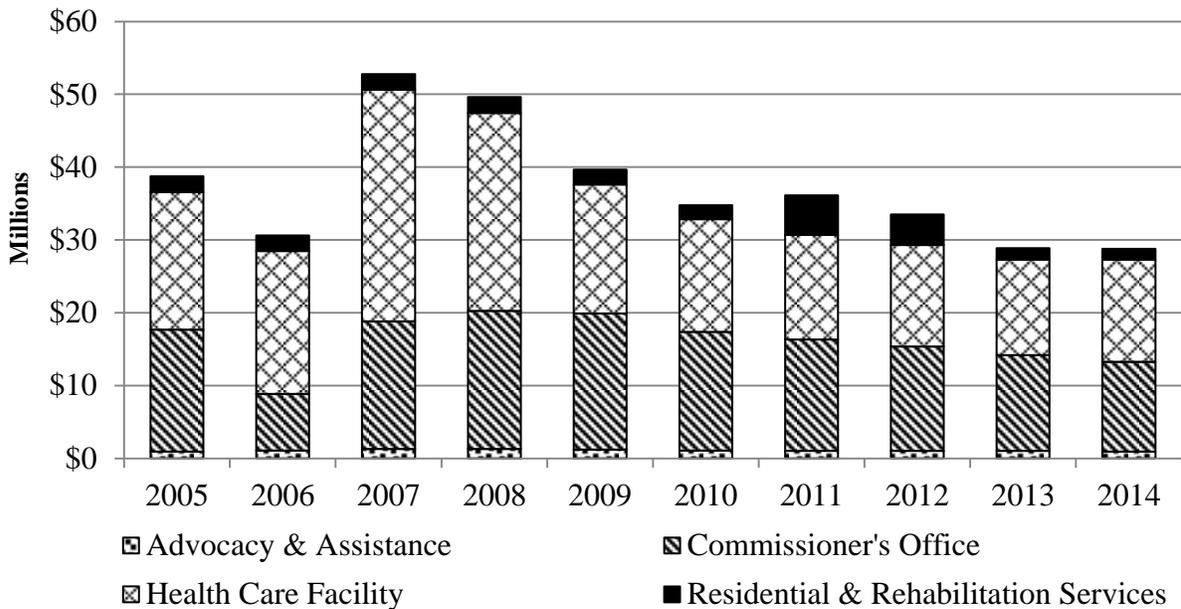
- Total expenditures (includes all state, federal, and capital funding)
 - DVA: \$28.8 million
 - Veterans’ Home (DVA, excluding OAA): \$27.9 million (97 percent of total)
 - Health Care Facility: \$14 million (49 percent)
 - Commissioner’s Office: \$12.3 million (43 percent)
 - Residential and Rehabilitation Services: \$1.5 million (5 percent)
- Personal Services (staffing)
 - DVA: \$21.7 million
 - Veterans’ Home: \$20.8 million (97 percent of total)
 - Health Care Facility: \$11.5 million (53 percent)
 - Commissioner’s Office: \$8 million (37 percent)
 - Residential and Rehabilitation Services: \$1.3 million (6 percent)
- “Other Expenses” (e.g., maintenance supplies and services, utilities, motor fuel, heating oil, medical supplies, drugs/pharmaceuticals, laundry services)
 - DVA: \$5.5 million
 - Veterans’ Home: nearly all (OAA only accounted for \$30,000)
 - Commissioner’s Office: \$3.4 million (62 percent)
 - Health Care Facility: \$2.1 million (38 percent)
 - Residential and Rehabilitation Services: \$2,000 (0 percent)

Total expenditures. DVA total expenditures from all funding sources for FYs 05-14 are shown in Figure III-1 below. Overall, expenditures for the department ranged from \$28.8 million in FY 14 to \$52.8 million in FY 07. DVA expenditures averaged \$37.3 million annually.

Initial analysis of the expenditures shows the two key programs providing residential services and programs to veterans at the Home – Health Care Facility (50 percent) and Residential and Rehabilitation Services (7 percent) – accounted for 57 percent of the department’s expenditures over the 10-year period. This was followed by the Commissioner’s Office (41 percent), which includes staff vital to run the Home, and Advocacy and Assistance (3 percent).

The relatively large expenditure increases in FYs 07 and 08, followed by a gradual decline, were mostly due to an influx of federal and state funding for building the Home’s new nursing care facility (the HCF) to replace the previous hospital building. Additional improvements to the main Domicile building were made in FY 11. These life safety upgrades – new roofs and air conditioning, and upgrades to bathrooms and the fire sprinkler system – were funded through the recent federal recovery act.

**Figure III-1. Department of Veterans' Affairs
Total Expenditures by Program Unit: FYs 05-14 (in FY 14 dollars)**



Notes: Expenditures include IGWF. Veteran Worker Program expenditures included in Commissioner's Office.

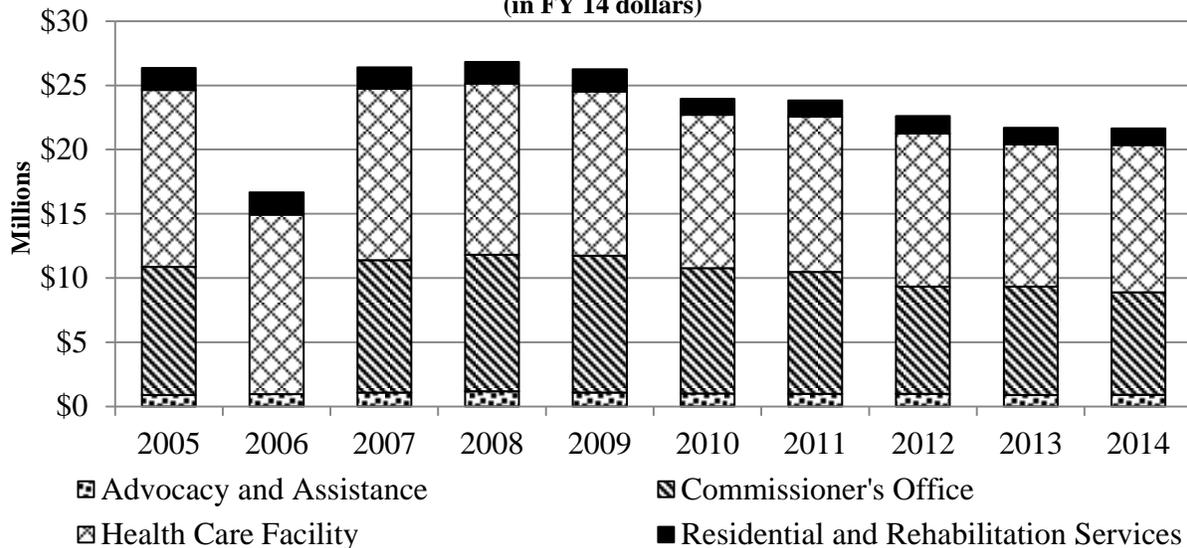
Source of data: Department of Veterans' Affairs.

Personal Services. Typically, the largest expenditure incurred by state agencies is staffing costs, called Personal Services, which holds true for the veterans' affairs department.

Figure III-2 shows staffing costs (not including benefit expenditures and temporary staff) were generally stable, between \$21 and 26 million, for the 10-year period, but have been decreasing somewhat since FY 09, to their lowest level of \$21.6 million in FY 14. In FY 06, staffing expenditures dropped sharply. This decrease occurred within the commissioner office's budget due to an accounting technique through the Office of Policy and Management to maximize the first year of reimbursement payments to DVA from the Disproportionate Share Hospital program. Budget data from the department shows a negative staffing expenditure of \$420,000 for that fiscal year because almost \$8.5 million was transferred back to OPM. Without the transfer, the personnel expenditures for that year were \$16.7 million.

In FY 2012, the agency attempted to stave off a budget cut to its staffing. The governor called for a \$3.1 million reduction in the department's personal services budget. The cut primarily included the elimination of vacant positions (in large part due to retirements) and a reduction in overtime funding for the Health Care Facility. Despite the agency's attempts to reduce or eliminate the cut, it was made. The department reports that over time, reductions to its personal services funding have resulted in losing approximately 30 staff throughout the agency. (Committee staff will be further examining the staffing reductions and their relative impact on overall expenditures and residential services provided at the Home.)

**Figure III-2. Department of Veterans' Affairs
Personal Service Expenditures by Program Unit: FYs 05-14
(in FY 14 dollars)**



Note: Costs for temporary staffing costs are under the budget category "Other Expenses", and not "Personal Services".

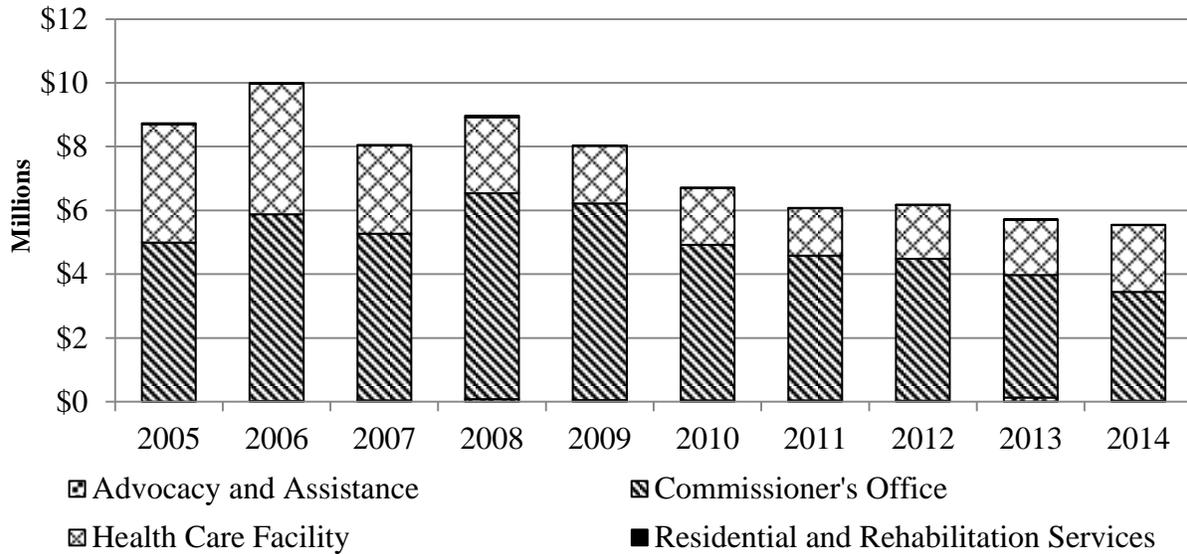
Source of data: Department of Veterans' Affairs.

Other Expenses. Aside from staffing costs, the department’s “Other Expenses” (OE) budget category had the largest expenditure totals. Other Expenses is a state budget classification that includes an agency’s non-personnel-related expenditures, such as utilities (e.g., electricity, heating oil, natural gas, water), fleet, repairs, and maintenance. Given the Veterans’ Home is a residential facility offering domiciliary and nursing care, expenditures for drugs and pharmaceuticals, medical supplies, food and beverages, and laundry services also are categorized as “Other Expenses.”

Figure III-3 shows OE expenditures for FYs 05-14. Annual expenditures for this expense category ranged between \$5.5 million (FY 14) and \$10 million (FY 06), and averaged \$7.4 million a year. Since FY 08, other expenses expenditures have decreased 38 percent, from \$9 million to \$5.5 million.

As indicated in the figure, almost all OE costs were incurred in the Commissioner Office’s Office and Health Care Facility budgets. This is because the budget for the Commissioner’s Office accounts for Other Expenses expenditures for domiciliary care and centralized services, while the HCF budget incorporates OE expenditures of the Health Care Facility, which is a high-cost facility to operate at the Home.

**Figure III-3. Department of Veterans' Affairs
Other Expenses by Program Unit: FYs 05-14 (in FY 14 dollars)**



Note: Costs for temporary staffing used by the Home are included under the budget category "Other Expenses", and not "Personal Services".

Source of data: Department of Veterans' Affairs.

Non-State Revenue Generated by the Veterans' Home

The bulk of budget resources within the Department of Veterans' Affairs are dedicated to providing residential and programmatic services for veterans living at the Home. Chief among those residential facilities is the main Residential Facility, which currently houses 237 residents. The Home's Health Care Facility is the second largest residential structure on campus, with a capacity of 124 beds in operation and a recent average daily census of 118 residents.

The Veterans' Home has the ability to generate revenue (primarily through federal reimbursements and resident billing) to help offset the state's cost of providing services at the Home, though not necessarily the Home's full cost of providing services. Some of the revenue is earmarked for a specific fund – known as the Institutional General Welfare Fund (IGWF) – to be used directly by the department for non-staff related costs. The remaining revenue and reimbursements go directly to the General Fund. The revenue streams mainly include:

- federal per diem grant payments for domiciliary care and care provided by the Health Care Facility. Veterans with 70 percent or more service-connected disability receive a higher per diem payment from the VA, which the HCF considers full payment for such veteran);

- direct resident payment, which is the program fee paid by domiciliary care residents and the applied income payment determined by DSS for the HCF residents who have Medicaid; and
- Medicaid and Disproportionate Share Hospital (DSH) claims generated by the Home and submitted through the Department of Social Services for federal reimbursement.⁵ The returning federal reimbursements are returned to the General Fund. (Note: Medicaid and DSH claims on behalf of the Veterans' Home are discussed separately below.)

DVA provided committee staff with revenue data by source. The information is grouped by revenue generated by the Home and earmarked for the General Fund and revenue kept by the Home in its Institutional General Welfare Fund. Individual revenue streams are included within each broad category: 10 for the General Fund and seven for the IGWF for FY 14.

A summary of committee staff's preliminary analysis of DVA revenue/reimbursement data shows for FY 14:

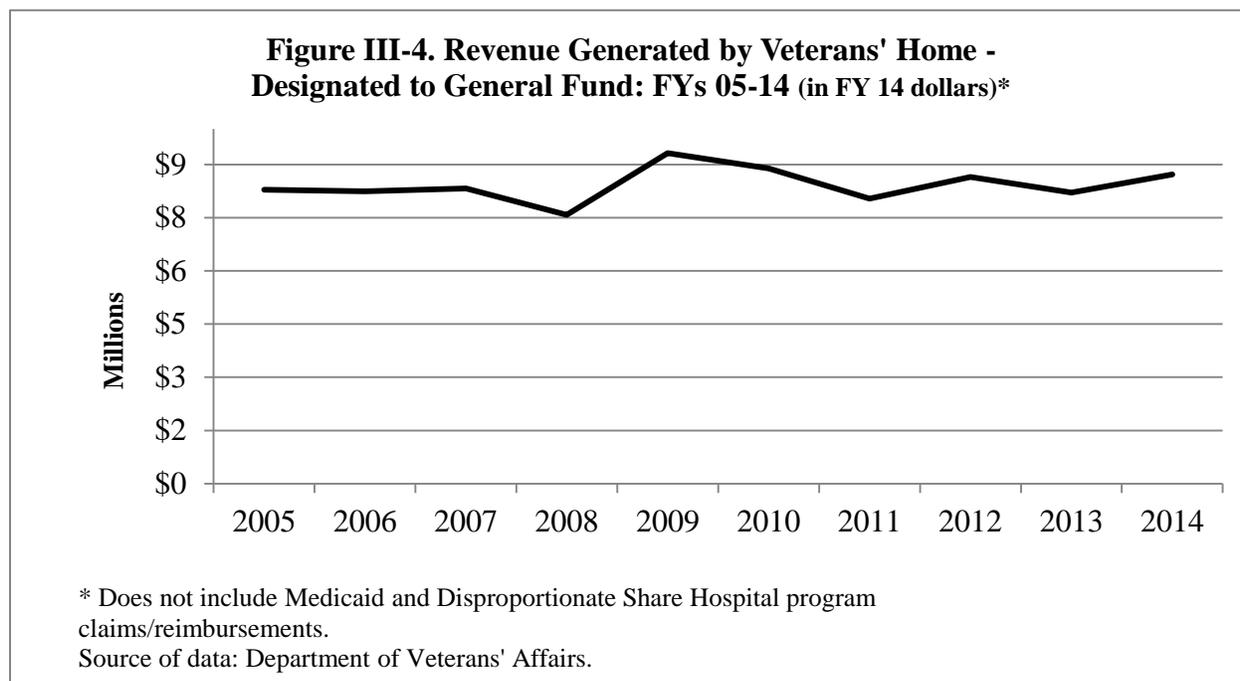
- Total revenue and reimbursements generated by the Department of Veterans' Affairs \$23 million (including 50 percent reimbursement rate for Medicaid claims and full reimbursement for DSH claims).
- The main sources of DVA-generated revenue/reimbursements are:
 - federal VA per diem grant payments: \$8.5 million;
 - domiciliary and nursing care residents' contributions towards their cost of care: \$2.6 million;
 - Medicaid claims: \$7.3 million (based on 50 percent reimbursement rate);
 - Disproportionate Share Hospital Share program reimbursement: \$4.4 million; and
 - burial headstones (VA plot allowances): \$185,000
- Of the total revenue/reimbursements generated by DVA, \$20.4 million (89 percent) was dedicated to the General Fund, while \$2.6 million (11 percent) remained for the Home's use in its Institutional General Welfare Fund.

DVA Revenue Designated for the State General Fund

Similar to other revenue-producing state agencies, most non-State revenue generated by the Veterans' Home is considered a receipt of the General Fund and not automatically returned to the Home in its biennial budget appropriation dollar-for-dollar. The department said it has generated more revenue over time for the General Fund than it has received back in appropriations – an area committee staff will further analyze. Of the revenue turned over to the General Fund, not including Medicaid and DSH reimbursements which are presented separately, the Home's largest source is the per diem payments made by the federal VA.

⁵ Medicaid is a shared state/federal health insurance program; state claims are reimbursed 50% by the Centers for Medicaid and Medicare Services. The Disproportionate Share Hospital program provides a level of federal reimbursement to the hospitals within the state that serve a greater portion of low-income and uninsured patients.

Figure III-4 shows the trend in revenue generated by the Home and designated to the General Fund for FYs 05-14. Almost all of the DVA revenue was generated through the VA per diem payments. Other federal reimbursements, namely for burial headstones, are included. Over the 10-year period, the annual revenue amounts fluctuated between \$7.5 million (FY 08), to \$9.3 million (FY 09).

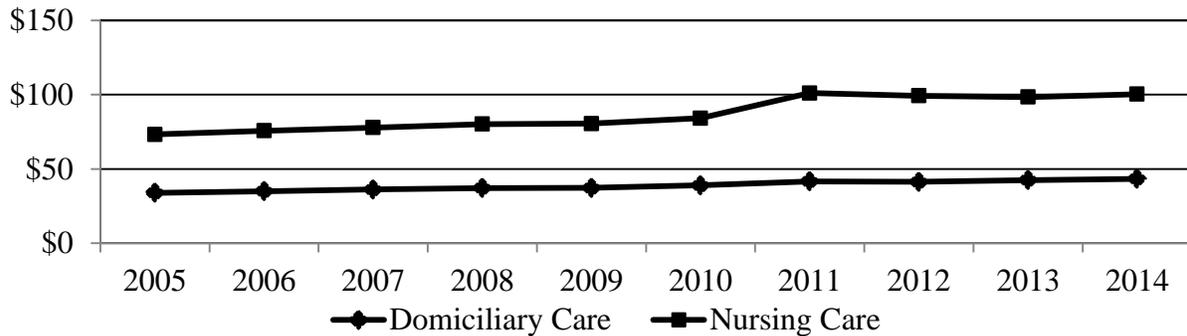


Federal per diem grants. The VA administers a grant program to support state veterans homes. To qualify for the program, a home must meet specific criteria, provide care to eligible veterans, and be recognized by the VA as state veterans home. The per diem, per resident payment program is based on the daily number of residents at the Home, information which the Home forwards to the VA.

The per diem grants are available to states providing care to veterans in at least one of three settings: 1) domiciliary care; 2) nursing home care; and 3) adult day health care. The grant amount is different for each level of care, and it is calculated simply by multiplying each day's resident count (census) by the setting's per diem rate. The rates are changed every October 1.

Figure III-5 shows the federal VA per diem rates for domiciliary and nursing care for FYs 05-14. Both rates rose since FY 05. The rate for domiciliary care increased 28 percent, to \$43.32, and the nursing care rate increased 37 percent, to \$100.37. The increase for both rate categories was steady for the period examined, except the nursing care rate experienced a noticeable increase in FY 11 compared to the prior year, from \$84.20 to \$101.06. Again, since the rates are federally established, the increase in FY 11 was due to federal action, not anything done specifically by Connecticut.

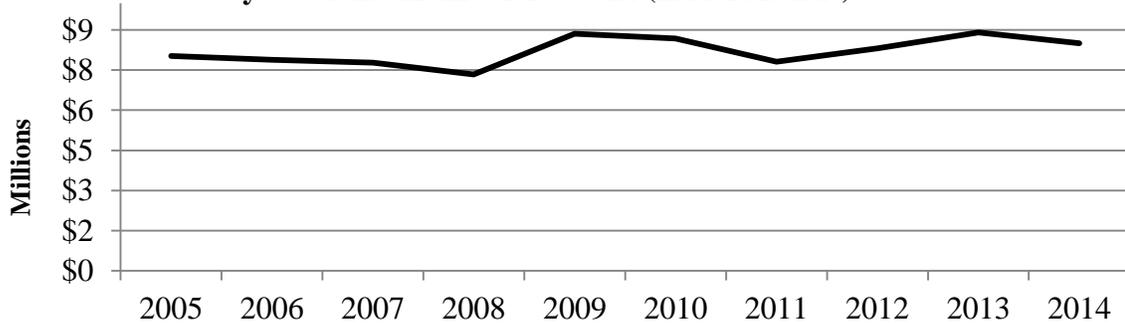
Figure III-5. Federal VA Per Diem Rates: FYs 05-14
(in FY 14 Dollars)



Source of data: Department of Veterans' Affairs.

The Connecticut Department of Veterans' Affairs bills the federal VA directly for its per diem grants payments. The department follows a specific process to capture the pertinent information required by the VA before payments will be released, including the daily census of residents receiving domiciliary or nursing care. The VA per diem payments are provided monthly for transfer to the state General Fund. Figure III-6 shows the annual amounts of VA per diem grants received for FYs 05-14, adjusted for inflation; the revenue generated was slightly declining until FY 08, and since then, has periods of growth and decline.

Figure III-6. VA Per Diem Grant Payments - Total Revenue Generated by Veterans' Home: FYs 05-14 (in FY 14 Dollars)



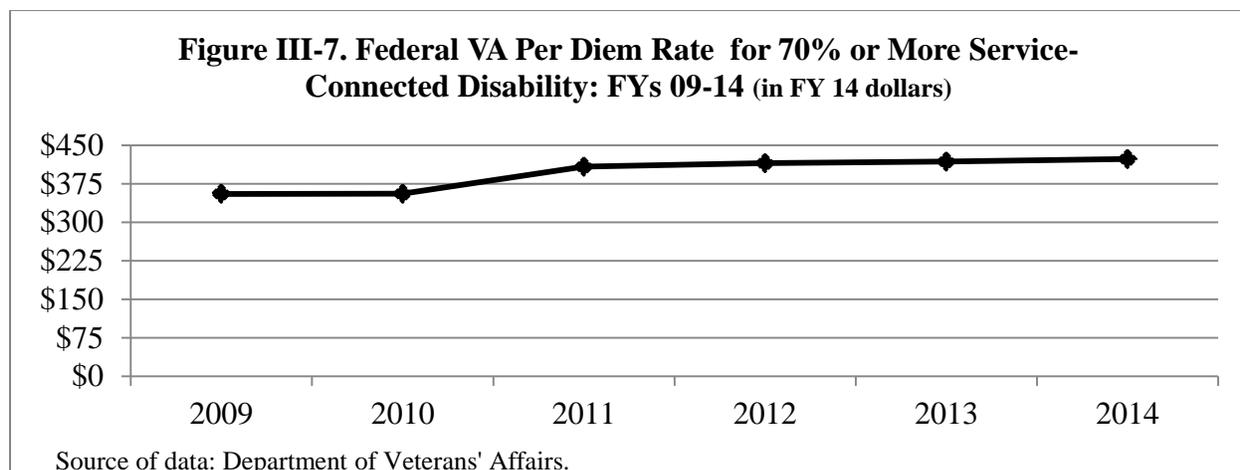
Source of data: Department of Veterans' Affairs.

VA per diem payments made to the state on behalf of the Veterans' Home consistently accounted for the largest share of non-State revenue generated by the Home (designated for the

General Fund) for FYs 05-14, usually around 97 percent. The per diem grant payments ranged from \$7.3 million (FY 08) to \$8.9 million (FY13).⁶

Service-connected disability. The VA provides a higher per diem payment for veterans in the Health Care Facility with disabilities determined to be 70 percent or more service-connected. The federal VA requires the HCF to accept this per diem rate as full payment for these veterans, meaning the veterans do not have to apply for Medicaid. At present, 17 residents in the HCF out of approximately 118 (14 percent) meet the criteria.

Figure III-7 shows the per diem rate for this category of HCF residents. The federal VA payments for service-connected disabilities related to long term care began in FY 09. The rate since then has increased just over 19 percent, from \$355.19 to \$423.04.



Medicaid claims. Veterans residing in the Home’s Health Care Facility require a higher level of medical and nursing care than domiciliary care residents, and are required to pay a higher share of their more costly care.⁷ As such, many HCF veterans rely on Medicaid to help pay for their cost of care.

Rules for the Health Care Facility around payment for services are similar in to those of any licensed nursing home throughout Connecticut, in most respects. Residents receiving care are required to pay to the extent they are financially able, including “self-pay” or use of Medicaid for their long term care costs. A key difference from private nursing homes (i.e., skilled nursing facilities) is the Veterans’ Home Health Care Facility is licensed by the state as a

⁶ The VA per diem payment data provided to committee staff at this point in the study was the annual payment totals. There was no distinction in the data between per diem revenue generated for residents receiving domiciliary versus nursing care.

⁷ Veterans receiving long term care services at the Veterans’ Home receive 24-hour nursing care due to many factors, including a service-connected disability. Determination of a veteran’s service-connected disability is made at the time the veteran enrolls for federal VA benefits. The VA assigns the veteran a service-connected disability rating. Depending on the degree of the veteran’s disability(ies), a rating from 0 to 100 percent is assigned, with 100 being totally disabled.

chronic disease hospital, not a skilled nursing facility.⁸ As such, the Health Care Facility cannot bill private insurance companies, whereas licensed skilled nursing facilities (and acute care hospitals) have that option.

Residents who are considered self-pay (i.e., ineligible for Medicaid or full federal VA payment) pay the same daily rate as Medicaid. The allowable Medicaid daily rate used by the Veterans' Home HCF is \$597.38, or just over \$18,500 per month. Self-pay residents (or their legally liable relative) are billed monthly. The costs for residents covered by Medicaid are billable through the Department of Social Services. Federal reimbursement of Medicaid claims on behalf of veterans at the HCF is transferred to the General Fund.

Long term care residents applying to DSS for Medicaid coverage go through an income and personal assets check to ensure they meet the program's eligibility criteria.⁹ Per federal Medicaid requirements, long term care patients (including Veterans' Home residents), are permitted allowances for personal needs and an asset disregard. The personal needs allowance is to help cover expenses a person can reasonably expect to incur for personal care (i.e., haircuts, toiletries). The Department of Social Services, as the state's Medicaid agency, uses a monthly personal needs allowance of \$60, and the DVA allows an additional \$90 for Home residents, for a monthly total of \$150. The asset disregard allowance permits a person receiving Medicaid to maintain a maximum of \$1,600 in liquid assets each month to remain eligible for the program.

If a veteran's income is insufficient to cover the monthly Medicaid rate (i.e., the Home's self-pay rate), the amount the person can contribute to the cost of care is determined by the Home. The veteran's "applied income" is calculated by taking total monthly income from all sources and subtracting the \$150 personal needs allowance and other expense deductions permitted under state Medicaid rules (e.g., residence, family allowance, Medicare or Medigap premium). The applied income amount is the resident's share of the monthly cost. The balance remaining between the applied income amount and the Medicaid daily rate amount is billed to Medicaid through the state's billing process. The amount reimbursed by Medicaid is accepted by the HCF as full payment for the resident.¹⁰

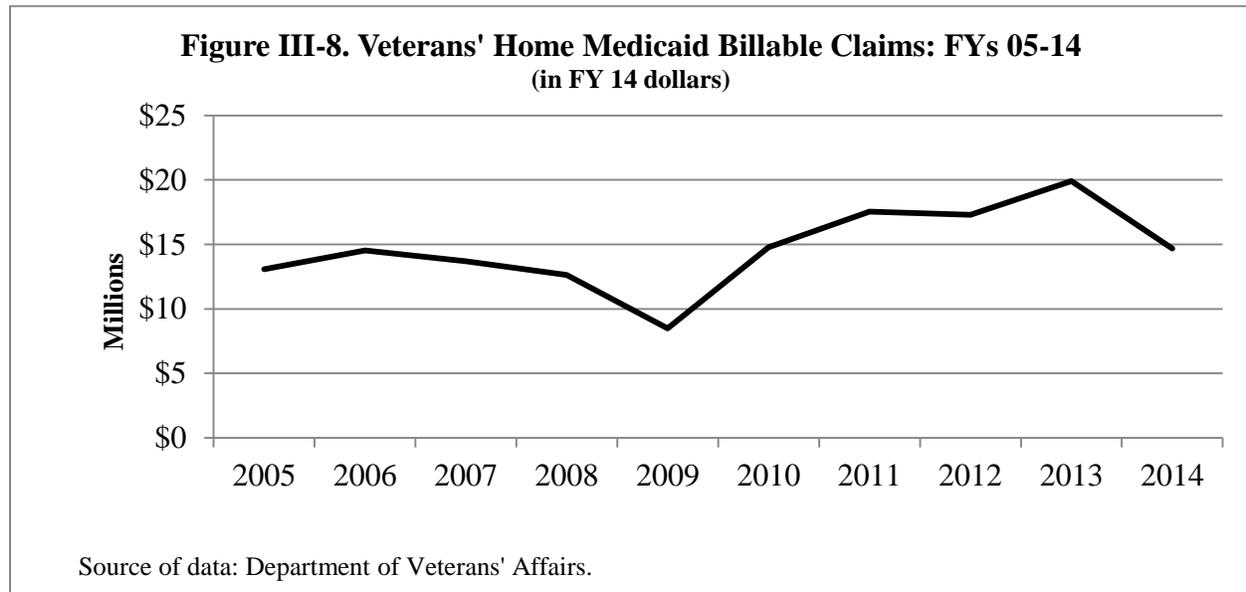
Figure III-8 shows the Medicaid billable claims submitted by the Veterans' Home for FYs 05-14. The claims represent the total amounts billable allowed under Medicaid. The billable claims ranged from \$8.4 million (FY 09) to \$19.9 million (FY 13). Since Medicaid is a

⁸ There are five licensed chronic disease hospitals in Connecticut.

⁹ Income consists of: Social Security Disability; Social Security Retirement; VA pension; VA compensation; full time/part time employment; and other (e.g., pensions VA educational stipends). Assets not considered are the veteran's primary home (with a cap on value), one car, and personal belongings. Also, for residents of a long term care facility who are married, there is a separate "community spousal" allowance and a different asset disregard allowance. These federally-approved allowances vary, and were established to ensure a resident's spouse does not become totally impoverished due to long term care costs. Individuals may be required to "spend down" their assets to meet the eligibility threshold for Medicaid. Medicaid rules require a "five-year look back" to determine if a person simply transferred assets during that time to qualify for Medicaid, without receiving something of equal value in return. Program rules account for such transfers when determining Medicaid eligibility.

¹⁰ The HCF, as a chronic disease hospital and not an acute care facility, can only bill *Medicare* for the very few times residents' care is considered acute. Revenue generated from Medicare is comparatively minimal to the other revenue streams used by the Home. Medicare revenue in FY 14 was \$27,472 of the \$30.3 million generated by the Home from all sources.

state/federal shared health insurance program, the federal government reimburses the state, generally at the 50 percent level, based on the claims the state submits. As such, the Medicaid reimbursement amounts realized by the state General Fund are not the full amounts of billable claims. If information is available, committee staff will try to analyze the Medicaid reimbursement revenue based on the Veterans' Home's claims in greater detail for the next report.



Disproportionate Share Hospital program. Another large source of revenue generated through the Veterans' Home for the State is claims made by the Home to DSS as part of the federal Disproportionate Share Hospital program (i.e., payment for uncompensated care). Federal law requires state Medicaid programs to provide additional reimbursement to qualifying hospitals that serve a large number of Medicaid and uninsured low income individuals.¹¹ Federal law further establishes an annual DSH allotment for each state. Connecticut's FY 14 allotment is roughly \$213 million for hospitals throughout the state, including the Veterans' Home HCF.¹² The Home began participating in the DSH program beginning in the mid-2000s.

DSS administers the state's DSH program and issues payments to hospitals based on information the hospitals report to the department, including Medicaid and low income patient utilization rates, Medicaid payments, and uncompensated care rates.¹³ Under the federal Affordable Care Act, DSH payments to hospitals (including the Veterans' Home HCF) are expected to begin decreasing in 2014, which may impact the Veterans' Home's revenue. The decline in DSH funding is due to anticipated lower hospital uncompensated care costs from

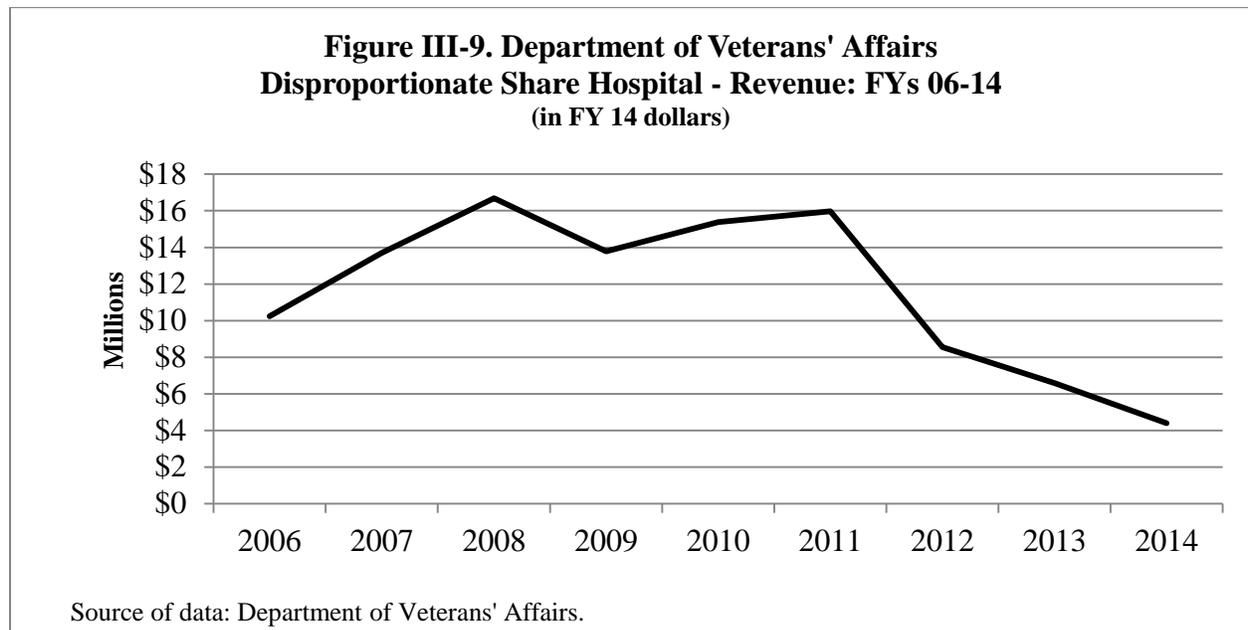
¹¹ See: <http://www.medicaid.gov/About-Us/About-Us.html>, accessed August 29, 2014.

¹² See: <https://www.federalregister.gov/articles/2014/02/28/2014-04032/medicaid-program-preliminary-disproportionate-share-hospital-allotments-dsh-for-fiscal-year-fy-2014#page-11441>, accessed August 29, 2014.

¹³ C.G.S. Sec. 17b-239(c)

expanded health insurance coverage requirements.¹⁴ However, as noted above, as a CDH, the Health Care Facility cannot accept private health insurance, unlike an acute care hospital.

Figure III-9 shows the revenue generated through billable DSH claims made by the Veterans’ Home for FYs 06-14. DSH annual payment to the Home ranged from a low of \$4.3 million in FY 14, to a high of \$16 million in FY 11.¹⁵ Payments increased 63 percent for FYs 06-08, and then fluctuated through FY 11. Since then, payments decreased 72 percent.



Institutional General Welfare Fund

Residents of the Veterans’ Home are required to pay for the charged cost of their care, whether it is domiciliary or nursing care, unless inability to do so.¹⁶ The department’s initial determination of a person’s financial capacity must be made within 30 days after admission to the Home.¹⁷ Practically speaking, however, the Home requires nursing care applicants to submit financial information before admission so the resident’s payment source(s) is known. Redetermination of residents’ financial means to pay for care must be made from time to time, at the commissioner’s discretion. The Home’s Chief Fiscal Officer may examine any change in a resident’s financial circumstances based on information received that the resident’s income or assets may have increased or decreased. Veterans are required to immediately notify the Business Office of any changes or if they want to request a fee waiver.

Fees for domiciliary care have been established by the Home, and the fee for nursing care is the daily rate allowed by Medicaid. Fee collections through patient billing for all residents are

¹⁴ Office of Legislative Research report 2013-R-0266.

¹⁵ Disproportionate Share Hospital reimbursements to the State are made at 100 percent.

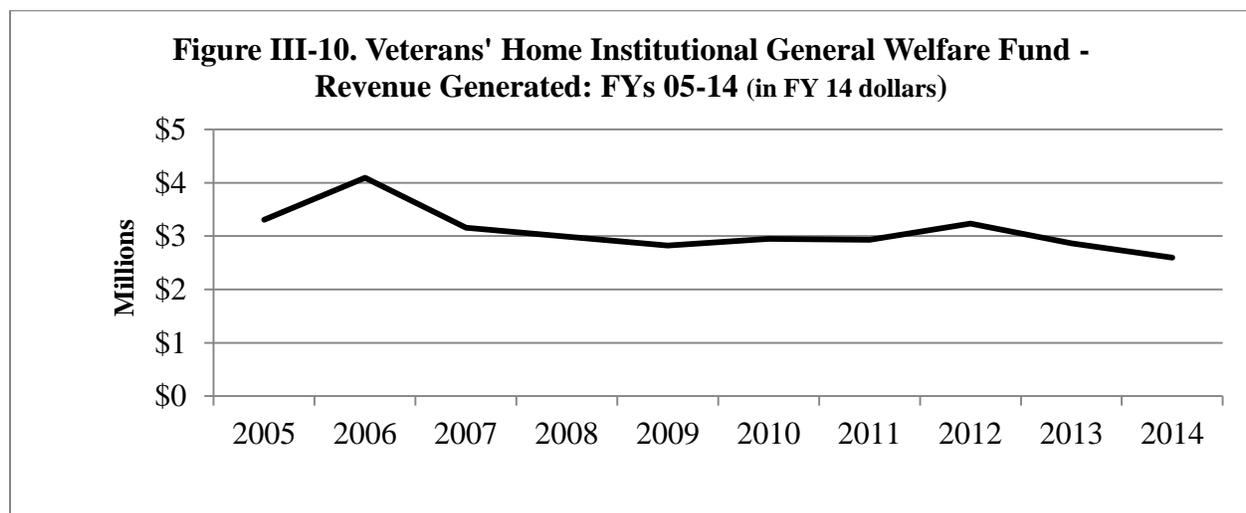
¹⁶ Regs. Conn. State Agencies (R.C.S.A.) 27-102l(d)-254(a)

¹⁷ R.C.S.A. 27-102l(d)-256(a)

transferred to the Home’s Institutional General Welfare Fund. The IGWF is a separate fund maintained by the Home, and does not include state General Fund monies. In addition to the resident fees, the fund primarily consists of all private monetary donations made to the state DVA or to the Home specifically.

The purpose of the IGWF is to assist veterans at the Home in various ways, including providing financial assistance to those transitioning out of residential care and moving back into the general community (e.g., security deposit, kitchen supplies). The fund also helps offset costs incurred for transporting residents to their off-site appointments (including medical), recreational activities sponsored by the Home, and the Home’s annual Stand Down event.¹⁸ The IGWF is not to be used by the Home for its staffing costs; however, expenditures from the fund may be budgeted and used to offset operational costs that benefit the general welfare of the veterans or the Veterans’ Home.¹⁹

Figure III-10 shows the total amounts of the Veterans’ Home Institutional General Welfare Fund for FYs 05-14. The fund’s annual totals over the 10-year period ranged from \$2.6 million in FY 14 to \$4.1 million in FY 06. The fund remained relatively steady for FYs 08-11 at roughly \$2.9 million, before increasing to over \$3.2 million in FY 12. Since then, there has been a downward trend in the Home’s IGWF. Overall, the fund averaged \$3.1 million annually, which includes carry-over balances from previous years. Similar to other revenue streams, IGWF revenue is primarily driven by the number of veterans residing at the Home.



¹⁸ Stand Down is a day-long event held at the Home for veterans throughout the state (see Chapter II for a description). Transportation to/from the event is provided free of charge by the Veterans’ Home. According to the department, the event is typically attended by over one thousand veterans. Until this year, the Home accepted outside donations of personal care items and clothing for the event. Tax law allows the Home to accept financial contributions for Stand Down, which are kept by the Home in a separate account for the event.

¹⁹ C.G.S. Sec. 27-106(b)

State law requires the Veterans' Home's budget office director to submit an itemized accounting of expenditures made from the IGWF to the commissioner at least every two months.²⁰ The list must show all the fund's expenditures during the previous two months. The expenditures must directly benefit veterans or the Veterans' Home, as determined by the commissioner and the board of trustees. The commissioner is further required to submit an accounting of all planned expenditures for the next fiscal year from the IGWF to the legislature's appropriations committee.

Resident billing: Domiciliary Care. Veterans' Home domiciliary care residents in the past would be assessed a program fee based on their overall ability to pay, meaning residents were paying different fees up to a uniform cap. In 2008, the commissioner (and board of trustees) transitioned the Home to a flat fee for its domiciliary care residents based on length of stay. Although the commissioner has the discretion to adjust the rates, the rates currently in place originated in 2008 and were made indefinite as of January 2014. The original DVA rate schedule recommended by the board of trustees to the commissioner in 2008 had rates from \$200 to \$500, based on a resident's length of stay. The commissioner has chosen to maintain the lower fee schedule.

Table III-1 provides the domiciliary care fee structure. Residents may live at the Home for up to three full months at no charge. Residents living there longer must pay a monthly program fee of \$200.

| Table III-1. Veterans' Home Domiciliary Care Monthly Fee Structure (as of August 2014) | |
|---|-----------------------------|
| Length of Stay | Monthly Billing Rate |
| 0-3 Months | \$0* |
| >3 Months | \$200 |
| *Veterans admitted after the 15 th of the month or discharged prior to the 15 th of the month are not billed for that month. Source of data: Department of Veterans' Affairs, Residential Facility Rules and Regulations Handbook, 2014. | |

DVA estimates a resident would need income of \$600-800 a month to afford the \$200 resident fee.²¹ Residents unable to pay the fee may submit a billing exception form each month. The request must be reviewed and approved by the Home's residential facility director and the fiscal office chief. If approved, the resident is not required to pay the fee for that month. (Committee staff is awaiting information on the breakdown of domiciliary care residents paying the fee and those not paying the fee.)

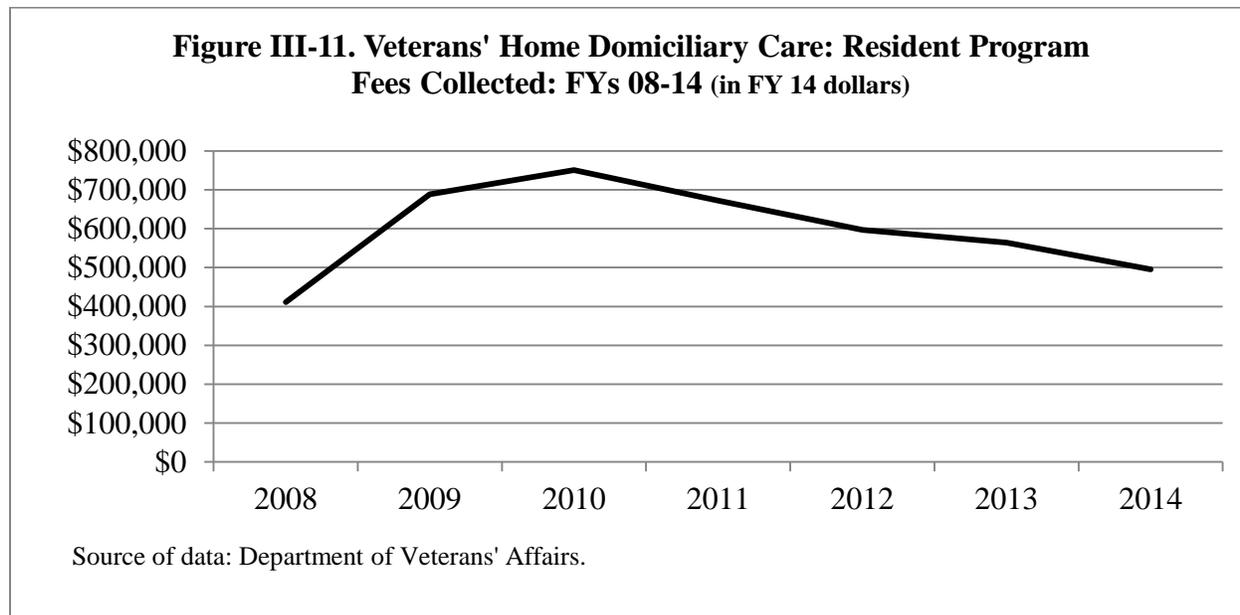
Residents are billed the fee monthly, and the Home makes the process to pay the fee relatively convenient for residents. Different forms of payment are accepted, and payments for domiciliary care residents may be made at a centralized drop box within the main Residential Facility. If a person is no longer a resident at the Home but still owes money, the department

²⁰ C.G.S. Sec. 27-106(b)

²¹ Possible sources of income include employment at the Home, outside employment, and veterans benefits.

may attempt to collect the outstanding balance. Any amounts collected are then deposited in the IGWF.

Figure III-11 shows the annual revenue generated for the IGWF through domiciliary care resident fees. Fee revenue averaged \$597,000 a year for the seven-year period. Domiciliary care fee revenue reached a high of \$751,000 in FY 10, but has been steadily declining to its current level of \$500,000. Overall, resident fees for domiciliary care have accounted for 21 percent of all IGWF revenue since FY 08.

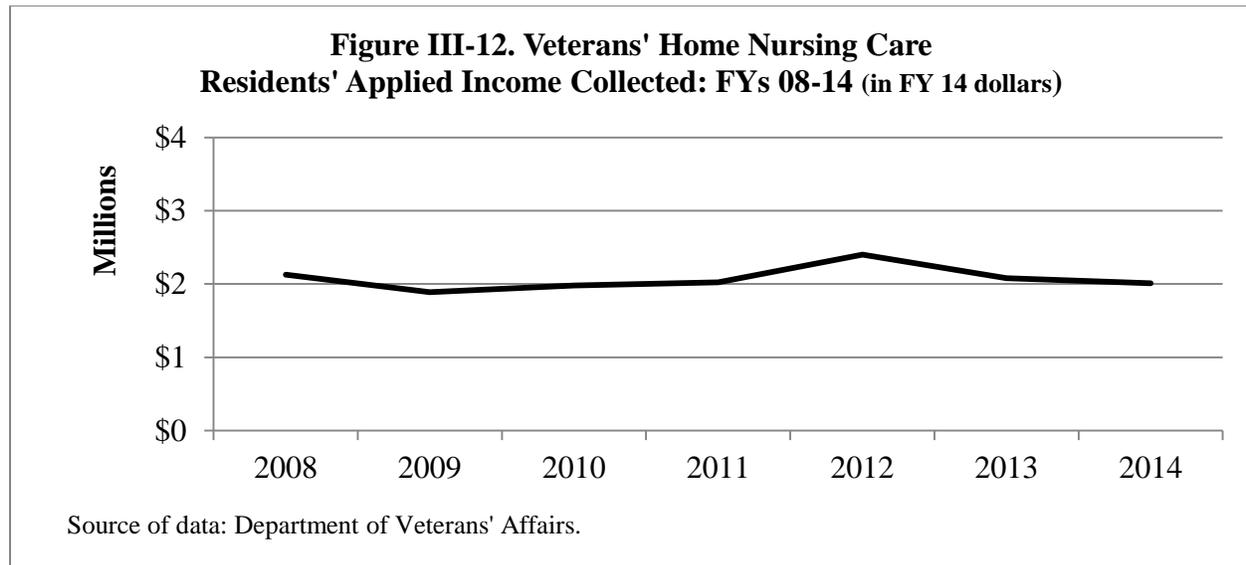


Resident Billing: Nursing Care. Residents of the Health Care Facility also are required to contribute to their cost of care. As discussed above, HCF residents' contribution to their care is based on three factors: 1) whether the veteran is paying for care through personal funds; 2) if Medicaid pays for most of the care costs; or 3) if the VA pays the service-connected disability rate. The amount billable to the resident (i.e., applied income), not Medicaid, remains in the IGWF, while Medicaid and federal VA reimbursements go to the General Fund.²²

Figure III-12 provides the annual revenue generated by the Veterans' Home HCF for FYs 08-14 from residents' share of their HCF cost (i.e., applied income for Medicaid and self-pay). The range was between roughly \$1.9 million (FY 09) and \$2.4 million (FY 12). Overall, resident billing receipts for HCF residents have accounted for 71 percent of all IGWF revenue since FY 08.

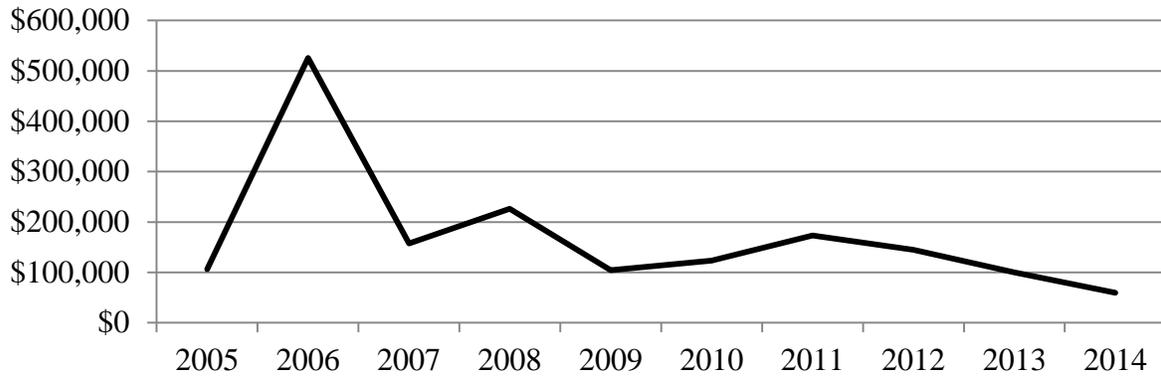
²² Someone coming to the HCF from the Residential Facility may be admitted to the facility under the \$200 residential fee for 90 days. Each new arrival to the HCF from domiciliary care starts a new 90-day count. As the 90-day threshold nears, the Home's central Finance Office contacts the veteran to determine if the person participates in Medicaid and, if not, will begin working with the person to help ensure Medicaid eligibility.

Donations. Monetary donations to the Veterans' Home make up the third largest revenue stream of the Institutional General Welfare Fund. (Additional smaller revenue sources include federal reimbursement for grave markers, estate collections, and fund interest.) Although no state policy forbids the Home from proactively soliciting private donations/contributions that is not the Home's practice. As such, all financial donations made to the home are unsolicited.



For accounting purposes, donations are maintained in a separate, interest-bearing account from the Home's residents' program fees and HCF patients' applied income. DVA believes this encourages donations to the Home because donors might not want their contributions going toward costs they believe the State should be obligated to pay as part of its operation of the Veterans' Home. Figure III-13 shows the revenue received through outside contributions for FYs 05-14 ranged from \$60,000 (FY 14) to \$525,000 (FY 06). Donations were at their lowest level this past fiscal year and have been trending downward since FY 11. On average, donations have accounted for 4.5 percent of IGWF revenue since FY 08. The large increase in FY 06 was due to one person's substantial donation.

**Figure III-13. Veterans' Home Private Financial Donations Collected:
FYs 05-14 (in FY 14 dollars)**



Source of data: Department of Veterans' Affairs.

Estimated Cost of Care

Not included in the budget information presented above is the estimated cost of providing domiciliary and nursing care at the Veterans' Home. The Office of the State Comptroller (OSC) annually calculates the estimated daily per resident cost for care provided by the Home. The calculations are primarily based on the Home's expenditures for the previous year, Medicare cost reports submitted by the Home, direct (e.g., staff, equipment) and indirect (e.g., administration, square footage) costs, and the Home's census. The OSC-determined costs can be thought of as the "true cost" (per person, per day) for running the Home. Table III-2 shows the OSC daily, per capita cost calculations for FY 14.

**Table III-2. Daily Per-Resident Domiciliary and Nursing Care Costs as Determined by
Office of the State Comptroller (FY 14)**

| Type of Residence | Daily Per-Resident Cost |
|--|-------------------------|
| Main Residential Facility | \$104 |
| Substance Use Treatment (Fellowship House) | \$135 |
| Health Care Facility | \$717 |

Source of data: DVA, per memorandum from the Office of the State Comptroller (May 15, 2014).

STAFFING

Staffing levels for the Department of Veterans' Affairs have declined recently, as in other state agencies. The numbers of overall and filled positions have both dropped.

The staffing resource information presented below is based on aggregate department data provided by DVA. It excludes residents participating in the therapeutic Veteran Worker program, who are not considered Home staff. Current staffing information for individual programs and services for domiciliary care is provided in Chapter V, Chapter VI for the Health Care Facility, and Appendix C for certain campus-wide services. Additional data and analysis are necessary to more fully understand the staffing resource trends of areas at the Veterans' Home.

Committee staff obtained staffing resource data from DVA for FYs 08-14. The information was provided according to employee type (full-time, part-time, or temporary part-time), as well as by position status, which are:

- *Established*: the total number of positions the agency is allowed to have, and is frequently referred to as "position cap;"
- *Filled/Paid*: the position is a non-vacant, established position;
- *Filled/Not Paid*: the position is an established position filled by a worker who for a specific reason is not being paid (e.g., family/medical leave, unpaid leave); and
- *Vacant*: the position is an established one but not filled by a worker.

As noted earlier, the staffing resources within DVA consist mainly of positions to support and operate the Veterans' Home. The number of "filled/paid" positions is the level of effective staffing – staff actually working.

Table III-3 shows the number of positions by category for FYs 08-14. The department's total number of filled/paid positions within the department decreased 17 percent over the seven-year period, from 379 to 313. This includes full- and part-time positions. There also was a 20 percent drop in full-time/paid positions, from 292 to 236, and an 11 percent drop in part-time/paid positions, from 87 to 77. It should be noted, the loss of full-time/paid positions was a loss in positions and not a shift to part-time/paid positions. Finally, the number of total vacant positions dropped from 31 to 18 (42 percent), indicating overall employee levels decreased. As expected, the number of filled/not paid positions in any given year was low in comparison with all other filled positions.

| Table III-3. DVA Position Counts: FYs 08-14. | | | | | | | |
|---|-------------|--------------|-------------|--------------|--------------|--------------|--------------|
| | FY08 | FY 09 | FY10 | FY 11 | FY 12 | FY 13 | FY 14 |
| Full Time | | | | | | | |
| Established | 310 | 292 | 270 | 269 | 264 | 251 | 248 |
| Filled/Paid | 292 | 288 | 256 | 261 | 241 | 242 | 236 |
| Fill/Not Paid | 4 | 0 | 2 | 1 | 2 | 3 | 3 |
| Vacant | 14 | 4 | 12 | 7 | 21 | 6 | 9 |
| Part Time | | | | | | | |
| Established | 104 | 84 | 82 | 83 | 79 | 80 | 87 |
| Filled/Paid | 87 | 83 | 82 | 79 | 75 | 75 | 77 |
| Fill/Not Paid | 0 | 1 | 0 | 1 | 1 | 0 | 1 |
| Vacant | 17 | 0 | 0 | 3 | 3 | 5 | 9 |
| Grand Totals | | | | | | | |
| Established | 414 | 376 | 352 | 352 | 343 | 331 | 335 |
| Filled/Paid | 379 | 371 | 338 | 340 | 316 | 317 | 313 |
| Fill/Not Paid | 4 | 1 | 2 | 2 | 3 | 3 | 4 |
| Vacant | 31 | 4 | 12 | 10 | 24 | 11 | 18 |
| Note: Data are “point-in-time” for June 30 of each fiscal year (i.e., the fiscal year’s end). Source of data: Department of Veterans’ Affairs. | | | | | | | |

Campus Facilities, Grounds, and Infrastructure

The Veterans' Home has been at its Rocky Hill campus since 1940. Most of the Home's buildings are located on the north side of West Street, just over a mile off Interstate 91. The campus is on a hillside and has substantial grass-covered open space. This chapter describes the Home's buildings, grounds, and infrastructure, along with relevant staffing.

Facilities

Number. Forty buildings are located on the Home's grounds. Thirty-one of the buildings are north of West Street and accessible through a security gate. A fence surrounds this portion of the campus. South of West Street, there are six houses, a garage, an office building, and a tool shed for the State Veterans' Cemetery, which also is located there.

Age. Most of the Home's buildings are nearly 80 years old. They were constructed between 1935 and 1938 through the federal Works Progress Administration.¹ These include the main Residential Facility buildings and its medical clinic, the Commissary that hosts the Home's kitchen and domiciliary care dining hall, and the state DVA administration building. Its physical plant building is also in the group of aged buildings.

Several buildings are somewhat newer. Through the 1940s and 1950s, nine more buildings were constructed, including the West Street houses, which host the Patriots' Landing program, and Fellowship House, which now provides residential substance use treatment. In 1994, an office building was added on the south side of West Street to host daycare (though it has not done so in a while). More recently, in 2008 the Health Care Facility opened, becoming the new location of the Home's 24-hour nursing care services.

Residential buildings. The five buildings on campus currently used for resident housing are:

1. the main Residential Facility's East and West domiciles;
2. Fellowship House;
3. the STAR townhouse-style apartments, for veterans who are employed full-time off-campus and working toward moving out of the Home;
4. the Health Care Facility; and
5. the five West Street houses, for veteran-headed families as well as women veterans participating in the Patriots' Landing program.

¹ "Veterans' Home Master Plan Study," Friar Associates Inc., July 2005.

While the Health Care Facility and West Street houses are currently near capacity, the Home's other residential buildings are not (see Chapters V and VI).

The campus also has a number of buildings that previously were used residentially:

1. three houses (one quite large) and two duplexes, informally called "Sugar Hill," now primarily hosting occasional meetings and, in one case, serving as office space for a veteran organization (Spanish American Legion);
2. two buildings consisting of apartments that have a combined 32 bedrooms; and
3. the original Hospital building, whose lower floors contain a mail sorting room, office space, and storage.

In addition, there is one large house next to the West Street houses that is unusable without tremendous renovation, according to state DVA staff.²

Conditions. The most recent systematic assessment of the Veterans' Home buildings, completed by a consultant in 2005, found the buildings overall needed "extensive restoration and/or replacement." The evaluation indicated substantial masonry (brick) and foundation work was needed, as were "accessibility upgrades, fire safety upgrades, toilet and shower renovations....and interior finish upgrades." The consultant also called for other renovations to raise residents' quality of life. Overall, the report found:

1. "poor" conditions for 18 buildings, including the Hospital, the West Street houses, Fellowship House, and the STAR apartments;
2. "poor to fair" conditions for six buildings, including the East and West Domiciles, as well as nearly all the Sugar Hill accommodations;
3. "fair" conditions for five buildings, including the Commissary and Administration; and
4. "good" conditions for three buildings, two of which are plant-related.

The plan recommended two major changes, in addition to moving some functions around and completing the needed renovations. First, the plan called for constructing a new health care facility for nursing care residents, which was done. Second, the plan recommended demolishing the West Street houses to replace them with row housing, to maximize the number of veterans that could be housed.

Since the plan was issued, key residential buildings have undergone some renovations. Specifically:

- the West Street houses were completely renovated between 2005 and 2008;

² The 2005 facilities assessment, discussed in this chapter, found the building to be in fair condition (nine years ago).

- the Home’s kitchen (located in the Commissary) became air-conditioned;
- bathrooms were renovated in the main Residential Facility (but not in Fellowship House or the STAR apartments);
- the main Residential Facility’s East and West Domiciles have become air-conditioned – the buildings previously lacked a cooling system;³ and
- additional asbestos tile remediation is scheduled to occur in the main Residential Facility.

Planned and ongoing improvements include upgrades to building fire alarms and sprinkler systems, as well as a new boiler and blow off (see below).

Appendix B contains a chart listing, for each building:

- current use;
- whether the use level is at or near the capacity;
- whether use is consistent;
- the condition, as assessed in 2005;
- the amount (in unadjusted dollars) that would have been necessary in 2005 to bring the building’s condition up to “excellent” at that time (nine years ago); and
- any major renovations that have occurred recently or are planned for fall 2014.

Infrastructure and Fleet

Infrastructure. The Home has various operations to deliver power, water, and other utilities to the campus buildings. In addition, the Home’s water system feeds water to a few nearby State facilities.

Water. Water is pumped from the Metropolitan District Commission; water mains encircle the campus and pipes deliver water to the buildings. The campus has two water towers. The smaller tower is not normally in operation; it is used only when the other water tower is being repaired, or in certain other situations that call for additional or replacement capacity. The campus’s water system serves the nearby State buildings of Dinosaur State Park and State Records.

Power Plant. The Home’s power plant generates heat, hot water, and electricity for the entire campus (except the Health Care Facility and one building on the south side of West Street). The boilers are old; for several years, the Home has been working with the State Department of Construction to replace them. There is an emergency generator that is in the process of being replaced because there is insufficient power to operate it (to have it be on-call) when the buildings’ air conditioning is on. Steam mains feed all the buildings.

³ The other buildings currently used as residences do not have central air conditioning. The Fellowship House has window units in the meeting rooms and main gathering room. The STAR program has two window units per apartment. Each Patriots’ Landing house also has two window units.

Because all campus facilities must have operational fire alarms, electricity needs to be supplied even when a building is unused. Unused buildings, including the 260,000 square foot old hospital building, need to be heated to maintain structural integrity.

Health Care Facility. The Health Care Facility has its own boilers, chiller, heating, and cooling under an energy management system. One side of the HCF's double-sided chiller is permanently broken. The remaining side is sufficient for the building as long as it continues to function well.

Fleet. The Home has bus and small passenger vehicles in its own fleet. There are three buses, one 44-passenger bus and two 24-passenger buses. The buses are wheelchair-accessible; one wheelchair requires two seat spaces. The buses transport residents to:

- the federal VA medical centers in West Haven and Newington;
- the University of Connecticut Health Center;
- shopping, on Saturdays; and
- scheduled recreational activities.

Two of the three buses run a scheduled shuttle service among the medical centers and the Home on weekdays.

The small passenger vehicle side of the fleet contains 25 vehicles. The Home's Security unit uses one fleet vehicle and one additional DVA vehicle. The others are available to transport residents to educational, vocational, or important personal (e.g., court) commitments. In addition, on occasion staff will use a car (e.g., to transport a resident to court, or to purchase clothing for a new resident who needs some). Employees and Home residents who are participating in the Veteran Worker program (see Chapter V) drive residents and staff who need to use a fleet car.

Equipment and Staff Resources

The Home runs on its own equipment and staff, with one small exception. Once a year, a lift is rented for a month and shared among all the Facilities departments.

In total, Facilities employs 38 state employees, along with 21 Veteran Workers. It should be noted that until summer 2014, there was no Building Services (i.e., janitorial) state employee assigned to occupied domiciliary care buildings. Now, one Building Services employee is stationed there, joining two Veteran Workers.

Domiciliary Care

Veterans who can walk without assistance and care for themselves may reside in one of the Veterans' Home's four residences that provide domiciliary care. Domiciliary care consists of shelter, food, and rehabilitative services.¹

Most domiciliary care residents live in the main Residential Facility's East and West Domiciles (called the "Dom" or "Domicile" which have eight wings labeled A-H). Each living space there accommodates twelve people. There are a few special settings within the Domicile, including a designated women's wing and the Residential Plus Program for residents who need additional care but not 24-hour nursing care. Veterans participating in residential substance use treatment live in private rooms in a separate building known as the Fellowship House. Residents working full time off campus with the goal of moving out of the Home, can live in the STAR apartments.² In addition, five separate homes, located across West Street from the main campus, are open to veterans with families and single women veterans through the Patriots' Landing program.

This chapter describes the Home's domiciliary care:

- capacity and occupancy
- admissions requirements and process;
- rehabilitative services;
- settings;
- resident rules and consequences;
- discharge (i.e., moving out) processes; and
- methods for hearing resident concerns and complaints.

Occupancy

The Department of Veterans' Affairs provided committee staff with domiciliary care number of beds in operation (i.e., capacity) and residents for certain years based on the Home's data availability.³ Committee staff examined domiciliary care information using four specific dates as data points over each calendar year for 2009-2014.⁴ For most of the information provided below, staff averaged the year's data points as an approximation of the annual average.

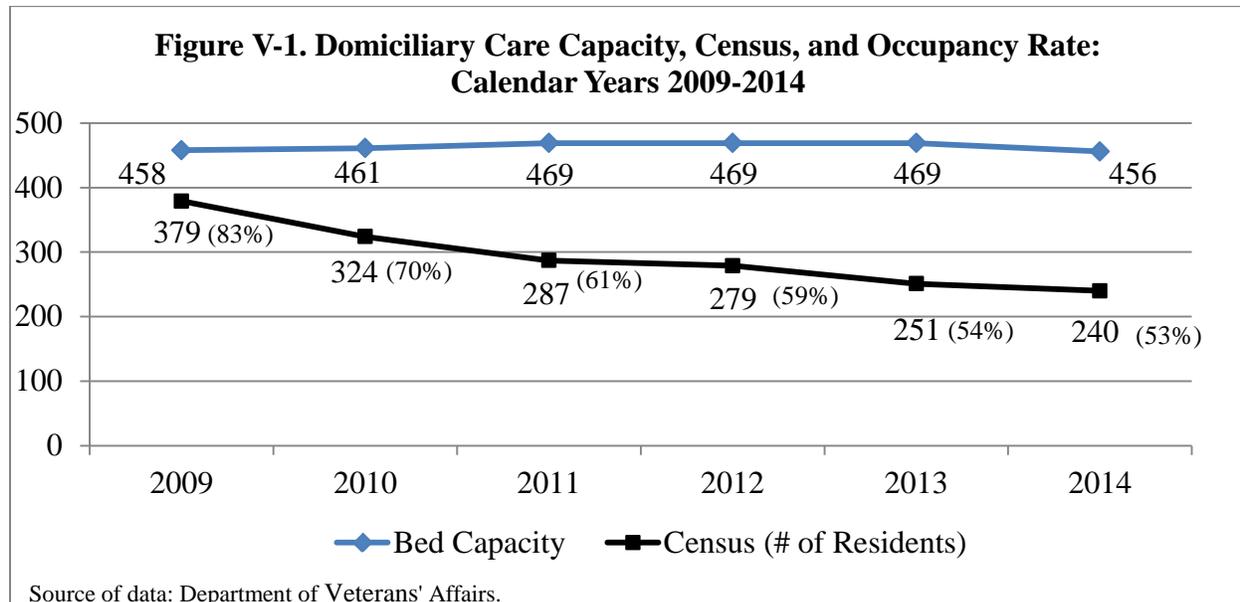
¹ Veterans needing 24-hour nursing care live in Home's Health Care Facility, which is described in Chapter VI.

² In addition to working off-campus, Veterans' Home residents may work up to full-time in an on-campus therapeutic work program, commonly known as the Veteran Worker program. These residents are ineligible for the STAR apartments.

³ Additional examination is needed regarding the number of beds unavailable for veterans and the reason(s) why those beds cannot be occupied.

⁴ The point-in-time dates selected by the Home for domiciliary care were January 31, April 30, July 31, and October 31.

Overall. The number of beds available to veterans for domiciliary care fluctuated between 2009 and 2014, as shown in Figure V-1. It rose from 458 to 469 in 2011 (up 2 percent), remained flat through 2013, and then declined to 456 in 2014 – just under 2009 capacity. The decline is due to the reconfiguration of the West Street houses’ programming. The number of residents occupying beds (i.e., census) steadily decreased over the six years. The number of veterans receiving domiciliary care in Calendar Year (CY) 2009 was 379, which dropped 37 percent to 240 residents in CY 2014. Overall, the occupancy rate decreased in the last six years. In CY 09, the rate was 83 percent, which dropped to 53 percent in CY 14. Committee staff will further examine the possible reasons for declining occupancy.

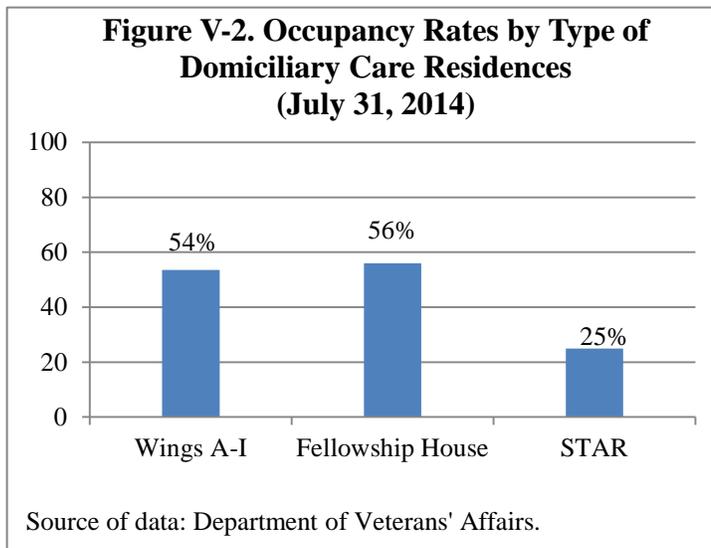


By residence type. Table V-2 provides the number of beds in operation at the various residences offering domiciliary care, as of July 31, 2014. The main Residential Facility accounts for almost eight of every ten beds. Sixteen percent of domiciliary care beds are for substance use recovery in the Fellowship House, while the STAR and Patriots’ Landing programs account for three and two percent, respectively.

| Table V-2. Bed Capacity by Type of Residence: Domiciliary Care (July 31, 2014) | | |
|---|---|-----------------------------|
| | <i>Total Beds Available to Veterans</i> | <i>% of Total (rounded)</i> |
| Total beds available | 456 | --- |
| Main Residential Facility (Wings A-H) | 362 | 79% |
| Fellowship House (substance abuse recovery center) | 75 | 16% |
| STAR program (veterans working full-time off campus) | 12 | 3% |
| Patriots’ Landing (five, 3-bedroom houses on West Street, with four houses for veterans and their families and one house for up to three single women veterans) | 7 | 2% |

Source of data: Department of Veterans’ Affairs.

Figure V-2 shows the current overall occupancy for each type of residence on July 31, 2014. Wings A-I in the main Residential Facility and the Fellowship House were over half full (54 percent and 56 percent, respectively). The STAR occupancy rate on that day was 25 percent. Additional analysis is needed to determine the occupancy rate of the Patriots' Landing homes, due to their uniqueness, and will be done for the next report. The information presented in the figure is for context only, and may not be indicative of occupancy rates in previous months or years.



Resident Characteristics

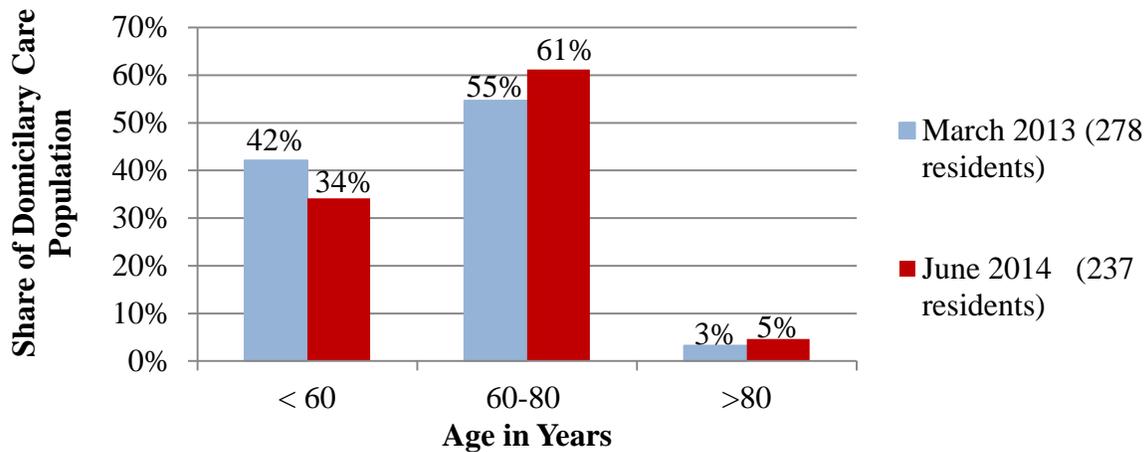
Most domiciliary care residents are older and dealing with a variety of medical conditions, according to limited data provided by Home staff.⁵ Just under half have lived at the Home for more than five years. The resident population appears to be aging and experiencing increased health problems, based on data from March 2013 and June 2014. As discussed above, the domiciliary care resident population also has been contracting; it dropped three percent over this period, to 240 residents.

Age. Two-thirds of domiciliary care residents are at least 60 years old. Most (61 percent) are between 60 and 80 years, and five percent are older than 80.

The domiciliary care population seems to be rapidly aging, as illustrated in Figure V-3. Between just the 14 months examined, the share of residents under 60 years old dropped by almost one-fifth (from 42 to 34 percent). Simultaneously, the portion over age 80 remained relatively small but rose more than two-fifths (from 3 to 5 percent), while the percentage between ages 60 and 80 – the largest segment of the population – increased by one-eighth. Overall, the share of residents age 60 and up grew by one-seventh (rising from 58 to 66 percent).

⁵ The data exclude Patriots' Landing and are limited to two recent points in time. Much additional data regarding resident characteristics were requested by program review committee staff, but the DVA could not produce more than the information shared in this chapter for this report.

Figure V-3. Domiciliary Care Residents' Ages, By Share of The Resident Population, 2013 and 2014



Source of data: Department of Veterans' Affairs.

Medical conditions. Overall, a large share of the domiciliary care resident population appears to be dealing with at least one serious medical condition, as Table V-3 shows.

Table V-3. Share of Domiciliary Care Residents Experiencing Medical Conditions and Impairments, 2013 and 2014

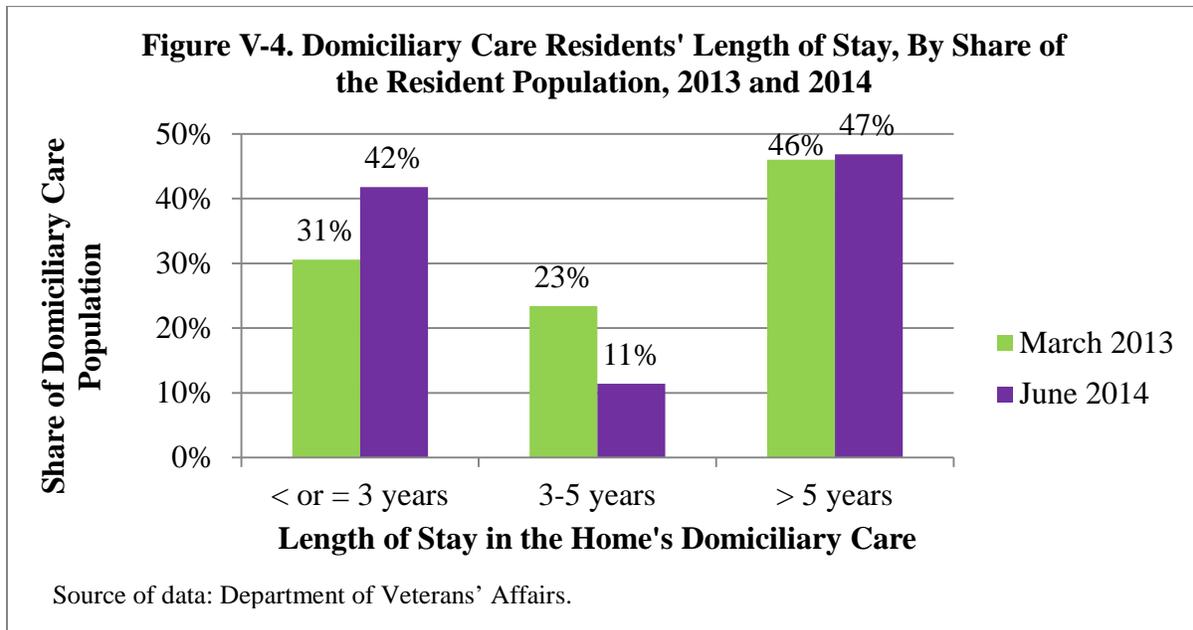
| | <i>Share of Resident Population</i> | | <i>Percent Change</i> |
|--|-------------------------------------|------------------------------|-----------------------|
| | <i>March 2013 (n=278)</i> | <i>June 2014 (n=237)</i> | |
| Medical Conditions | | | |
| Psychiatric diagnosis | 79% | 87% | 10% |
| Substance use | 72% | 83% | 16% |
| Diabetes | 51% | 46% | -9% |
| Hypertension / Elevated cholesterol / Heart disease | 73% | 87% | 18% |
| Cognitively impaired | 30% | 31% | 3% |
| Hepatitis C | 16% | 16% | -1% |
| Kidney Disease | 4% | 8% | 95% |
| Impairments | | | |
| Impaired ambulation (needs walker, scooter, etc.) | 8% | 17% | 109% |
| Extreme vision impairment | 1% | 2% | 56% |
| Extreme hearing impairment | 0% | 1% | 135% |

Source of data: Department of Veterans' Affairs.

For example, 87 percent have received a psychiatric diagnosis and 87 percent have heart disease or common precursors (hypertension, elevated cholesterol). A strong majority (83 percent) has a recent history of problematic substance use. In addition, 46 percent of veterans have diabetes and/or 31 percent have cognitive impairment. One in six needs assistance from a device like a walker or scooter in order to be mobile.

The domiciliary care population seems to have growing medical needs. Table V-3 indicates that nearly all medical conditions have become more prevalent, over just the 14-month period examined. Rates of psychiatric diagnosis, substance use, heart disease and its precursors all experienced double-digit percent increases (10 to 18 percent). The highest jumps were in rates of kidney disease (up 95 percent, to 8 percent of the population) and impaired ambulation (up 109 percent, to 17 percent).

Length of stay. Nearly half of domiciliary care residents (47 percent) have lived at the Veterans' Home for more than five years. This share increased minimally (up 2 percent) from March 2013 to June 2014. Interestingly, there was substantial change in the length of stay at the lower end of the spectrum, as depicted in Figure V-4. The percent of residents who had lived in domiciliary care for three years or less rose by more than one-third (up 37 percent, to 42 percent). Correspondingly, the share of residents who had lived there between three and five years dropped by about one-half (down 51 percent, to 11 percent).



In March 2013, just over one-fifth (22 percent) of domiciliary care residents had lived at the Home for more than ten years. Comparable data were unavailable for June 2014.

Admission

Residential and support services at the Veterans' Home are available to any veteran who meets specific eligibility requirements. Veterans seeking admission to the Home must submit an application for consideration by the Home's admission team. The application review process consists of several key steps:

- pre-application review by the application coordinator;
- admission team's review of application and supporting documents;
- re-review of application, if necessary;
- admission team's decision; and
- appeal decision by the commissioner, if necessary.

Admission eligibility. The department requires veterans applying for domiciliary care be ambulatory without the need for assistance. Veterans must not need any nursing care, generally be able to take their own medication, dress without assistance, make their own bed, and participate in an assigned chore or work duty at the Home based on their physical ability. Veterans applying for admission to the Home may also have to meet with the Home's clinicians for a medical, psychiatric, or substance use "prescreen" before a final determination is made.

Application. The Home's admission application is the same for domiciliary and nursing care. The application requires veterans to provide information on:

- personal data (e.g., name, address, date of birth, race);
- reason for admission;
- medical history;
- military service history;
- conservatorship/power of attorney;
- advance health directives;
- education history;
- family/spouse;
- substance abuse/recovery support;
- health insurance;
- legal history; and
- financial history.

A medical certificate, signed by the veteran's primary care physician, showing the recent results of a physical exam, medication regimen, tuberculosis test, and vaccination information is also required.

Veterans must sign two release forms when submitting applications. The forms authorize the Connecticut Department of Veterans' Affairs to obtain records from any of the federal VA medical centers, VA regional office, and any other treatment facilities deemed necessary by the Department of Veterans' Affairs. The records include health, substance abuse history, psychiatric treatment, and military service. Another form allows the department to collect information from the Social Security Administration, including monthly Social Security benefit or Supplemental Security Income, and Medicare claim/coverage.

A Residential Facility staff person is responsible for coordinating applications and supporting materials. The coordinator estimates 30 to 80 questions about admission to the Home are received weekly. Inquiries, including phone calls and walk-ins, come from veterans, family members, medical personnel, case workers, shelter staff, and probation/parole officers. Voicemail messages are tracked in a log. Veterans can schedule a tour of the Home at any time.

As part of the pre-application process, the coordinator determines if the veteran's application is complete, and if they meet the basic eligibility requirements for admission. The coordinator will also learn if the person was previously a Veterans' Home resident and, if so, whether there are past/pending resident fees, disciplinary issues, or involuntary discharges from a previous stay. In addition, searches are conducted of the state Judicial Department's website to see if the applicant has any pending legal issues. If the person does not meet the basic statutory requirements, the coordinator provides information either to the veteran or a case manager so the appropriate housing and/or services may be found.⁶

State regulations say if an applicant fails to substantially complete an application, as required, within sixty days the application must be returned to the veteran.⁷ A Home representative said the application information and its accompanying documents take time for veterans to collect and submit, and that time beyond the regulatory deadline may be granted if necessary. Veterans may also withdraw their applications at any time. In addition, current domiciliary care residents do not have to submit an application if being transferred to nursing care at the Home's Health Care Facility.

Application review. The application review process is conducted by a team of staff consisting of the domiciliary care director, the Fellowship House supervisor (who is a psychologist), nurses (two of whom work at the domiciliary care medical clinic, including a nurse practitioner)⁸, and domiciliary care application coordinators.⁹ DVA medical personnel may be consulted, if needed. The admissions coordinator provides each team member with advance copies of the veteran's application and supporting documents, including medical notes from the federal VA. Application materials must be substantially complete for the review team to consider the application.

The team reviews admission applications weekly. The coordinator develops an agenda of the applications, including re-reviews of applications, for consideration by the team.¹⁰ Each application is then discussed, and the team decides whether to admit, suspend, or deny the application.

⁶ Veterans are told about the federal HUD-VASH housing voucher program, and provided with telephone numbers for various programs, including the federal VA's homeless services.

⁷ Regs. Conn. State Agencies (R.C.S.A.) Sec. 27-102I-103(g).

⁸ All nursing personnel for the Veterans' Home are considered staff of the Home's Health Care Facility, even those who work in the domiciliary care medical clinic.

⁹ The admission team's meeting observed by committee staff was attended by all but the nursing supervisor and admission coordinators.

¹⁰ R.C.S.A. Sec. 27-102I(d)-107 requires prior approval by the commissioner for any readmission of a veteran whose prior discharge was within six months and the discharge was for certain reasons, including failure to comply with rules, involuntary discharge, billing account not in good standing, or absent without leave. Certain conditions may be placed on the veteran for admission, including drug testing.

- If admitted, the team determines where the veteran will reside (i.e., which wing or program), and the veteran is notified by phone within 24 hours.
- If the decision is suspended, it is usually because additional information is needed, such as a certain medical or psychological test, beyond the standard application requirements. In this case, the veteran is notified and asked to send the information.
- If the application is denied, a form letter identifying the reason(s) for denial is sent to the veteran.

All applications are kept on file in case the veteran re-applies for admission to the Home, and sign-off by the commissioner is not needed for admission team decisions.

Appeal. Application denial decisions may be appealed in writing by a veteran to the DVA commissioner within ten days of receiving the denial notice. The appeal is reviewed by the commissioner and domiciliary care administrator. The final decision is made by the commissioner.

Intake: moving into domiciliary care. Veterans admitted to the Home are contacted by the admissions coordinator, usually within one day, to determine a move-in time. If no other application supporting documents are needed, intake usually occurs within two weeks, although no set timeframe exists. There is usually a wait of at least a few days because there may be a short wait until a domiciliary care medical clinic appointment is available. It is the Home's policy that a resident meets with the medical clinic nurse practitioner for a physical ability assessment for therapeutic work purposes, and an abbreviated physical the day of admission.

The admissions coordinator discusses transportation options with the veteran (or a representative of the veteran, including family member or case manager) for a timely arrival to the Home. If necessary, transportation will be provided by the Home at no cost to the veteran.

On the day of intake, the Home's Security staff checks the veteran's belongings to ensure no prohibited items are entering the campus (see "Resident Rules" later in this chapter). The admissions coordinator will then meet with the veteran to go through a checklist of items. The veteran receives a: Resident Handbook, list of resident rights and responsibilities, resource directory, campus map, and 90-day agreement form. The agreement form stipulates the veteran has a 90-day probationary period from his or her admission date, and that failure to comply with the Home's rules during that time may result in involuntary discharge.

Several other forms must be signed by the veteran, including documents stating the veteran met with various staff at the Home, understands his or her health information privacy requirements, consent for basic treatment, release of medication information, and any substance use testing requirements. Additional information about advance health directives is discussed; the social work department helps with the veteran about such decisions after admission, if necessary.

Basic information collected from the application and upon intake is entered into the department’s computer-based Patient Care System. The system also includes pharmacy and medication information, as discussed in Chapter II.

Patriots’ Landing application. The application for Patriots’ Landing program is separate from the Home’s application. Veterans applying to the program must meet the same statutory eligibility criteria, but submit a streamlined application for admission. These applications are reviewed by a separate team. Once admitted to the program, the veteran, a DVA representative, and a representative from the nonprofit that provides Patriots’ Landing social services must sign a program agreement, akin to a rental agreement.¹¹

Domiciliary care admission statistics. Table V-4 provides information about domiciliary care admissions, for CYs 2012-2014. The overall number of applications submitted to the Home was down 16 percent in 2013. The rate of denied applications has fluctuated between 27 and 42 percent. As well, the percent of veterans admitted to the Home ranged between 36 and 43 percent.

| Table V-4. Domiciliary Care Admission Statistics: CYs 2012-2014 | | | |
|---|-------------|-------------|--------------------------------|
| | 2012 | 2013 | 2014 (as of June 1) |
| Applications received | 149 | 125 | 69 |
| Applications denied | 57 | 34 | 29 |
| Applications withdrawn | 20 | 13 | 9 |
| Admissions | 55 | 54 | 25 |
| Note: Some applications either may carry-over from previous year or into the following year, which is why actions on applications do not equal the number of applications received. Source of data: Department of Veterans’ Affairs. | | | |

Services

Several services are available to nearly all domiciliary care residents while they live at the Veterans’ Home:¹²

- social work;
- vocational rehabilitation;
- substance use treatment;
- recreation; and
- medical care.

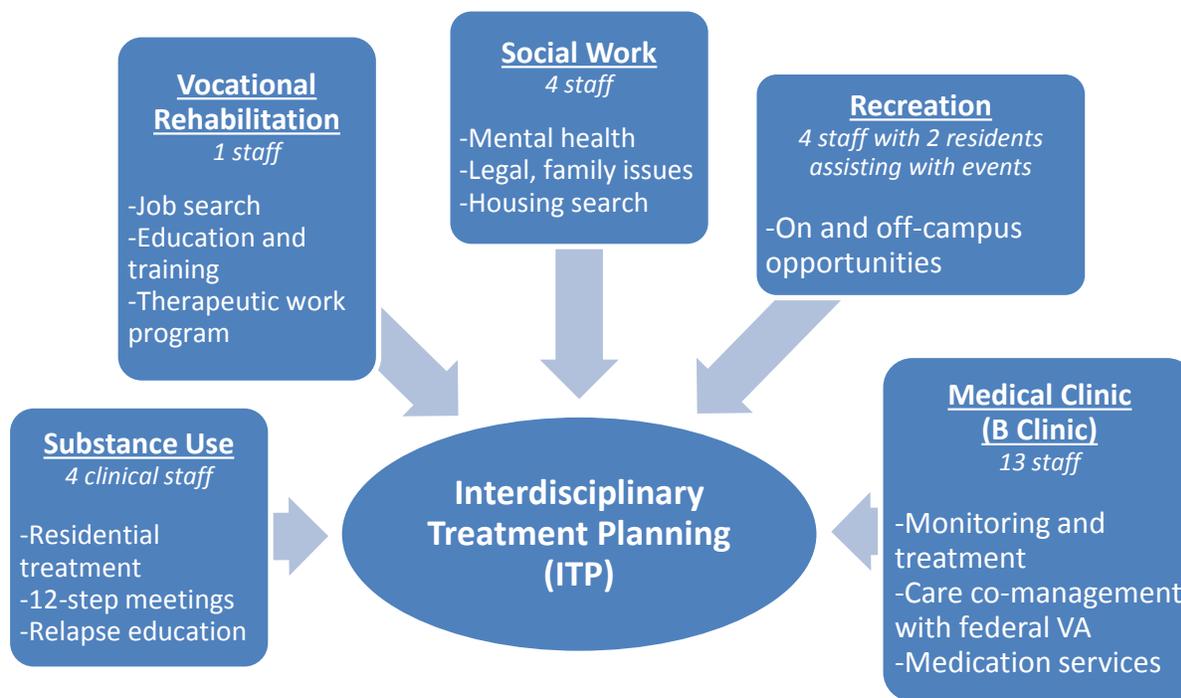
¹¹ Chrysalis Center provides case management services to Patriots’ Landing residents.

¹² As explained later in this chapter, residents of the Veterans’ Home’s West Street houses use social and other services provided by Chrysalis, instead of the services available to all other domiciliary care residents. This change was made in early 2014, and the new program was named “Patriots’ Landing.”

In addition, the Home employs chaplains for residents' spiritual needs and care (see Appendix C).

This section explains how each service functions and how staff work together toward the goal of preparing residents for productive, independent lives through the Interdisciplinary Treatment Planning (ITP) process and the Veterans Improvement Program (VIP). The ITP process focuses on resolving health and well-being issues, while VIP centers on setting goals that enable veterans to successfully move out of the Home. The chart below gives an overview of the major services available to domiciliary care residents, noting that staff from each service participate in the ITP process.

Figure V-5. Interdisciplinary Treatment Planning for Domiciliary Care Residents: Home Staff Participants



Source: PRI staff.

Interdisciplinary Treatment Planning (ITP). The goal of this process is to help each veteran in domiciliary care reach the highest possible level of physical, mental, and social health. Veterans' Home staff from the medical, recreation, physical rehabilitation, social work, and vocational rehabilitation departments participate, as does the domiciliary care administrator.

First meeting. Fourteen calendar days after a domiciliary care resident has been admitted to the Home, the first ITP meeting is held for the person. It occurs after the resident has met with staff from each department involved in ITP meetings (shown in Figure V-5), so the staff have started to become familiar with the person's needs and preliminary goals.

At the ITP meeting, staff participants meet with the resident. If the resident is conserved, as currently four are, the conservator is asked to attend the first ITP meeting by the social worker.¹³ If the conservator wants to attend, the meeting will be scheduled to make that possible. If the conservator does not care to participate, the ITP is held without that person. The resident may choose to invite a spouse or other family member(s). Goals in every area are discussed and agreed upon by all attendees, including the resident. There are prescribed forms to assist the veteran and staff in pursuing appropriate strategies to tackle various problems.

Follow-up meetings. Staff check with each other about every resident's progress during regularly scheduled ITP meetings. Domiciliary care residents are discussed three months after the initial ITP meeting and then every six months. The resident does not attend; if there is an issue to discuss and the person is conserved, the conservator will be invited.

The meeting, which lasts from one to three hours, is held weekly at the same day and time. Usually there are many residents whose progress and current status are reviewed, one at a time. The medical clinic's nurse director tracks who is due for a follow-up meeting and informs the ITP staff participants of that a week or so in advance. The notice allows the services staff to meet with the residents if necessary (e.g., if a social worker has not met with the resident in a while) before the team's ITP meeting. Staff can use the information learned at the ITP follow-up meeting to congratulate residents on progress made in aspects of their lives with which a particular staff person may be less familiar.

“Special ITP” meeting. If a significant event happens in a resident's life, and a follow-up ITP meeting is several weeks away, a “special ITP” meeting is called by either staff or the resident. Examples of such events include a major change in a health diagnosis, a substantial injury, a major conduct violation, or a family death.

A special ITP meeting also may be called when a resident receives a third, fourth, or fifth violation of the conduct rules. Sometimes, in lieu of a full ITP meeting, a substance use counselor and the resident's social worker will meet, if the violation involves substance use.

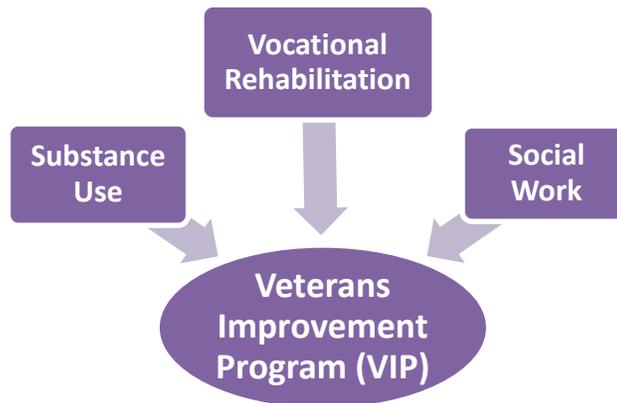
When a resident's situation has changed so a different Veterans' Home setting might be more appropriate, that may be discussed in a regular ITP meeting and in a special ITP meeting. A few additional Home staff may attend a special ITP meeting: a doctor or APRN from the Health Care Facility, a nursing supervisor, and the HCF administrator. Generally the staff will begin the special ITP meeting with discussion as a team and then ask the resident to join the rest of the meeting. The resident is always a participant in the second part of a special ITP because goals may be revised based on the new circumstances (which does not happen at a follow-up meeting).

Veterans Improvement Program (VIP). Individual domiciliary care residents and certain Home staff meet regularly to set goals that will help the veterans live successfully outside

¹³ A conservator is appointed by a probate court “to oversee the financial and/or personal affairs of an adult who is determined to be incapable of managing his or her own affairs.” The appointment may be short- or long-term, and a capable person can request a conservator, according to www.211ct.org (accessed September 22, 2014 at: <http://www.211ct.org/InformationLibrary/Documents/Conservator-Court%20Visitor%20Program%20rj.asp>).

the Home. Personnel from the social work, vocational rehabilitation, and substance use treatment departments are involved, as shown in Figure V-6. VIP meetings are held weekly.

Figure V-6. Veterans Improvement Program (VIP) Coordination



Source: PRI staff.

First meeting. After the veteran has lived at the Home for three months, the resident receives notice that a VIP meeting is scheduled and that a particular completed form should be brought to that meeting. The form outlines the resident's circumstances regarding:

- finances (e.g., income sources and level for each, debts, assets, whether the person has a checking account, and the person's estimate of how much income will be needed to live outside the Home);
- benefits receipt and advocacy assistance;
- legal issues;
- vehicle and driving ability;
- housing and position on Section 8 lists;
- health and substance use recovery; and
- employment and education.

At the meeting, the Home staff and the veteran collaborate to develop the Rehabilitation Treatment Plan. The plan is a form with space to set goals in each of the issue areas covered above, as well as specific targets regarding discharge date and monthly savings amount. Unless the resident is enrolled in higher education, the discharge date is expected to be within the next three years. The plan is signed by all meeting participants and the domiciliary care administrator. It is then used as a guide for the resident and as a tool for staff in helping the person successfully reach independence.

Periodic follow-up. The staff team and the resident meet every three months to discuss progress, revisit the plan, and update the goals as needed. In addition, the resident is to have a monthly meeting with the assigned social worker, as described further below.

Ending program participation. If a resident decides to stop planning to leave the Home, the person is withdrawn from VIP. The person's quarterly meetings cease.

If a person pulled out from VIP but later wanted to restart efforts to depart from the Home, he or she would be expected to collaborate with the social worker, working with other Home staff as appropriate. There is no re-entry into VIP.

Social work. The Veterans' Home's social work department seeks to help residents resolve their legal, behavioral health, family, end-of-life, and relationship concerns. Social work staff offices are in the main Residential Facility, with one additional office located in the Health Care Facility.

Activities. Social workers meet with residents for both scheduled and unscheduled appointments, perform casework-type activities on behalf of residents, and participate in ITP and VIP meetings. Each resident is assigned a social worker. Social workers split their resident caseloads about equally. Each resident is to formally meet with the assigned social worker within the first five days after arriving at the Home and then every three months while living there, for as long as participation in the VIP program continues.

First meeting with a new resident. The first meeting with a social worker involves a discussion of the resident's psychosocial history and an assessment regarding relationships and family communication. The social worker and resident then establish goals involving the key aspects of a resident's life. The meeting generally lasts between one and two hours.

Ongoing activities. The social worker then begins to assist the resident in resolving issues identified in the first meeting and reaching ITP and VIP goals (as set out in the VIP plan). The social worker schedules appointments or otherwise makes contact with residents:

- when necessary, for example to update them on the worker's progress in resolving an issue, or to provide support;
- every three months for each resident, before the staff follow-up ITP meetings; and
- monthly, with residents participating in the Veterans Improvement Program.

Periodic follow-up contact with a VIP participant may be either an in-person meeting or a written monthly progress update from the veteran; the choice is the resident's.

In addition to these scheduled contacts, residents are encouraged to stop by for assistance when pressing matters arise.

Types of services. In addition to what's described above, social workers help residents resolve legal matters, including helping with child support obligations and assisting residents in complying with probation terms.

Social workers also assist residents who have or need conservatorship, which is appropriate when a person's mental capacity prevents them from legal independence. They

monitor each resident who is conserved to ensure the conservator meets with the veteran at least once annually. If that does not happen, the social worker petitions the Probate Court to remove the conservator.

When Home staff begin to see a resident getting confused, the issue is discussed in the quarterly ITP meeting, if not sooner in a special ITP meeting. Then, the resident is asked to make an appointment with a psychiatrist, who will evaluate the person's mental capacity.

If mental capacity has declined to a certain level, the social workers will help the veteran select a potential conservator, and then assist that person in filing an application for conservatorship with the Probate Court. If the resident does not have a family member or other person who the resident would like to be conservator, either the court will appoint an attorney or, if a person is receiving Medicaid, the Connecticut Department of Social Services (DSS) commissioner is named (with the duties carried out by a DSS employee).

Staffing. The social work department's fully-staffed level is four full-time social workers who serve both domiciliary and Health Care Facility residents. For June through mid-September 2014, there were only two social workers. The shortage was due to a combination of a transfer to another state agency and a Family and Medical Leave Act absence. During those months, there was roughly one social worker for every 180 Home residents. At full-strength staffing, the estimated level would have been one for every 90. Social work staffing is due to return to its normal level in October, as the vacant position has been filled (with a scheduled start date in mid-September) and the person out on leave returns that month. For the next report, committee staff will identify any best practices regarding an appropriate social worker to resident ratio.

Vocational rehabilitation. The vocational rehabilitation coordinator assists residents in improving employability and obtaining jobs, both within and outside the Veterans' Home. The coordinator has an office within the main Residential Facility and there is a small computer lab nearby specifically for residents' education and employment-search activities.

Activities. The coordinator meets with residents, researches and assists in placement into education opportunities and jobs, participates in ITP and VIP meetings, and oversees the Veteran Worker program.

First meeting with a new resident. The vocational rehabilitation coordinator and new resident meet within a few days of the person's admission. By the time the meeting happens, the coordinator has received some relevant information – such as previous education level and abilities – that was gathered by admissions staff, as part of that process. The coordinator gives an overview of the services available and talks with the resident to learn more about the person's skills, work history, and interests. Then, the resident and coordinator discuss what services and programs might be most helpful, and set preliminary goals for the next three months.

The coordinator also works with the resident to determine the optimum way for the person to contribute to the Home – and, ideally, assist in the person's rehabilitation – through some sort of work. The options are a:

- Veteran Worker position, for minimum-wage pay up to 40 hours weekly, with a variety of possible assignments (e.g., Food Services, facilities and grounds, recreation);
- work “Detail”, for \$3 per hour up to 20 hours every two weeks for minimal tasks like light bathroom cleaning, sweeping and mopping, or picking up the mail; and
- “chore”, which is a small uncompensated task for a resident with highly limited physical ability.

Throughout the course of a veteran’s stay, it is possible to change the type of position held. Each resident, however, must contribute in some way to maintain the ability to leave and return to campus during non-curfew hours (6 a.m. to midnight), without first getting permission from various Home staff (see “Resident Rules and Consequences...” below). New residents usually are assigned to a Chore or Detail position while awaiting Veteran Worker options, if those are appropriate. In June 2014, 93 domiciliary care residents were Veteran Workers and 108 had a work Detail.¹⁴

A second meeting occurs, if necessary, to help solidify services, goals, and next steps. The coordinator urges the person to participate in some type of employment and, if appropriate, education, although some have high-need medical situations that demand most of a resident’s immediate attention.

Ongoing activities. The extent of the vocational rehabilitation coordinator’s activities for any particular resident varies based on how much assistance the resident desires. Some residents choose to meet on an as-needed basis with the coordinator, while a few opt for weekly meetings. During and between meetings, the coordinator might, for any resident:

- assist with writing a resume and cover letter, or with polishing job interview skills;
- familiarize the person with occupations that fit the person’s interests and skills, and advise on potential best matches;
- help the resident search and register for further education or training in the community,¹⁵ and obtain financial assistance (e.g., federal Pell grant via filling out the federal aid application, or small grant from the Home if needed after federal aid has been secured);
- aid in a job search; and

¹⁴ There was a three-person difference in the resident count accompanying the data between June 26 and June 27 (the dates for which the Detail and Veteran Worker participation data were given), a discrepancy that will be resolved in the coming weeks. Using the resident counts provided, 38 percent participated in the Veteran Worker program and 45 percent had a work Detail.

¹⁵ The coordinator encourages residents who are interested in college but have not been enrolled in education for some time to participate in Manchester Community College’s program (Adults in Transition) geared specifically toward that population and to perhaps concurrently take a credit-bearing course. The program consists of a non-credit course in study skills and navigating college.

- arrange transportation to education and training in the community, which can be done using the Home’s pool of vehicles or a resident’s own vehicle.¹⁶

The coordinator also sends out job postings to residents. He distributes the announcements to wing monitors, who then post them on the wing bulletin board. In addition, the coordinator e-mails or gives hard copies of announcements directly to residents he knows are job searching.

In the coordinator’s capacity as head of the Veteran Worker program, he has several duties. He matches interested and able new (or continuing) residents with positions, including reaching out to those on the program’s waitlist when there is a new opening. When there are worker-supervisor problems, he may help resolve those issues. He also receives and files the workers’ quarterly evaluations, which are completed by their work supervisors.

Finally, the coordinator oversees the special settings designated for residents who are employed full-time or enrolled in an education or training program. Both settings require residents to sign behavioral contracts, which the coordinator reviews. In addition, the coordinator receives and checks course grades to ensure residents are pursuing education as agreed upon.

Staffing. There is a single vocational rehabilitation staff person. In addition to his vocational rehabilitation duties, he helps with hiring wing monitors (see “Residential support” below).

Substance use treatment. There is residential and limited outpatient substance use treatment available to domiciliary care residents. All substance use treatment is delivered in the Fellowship House (also called the “Recovery Support Center”), which is separate from the main Residential Facility. Fellowship House has three substance use counselors (including two Certified Alcohol and Drug Abuse Counselors¹⁷); a director, who is a state licensed psychologist; and an administrative assistant.

Veterans living at the main Residential Facility can participate in a few programs at Fellowship House, described below. Residential substance use treatment is described later in this chapter, along with other settings outside the main Residential Facility.

12-Step meetings. All domiciliary care residents are welcome to attend the House’s daily Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings, which are also open to anyone living in the community (i.e., off-campus).

Recovery Education Program. Residents of the main Residential Facility (and Fellowship House) who have a first positive substance or alcohol test can participate in the Recovery Education Program (REP). Participation is mandatory for Fellowship House residents and is strongly encouraged for Residential Facility veterans, upon the domiciliary care administrator’s decision. This program involves one hour of relapse education for three weeks. It began in March 2011.

¹⁶ The Home does not encourage carpooling to education or training programs in resident vehicles.

¹⁷ A Certified Alcohol and Drug Counselors (CADCs) has sub-baccalaureate training in delivering this specific type of counseling. Someone with a higher-level postsecondary degree may also become a CADC.

Intensive Recovery Education Program. Domiciliary care residents with a second positive test enroll in the Intensive REP, which started in June 2013. In this program, residents are expected to participate in:

- one hour of relapse education for three weeks;
- daily AA/NA meetings;
- weekly contact with a recovery sponsor;
- a series of group sessions composed primarily of Fellowship House’s newer residents;¹⁸ and
- weekly individual counseling.

Recreation. Rehabilitation staff offer organized recreational opportunities on- and off-campus to domiciliary care and Health Care Facility residents. Domiciliary care residential staff oversee most recreational facilities.



Library



Exercise Room

The Veterans’ Home’s recreational facilities focused on domiciliary care residents include:

- a craft room, open two evenings each week and stocked with mainly donated items, like model kits;
- a softball field;
- one exercise room in the main Residential Facility and another in Fellowship House, which offer cardio equipment and weights;
- a library, which has books, periodicals, music, and movies, as well as two computers;
- the Winners Circle, which is an evening gathering place with several televisions similar to a non-alcoholic sports bar that offers free “Keurig” coffee, soda, and bottled water, as well as ice cream and other types of coffee;¹⁹

¹⁸ The groups for Intensive Recovery Education Program are: Anger Management, Cinema Therapy, Conversations with the Chaplains (Spirituality), Exercise/Relaxation, and Meditation/Check-in. Each group runs for several weeks.

- a game room, with several billiards tables and a ping pong table; and
- a greenhouse, accessible via key that can be requested from rehabilitation staff.²⁰



Winners Circle

In addition, some activities are held in the main Residential Facility’s dining hall or in one of the lounge rooms. There are seven lounge rooms in the main Residential Facility, including a large room in the men’s section. Each has a big-screen television and multiple chairs.

Activities. Each rehabilitation therapist is responsible for multiple wings of the main Residential Facility, with one additionally assigned to the Fellowship House, as well as part of the Health Care Facility.

Individual meetings with residents. A new domiciliary care resident meets with the rehabilitation therapist assigned to their living space (by wing) within the first 14 days on-campus. The resident completes an interests survey. The therapist talks with the resident about recreational activities, as well as how to pursue them (e.g., signing up for trips, checking the Home’s newsletter for announcements), and encourages the person to develop friendships with other residents.

A domiciliary care resident’s recreational abilities and needs are discussed with the therapist again only when there is a significant change in condition (e.g., a social worker contacts the therapist because the person seems emotionally troubled).

Events. On five or six days of the week, there are scheduled recreation opportunities for domiciliary care residents. Some of the on-campus events are regularly scheduled, recurring on certain days of the week at the same time: outdoor games; card games; crafts; Bingo; and Bible study. During the summer, there are two or three softball games scheduled per week; over winter, there is a weekly bowling league. Recreational opportunities generally are open to both domiciliary care and Health Care Facility residents.

¹⁹ Small servings are 50 cents and large are one dollar, for both non-“Keurig” coffee and ice cream. Residents use pre-purchased tickets to pay for their items.

²⁰ There are also two tennis courts with basketball hoops that are not in useable condition.

There also are special on- and off-campus events organized or facilitated by recreation staff. For example, in June 2014, these scheduled events included a Corvette show, a monthly trip to the cinema, a monthly shopping outing, and a picnic sponsored by a local Elks club. In addition, on Saturdays there are regular Veterans' Home shuttles to local shopping centers.

The rehabilitation therapy staff's roles are to plan, publicize, and run the events. The staff take turns planning events, month by month, for the domiciliary care and Health Care Facilities. They then inform residents and staff of events by:

- posting flyers about events and the recreational calendar on bulletin boards throughout the main Residential Facility and in Fellowship House;
- announcing special events in the Veterans' Home's monthly newsletter for residents and staff; and
- talking with residents on their assigned wings to encourage participation.

Finally, the staff run the events, in some cases with assistance from Veteran Workers and the entire Recreation and Therapy department (which includes physical therapists and other rehabilitation staff).

At times, the domiciliary care residential staff also assists with scheduling and supervising recreational activities. For example, sometimes the residential staff arranges for:

- concerts in the Winner's Circle and in the main dining room;
- trips to services and celebrations of veteran-oriented holidays; and
- special events developed by the residents' Veterans' Council, such as an annual Black History celebration.

Staff. There are four full-time rehabilitation therapists who work 35-hour weeks. In addition, two Veteran Workers help with daytime games and run evening games for between 25 and 30 hours weekly, and one Veteran Worker staffs the craft room and assists with Bingo for a total of nine hours weekly.

The recreational staff are overseen by the physical therapy supervisor. In addition to the staff listed above, residents assist with recreational opportunities by staffing (for pay) the exercise room, library, and Winners Circle.

Medical care: B Clinic. Medical care is available to domiciliary care residents, within the "B Clinic." The clinic, located in a large divided room in the main Residential Facility's wing B, is staffed by licensed and certified nursing personnel. Between mid-June and late August 2014, it was open 24 hours daily. Previously, it was closed between 11 p.m. and 6 a.m.; since late August, it has been closed from 11 p.m. until 6:30 a.m. (The reason(s) for the hours change will be described in the next report.)

Activities. B Clinic offers a variety of services:

- co-management of residents' medical care, in collaboration with the federal VA;

- treatment of some conditions;
- medication storage and administration for some residents; and
- response to emergencies on the campus.

These services are explained to each new resident on the day of the person's move into domiciliary care. That day, the person meets with an Advanced Practice Registered Nurse (APRN) for a:

- basic physical and review of medical history;
- assessment of the person's physical abilities using the DVA-specific classification system, to assist in determining which type of work assignment (Veteran Worker, Detail, or chore) would be appropriate;
- explanation of B Clinic services and procedures; and
- tour of the space.

The APRN is the person's assigned care leader. There are two APRNs with equal patient loads.

Medical care co-management. A major task of upper-level staff at the B Clinic is co-managing domiciliary care residents' medical care, which is mainly provided by and at the federal VA. (A few residents have private healthcare providers because they lack VA health benefits.) Domiciliary care residents travel to either the Newington or West Haven federal VA center for annual physicals, follow-up examinations, and specialist care (including behavioral healthcare). Recently, there was a monthly average of 435 outside healthcare appointments.²¹

When the residents travel to the federal VA, they carry along a B Clinic consultation form with space for the federal VA to document what happened at the appointment. The residents may also take notes from the B Clinic staff, if those staff wish to communicate anything to the federal VA.

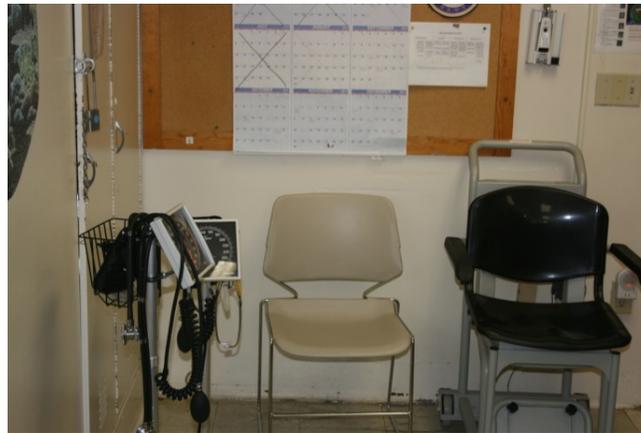
Upon returning from the federal VA, residents are to deliver the consultation forms to the B Clinic. Then, the top nurses at the B Clinic look at those forms, as well as at notes in the federal VA's electronic medical records, to review the care that was given, contact the federal VA if they have any questions or disagreement, and file the paperwork. The Veterans' Home has a paper records system currently, although the transition to electronic health records has begun (see Chapter II).

Co-management differs from the care previously offered by the Veterans' Home. Before the mid-2000s, primary care and some specialist care were provided by the Home, on-location. There are several reasons the Home switched from directly providing to overseeing care. First, because veterans use the federal VA for their lifetimes, it may be more beneficial to them to become comfortable navigating that system and receive better care continuity. Second, arranging care this way means the veterans are getting out into the community. Third, there is an argument that even though the federal VA provides primary and specialty care, the Veterans' Home still needs to be aware of residents' care, hence the co-management. This may be because: 1) it is an

²¹ Monthly average among March, April, and May 2014.

issue of patient safety since the Home sometimes treats the residents; and 2) the residents ultimately are the Home's responsibility.

Monitor and treat some conditions. Domiciliary care residents with chronic conditions have regular B Clinic appointments for monitoring. For example, those with diabetes may have blood sugar and weight monitoring, with subsequent nurse advising – as well as outreach to the federal VA for an appointment – when necessary. A resident whose condition is stable may have a B Clinic appointment every three to six months, while another whose illness is not stable could be seen weekly.



One of the spaces for working with B Clinic patients; there are other spaces, including a more private area typically found in a medical office

Residents experiencing other health problems may receive treatment on a walk-in, appointment, or bedside basis. For example, B Clinic staff may clean and bandage wounds, or visit a resident in his or her room if the person is too ill to travel to the B Clinic. In recent months, the B Clinic averaged 105 monthly visits for illness and 72 treatments.²²

Medication storage and administration. Just over one-third (36 percent) of residents use the B Clinic's Medication Administration Program (MAP).²³ The program involves B Clinic staff storing and/or administering medication, depending on the resident's particular circumstances.

The resident's agreement to participate in the program is sought by the clinic's nursing staff when:

- medication administration involves syringes, because while the veteran can self-inject at the B Clinic, syringes are not allowed in the residents' rooms;

²² Monthly average gathered over three months: March, April, and May 2014.

²³ As of June 12, 2014.

- the resident has some cognitive limitations that may impede with taking the medication as prescribed; or
- the resident has a history of misuse, abuse, or other noncompliance with medication instructions.



Left: B Clinic's medication room

Home staff report that most residents become part of the medication program upon admission into the Home. In these cases, the APRN would ask (or, in the case of syringe-administered medicine, require) the residents' permission to participate in the program. Other residents are asked to become part of the medication program after noncompliance, which can be discovered through illness (e.g., a very high blood pressure reading

for someone monitored due to heart disease). If no APRN or Health Care Facility doctor is available when noncompliance surfaces, the nurse on duty enters the person into the medication program and the APRN or doctor reviews and approves that step the same or next business day.

Emergency response. When there is an incident or urgent medical call reported to the Home's Security department, B Clinic personnel assist at the scene (see Appendix C for more information). If a resident is having a psychotic break and it is an emergency, the person would be assessed by the Home's psychiatrist or, in the psychiatrist's absence, a Home doctor. Upon a doctor's or local police officer's determination that the person is dangerous, an ambulance will provide transportation to an acute care hospital. If the situation is not emergent, then the B Clinic would do at least one of the following:

- check to see whether the person has been taking medicine as directed, and, if not, put them on the Medication Administration Program (if not already there);
- acquire medication refills if needed; and
- assist in further evaluation by its APRN staff and either Home behavioral health staff – or, by federal VA staff.

Staffing. Table V-5 below shows B Clinic's scheduled level of staffing per shift. Home staff report that nursing personnel assigned to one of the Home's settings (the B Clinic or the Health Care Facility) frequently will "float" for a shift to the other, to provide sufficient coverage. The night (third) shift staffing was in place only for summer 2014. The night staff did rounds on the Residential Plus Program (similar to an assisted-living type setting, described below) and were available in the B Clinic for other residents' nighttime needs.

| Table V-5. Domiciliary Care Clinic (B Clinic) Scheduled Staffing by Shift (as of July 20, 2014), Including the Staff For the Residential Plus Program | | | |
|---|---|--|---|
| | <i>First Shift: 6:45 a.m. to 3:15 p.m.*</i> | <i>Second: 2:45 p.m. to 11:15 p.m.</i> | <i>Third: June- August 28, 2014</i> |
| Registered nurse / Licensed practical nurse | 5 | 3 | 1 |
| Certified nurse aide | 2 | 1** | 1 |
| Office assistant | 2 | 0** | 0 |
| Total | 9 | 4 | 2 |
| *Two staff arrive at 6:30 a.m. to help residents prepare for the Home's 7 a.m. shuttle to the federal VA medical centers. | | | |
| **There is an additional one hour of nurse aide assistance and one-and-a-half hours of office assistance as certain first-shift staff's hours overlap with the start of second shift. | | | |
| Source of data: Department of Veterans' Affairs. | | | |

Residential support. Within the main Residential Facility, state employees called “Domicile supervisors”²⁴ and residents holding Veteran Worker positions of “wing monitor” offer support, guidance, and, at times, discipline.

Domicile supervisors. These staff get to know the residents by walking around the campus (doing “rounds” of all domiciliary care areas except Patriots’ Landing, once per shift for each staff person), give residents guidance, assist residents in resolving their personal disputes, and help enforce the Home’s rules for residents. They work especially closely with new residents, who they help obtain a campus identification card, get a work “Detail”, and understand the rules.

Regarding rules, the Domicile supervisors are involved in approving and extending passes to leave the grounds, carrying out inspections of living areas, completing morning census reports, and assisting wing monitors in the nighttime count (called “evening bed check”). When there is a suspected rules violation, the Domicile supervisors begin paperwork and ensure any penalties are enforced. Each of these areas is described later in this chapter.

In addition to these responsibilities, the lead Domicile supervisor may help new and discharging residents obtain needed goods. For these trips, a Veterans’ Home car and driver are used. First, if a new resident needs clothes, the supervisor takes the person to a local retail clothing store with which the DVA Business Office regularly makes purchase contracts. If the veteran needs sizes unavailable at that store, donated gift cards to other stores can be used to buy

²⁴ The Veterans’ Home usually calls these staff “Domicile Workers” or “Residential Facility Workers,” but this report uses “Domicile supervisors” to distinguish them from Veteran Workers, who are residents working at the Home. “Domicile supervisors” used to be the formal title and is still used informally.

the clothes. There is a list of standard items that may be purchased.²⁵ A new resident who needs toiletries is given donated items, which are kept in a main Residential Facility storage room.

Second, residents who are voluntarily discharging to community living can submit a list of basic home goods they need to the supervisor, who shops on their behalf using Home money (\$160). These are items like dishes, bed coverings, and kitchen supplies. The supervisor then gives the original receipts and a form with the veteran's signature that confirms the person received the goods to the Business Office.

Staffing. There are seven full-time Domicile supervisors. During weekdays, two or three may be present, though only one is scheduled at nights and on the weekends. When someone unexpectedly calls out, another supervisor scheduled to be off duty will fill in; the lead supervisor does so if no one else will. The lead Domicile supervisor oversees the others, and she reports to the domiciliary care administrator.

Wing monitors. Nearly every wing in the main Residential Facility has a wing monitor who in some ways resembles a resident advisor in a college dormitory setting. The wing monitor is a Veteran Worker position.

In addition to providing residents with guidance on navigating the Home and life in general, the wing monitors:

- schedule work "Detail," light housekeeping duties on each wing completed by some residents who do not participate in the Veteran Worker program;
- announce visitors (e.g., Home staff and inspectors) on the wing, to alert residents, and accompany Domicile supervisors on rounds;
- ensure visitors and residents who live in other wings or settings do not enter the wing; and
- may complete "evening bed checks" with the Domicile supervisors and issue passes to go off-campus in some situations, which are a few of the methods the Home uses to ensure all residents are accounted for (see "Resident Rules and Consequences" below).

Each wing monitor traditionally has had his or her own private, single-person room on the wing, which doubled as the person's office. The Home is transitioning toward wing monitors living in the multi-occupant rooms and using the single-person rooms as the offices. This change is designed to more easily allow a substitute wing monitor to complete the duties when a wing monitor is absent, especially for long periods of time (e.g., due to an illness).

Staffing. There are ten full-time and two part-time assistant wing monitors. The monitors are evaluated quarterly by the lead Domicile supervisor, though they report to the vocational rehabilitation coordinator.

²⁵ The items are: pants, shirts, underwear, winter coat, and footwear.

Special Settings within the Main Residential Facility

Residential Plus Program (RPP). In January 2014, portions of two wings (A and B) of the main Residential Facility became a designated space for Home residents who needed some assistance with daily living activities (e.g., dressing). There is dedicated RPP nurse aide staffing between 6:45 a.m. and 11:15 p.m. Two nurse aides staff the first shift (though one works until 5 p.m.), and a third is on second shift. There were 15 RPP residents as of July 10.

When the program began, it was accepting new applicants to the Veterans' Home, Health Care Facility residents who no longer needed the level of care provided there,²⁶ and domiciliary care residents. Most residents were previously living in the general domiciliary and had aged in place. The number of current Home residents who currently could be most appropriately served (within the Home) by RPP is unclear but likely exceeds two dozen, according to DVA staff. Starting in September 2013, there were assessments of HCF and domiciliary residents to determine whether the Residential Plus Program would be the most appropriate setting for them. The assessments involved evaluations of the residents' abilities by the Home's occupational, physical, and speech therapists.

Since early June 2014, admission to RPP has been stopped by the commissioner for multiple reasons. First, there were some cleanliness concerns. The medical situations of some RPP residents have meant that professional cleaning staff became necessary, for the first time. (For some years, the main Residential Facility has relied on Veteran Workers and residents doing "detail" chores for cleaning.) Consequently, a full-time first-shift janitor was recently hired specifically for the main Residential Facility.

Second, the staffing demands have been greater than anticipated. When the program was initially conceived, it was thought that perhaps residents would need only very occasional help that could be provided by B Clinic staff. However, it became clear before the program launched that dedicated staffing would be required. In addition, RPP residents' needs were one of the main reasons why the B Clinic had overnight staff during summer 2014.

Finally, DVA administrators are working with the Department of Public Health to understand what regulations might be most applicable to the program.

Education wing. Male residents who are attending educational or vocational training (including college) can live in a designated wing (H wing) of the main Residential Facility. Residents usually transfer here from other wings within the main Residential Facility or Fellowship House (upon completion of at least six months of residential substance use treatment), upon enrolling in an education-related course. This option is available to provide a quieter environment for those who want to study in their living space. In 2013, the education wing was moved from a separate building containing individual rooms to give residents wireless Internet access, air conditioning, access for those with physical limitations, and reliable plumbing. There were nine education wing residents on July 31, 2014.

²⁶ A Health Care Facility resident was asked whether he wanted to move to the RPP when his occupational therapy, physical therapy, and speech assessments showed the person could independently make his own bed, travel to and from the dining room, and eat without assistance.

Female veterans. Women veterans in the main Residential Facility live in a designated wing, E Wing. The wing has its own separate small lounge and is locked for residents' comfort and safety. The women vets were moved in 2001 from Building 60, which had efficiency apartments, to the main Residential Facility. This decision was made in order to shorten the distance between living quarters and the Dining Hall (as well as B Clinic), make the wing wheelchair-accessible, and provide a higher level of oversight. There were four female veterans living in this wing on July 31, 2014.

Other Special Settings

1. Fellowship House. The House is a three-floor standalone building with offices for treatment staff, group meeting rooms, and 75 private bedrooms with shared bathrooms (but lacking air conditioning) for residential clients. It also has three kitchens (with microwaves as the only cooking devices), a small exercise room, a pool table, a laundry room, a lounge with a television, and an active vegetable garden. Fellowship House residents use the same services – such as meals in the dining hall and services from social workers – as those who live in the main Residential Facility. Although both men and women may participate in Fellowship House's treatment and other programs, only men may reside at the House. Women live in the designated wing in the main Residential Facility.



A Fellowship House resident's room (computer and decorations are resident's own)

Residential treatment. Veterans from the community who have been sober for at least three weeks, as well as main Residential Facility residents who have violated the Home's substance use policies several times, enter the residential treatment program (the Recovery Support Program).²⁷

Intake. Upon moving into Fellowship House, a new resident is assigned to a substance use treatment counselor. Together, they work through several forms, including: a self-assessment of recovery attitude; an assessment of the person's substance use historically and currently,

²⁷ Fellowship House lacks the medical expertise to care for veterans who need to detoxify. Those who are actively using substances and call the Home requesting admission are referred to the federal VA for a 21-day detoxification program.

including treatment history and the effects of use; a psychosocial assessment (legal, family, armed forces, education, and job history); and a brief gambling screen. They then develop a treatment plan, which essentially is for the resident to complete Phases I and II of the Recovery Support Program. Within ten working days, the House’s director meets with the resident to complete a psychological evaluation, and then reviews and approves the intake forms.

Program. Following intake, the resident begins the program, whose phases are described in Figure V-6 below. The program lasts about 12 months. However, a resident can choose to take advantage of single-year extensions available through application to live at Fellowship House for approximately three years. During the first six months, a resident is expected to focus solely on recovery; upon completing that phase, attention may be turned to finding or training for employment.

Figure V-7. Residential Treatment (Recovery Support Program) Phases



Throughout program participation, the resident receives weekly individual counseling and participates in their counselor’s weekly group session. The resident remains a member of



that group and involved with individual counseling for the duration of living at Fellowship House.

Phase I and Recovery in Motion each involve special group therapy courses, in addition to the counselor-based group (group room shown at left). During Phase I, a resident participates in numerous groups (about a dozen) and must complete each that is offered. The

groups vary in length (from about six to 12 sessions) and are held once or twice a week. Examples of the groups are: Anger Awareness; Cinema Therapy; Big Book Study; and Exercise/Meditation. During Recovery in Motion, groups focus on life skills, such as money management and communication. These are held less frequently (e.g., every other week).

Screening. For the first two years, Fellowship House residents must undergo weekly random substance use testing. A resident who has a third positive test is moved to the main Residential Facility and assisted with admission into a 60- or 90-day treatment program outside the Veterans' Home.

House meetings. All residential treatment participants are expected to attend weekly Fellowship House-wide meetings. The House meetings involve:

- updates of any House or domiciliary care news;
- responses to any complaints or problems;
- a recovery- or community-building exercise chosen and led by one of the House counselors; and
- monthly sobriety medallion presentation.

Outpatient treatment. As discussed above, Fellowship House has two programs for veterans who live elsewhere in the Veterans' Home: Recovery Education Program (REP) and Intensive REP. In addition, the House's AA/NA meetings are open to all on the campus.

Staffing. The Fellowship House's director, a licensed psychologist, oversees the program offerings and operation, in addition to serving on the domiciliary care admissions committee. She also meets weekly with each of the House's three substance use counselors for their clinical supervision. The counselors carry individual caseloads and run most of the group sessions. An administrative assistant also works at Fellowship House.

2. STAR. Veterans with full-time employment can apply to live in a special building near Fellowship House. This is called the STAR program (also known as "the ¾ House,") but residing in the building (shown below) and progressing toward independent living are the only program components.



This location has five furnished three-bedroom apartment-like units; however, one is used by the American Legion as office space. Each unit has its own kitchen (including cooking equipment), dining room, living room, and bathroom. Residents can choose to eat in the Dining Hall if they would like.



STAR bedroom and living room

In addition to more privacy, the STAR program offers greater autonomy. While residents are expected to use the pass system, they do not need to adhere to the curfew (midnight to 6 a.m.), which gives them employment flexibility. Veterans applying to the STAR program must have not had any rule violations in the previous six months. (Committee staff will learn about the application process in the coming months.)

The STAR program usually is used by Veterans' Home residents who have obtained full-time employment and are looking to transition to independent living in the community. However, veterans entering the Home with a full-time position can be placed directly into STAR. Direct placement is most common when a veteran has previously been a Home resident or is a State of Connecticut employee.

For most, the standard term of residence in STAR is one year, but an additional year is available if requested. Veterans who are or become State employees are limited to six months in STAR.

3. West Street Houses (Patriots' Landing). Five three-bedroom, single-family homes located across West Street from the Veterans' Home campus also are part of the Veterans' Home's residential options. These houses currently are called "Patriots' Landing," but they have held other names in the past. Pictured below are the kitchen and living room from one house.



The houses were built in the early 1950s as housing for campus staff. The precise history is unclear; at some point before 2000, the houses transitioned from staff to Home resident housing. During Governor M. Jodi Rell's tenure (which began in 2004), the houses were renovated using state funds and furnished through donations from various private veterans' organizations. From 2010 to 2013, the houses were used by Home residents who were single. In 2013, occupancy dropped to only one veteran, so DVA reconsidered how to best use the houses.

In early 2014, the DVA engaged in a collaborative effort to re-launch the West Street houses. Four of the five homes were designated for use by families with a veteran parent, and the fifth for use by single women veterans, for a total of seven veterans (except if a family has two veteran parents). The houses are reserved for veterans indicating they are homeless or at risk of homelessness.

While the DVA has continued to maintain the buildings and grounds, as well as ultimately control admissions, resident recruitment and services have been provided jointly with others. Veterans largely are drawn from the waitlists of certain other veteran housing options: the Victory Gardens housing development located on the Newington campus of the federal VA, and the federal veteran housing and supportive services voucher program (HUD-VASH). However, any veteran can apply. The maximum term of residence is two years.

The veterans and their families receive social work services from Chrysalis Center, Inc., whose staff also participate in the admissions process. Chrysalis Center was chosen because it was already providing similar services to Victory Gardens residents. In addition, it already had a contract with the Connecticut Department of Mental Health and Addiction Services (DMHAS). That means Chrysalis could be paid by DMHAS and services could be provided through a Memorandum of Understanding, which was quicker and more easily arranged than a bid process. (The DVA administration believed the Veterans' Home social work staff did not have time to serve families.)

The veteran resident of each house pays the same program fee as the other domiciliary care residents. The fee includes utilities, basic cable, and landline telephone services.

Resident Rules and Consequences, Including Involuntary Discharge from the Home

Nearly all domiciliary care residents must follow a set of rules. Those who violate the rules face consequences that increase in severity with the number of violations. A resident who accumulates five "minor" violations or a single "major" one is recommended for involuntary discharge.

Rules. The DVA commissioner is empowered by statute to make rules in order to safeguard residents' health and comfort.²⁸ Until Public Act 14-187 (effective July 1, 2014), many of the domiciliary care rules were in state regulation.²⁹ The rules are available in and shared with residents through the Resident Handbook, received on the day someone moves into the Home (or, by request, before admission). Upon admission, residents (or their legal representatives) must sign their names to the fact that they understand and agree to comply with the Veterans'

²⁸ C.G.S. Sec. 27-106

²⁹ The relevant state regulations became effective in January 1996.

Home’s rules, guidelines, and discipline policies. The handbook is always available from the domiciliary care administrator’s office.

The rules address a range of subjects, from personal living space and possessions to leaving the campus. The following chart lists the rules based on the Resident Handbook. Program review committee staff categorized the rules for ease of reading comprehension and noted which are considered “major” violations by state regulation. In addition to the rules listed in the chart, state regulation notes that repeated minor violations can become a major violation if the resident is given “formal written notice” to remedy the situation or behavior.³⁰

Visitors. Visitors are welcome between 10:30 a.m. and 8:00 p.m., as noted in the table. They must sign in at the Home’s security gate and be expected by a resident. Visitors are restricted to common areas; they may not go into the living spaces (the wings). Domiciliary care residents may have one visitor eat free in the dining hall every month.

| Table V-6. Resident Rules | |
|--|-------------------------------|
| | <i>Major Violation</i> |
| Personal living space and possessions | |
| 1. No heat-generating or flammable items (e.g., hot plate, coffee pot, microwave, propane); cigarettes, lighters, and matches <i>are</i> permitted | |
| 2. No moving existing or adding additional furniture without permission | |
| 3. Items may be taped or posted only on the inside of personal lockers (not on walls or furniture) | |
| 4. Lock valuables and medication not kept at the B Clinic | |
| 5. Have B Clinic permission for all medications kept in living space | |
| 6. Keep personal living space clean | |
| 7. No pets or pornography | |
| Campus-wide behavior: No -- | |
| 1. On-campus alcohol or illegal drugs, including un-prescribed drugs (sale, consumption or possession), or paraphernalia | X |
| 2. Intoxication (≥ 0.08 blood alcohol content) or positive substance use test | |
| 3. Weapons or ammunition | X |
| 4. Bullying | X |
| 5. Assault | X |
| 6. Behavior that did or could harm people or property | X |

³⁰ Regs. Conn. State Agencies (R.C.S.A.) Sec. 27-102l(d)-200(a)10

Table V-6. Resident Rules

| | <i>Major Violation</i> |
|--|------------------------|
| 7. Borrowing or lending money, or selling items or services | |
| 8. Gambling | X |
| 9. Leaving campus without a pass (<i>Note: Generally residents are free to leave and return as they please between 6 a.m. and midnight, and passes may be acquired for absences during overnight hours. See below for explanation.</i>) | |
| 10. Theft | X |
| 11. Interfering with emergency equipment, people responding to an emergency, or exit signs | X |
| 12. Refusal to submit to a random or directed substance use test | X-by reg. only |
| 13. Entering a restricted area | X |
| 14. Accumulating five minor violations (from any category in this chart) | X |
| 15. Disorderly conduct (e.g., loud disagreements) | |
| Community living | |
| 1. From 10 p.m. to 6 a.m., be quiet and use earphones with radios, televisions, and computers | |
| 2. Get consent from a resident before entering his/her living space | |
| 3. Stay in the common areas and in one's own wing | |
| 4. Talk on cell phones in common areas and outside (not in rooms or dining hall) | |
| 5. Smoke in designated outside areas | X* |
| 6. Visitors, welcome between 10:30 a.m. and 8 p.m., must sign in with Security and remain in common areas | |
| Motor vehicles | |
| 1. During the first 90 days living at the Home, a vehicle may be parked on-campus but not used, except for vocational or educational purposes | |
| 2. Obtain a permit from Security for parking and driving on-campus | |
| 3. Submit to a Security inspection of the vehicle upon moving in, and at any other time Security staff request | |
| 4. Follow all traffic signs and roads on-campus | |
| *Although smoking anywhere than in a designated area is considered a major violation by state regulation, Veterans' Home managers indicated that they would not discharge someone for it (similar to non-compliance with a requested drug screen). Instead, a verbal warning would be given for a first instance, and a violation for a second and proceeding instances. Designated smoking areas are: porches of the the Fellowship House and East and West | |

Table V-6. Resident Rules

| | <i>Major Violation</i> |
|--|------------------------|
| <p>Domicile porches; picnic tables in the quadrangle between the Domicile buildings; and outside the STAR program building and Patriots’ Landing homes. Domiciliary care veterans may smoke whenever they choose, as long as it is in a designated area.</p> <p>Note: For the past few years, the Home has not issued violations for failing to follow one’s own treatment plan, which state regulation classifies as a minor offense.</p> <p>Source of data: PRI staff review of the Veterans’ Home Residential Facility Rules and Regulations Handbook and of applicable state regulation (R.C.S.A. 27-102(d)-200 through -201).</p> | |

Methods to check compliance with rules. The Home uses various methods to ensure compliance with the rules. The ones most visible to residents are:

- the processes used to ensure the Home staff knows whether they are on-campus at any given time;
- room inspections; and
- substance use screens.

Processes to keep track of residents. Because the Veterans Home administrators understand the Home is responsible for the residents, and the federal government requires a precise daily resident count for its per diem contribution to the State’s costs of operating the Home, three main processes are in place to ensure the Home knows where its residents are.³¹

Pass system. The Home’s pass system uses both electronic and paper methods to track residents’ departures and returns to the campus. The chart below shows when a pass is needed and, when it is, the process to obtain and use one.

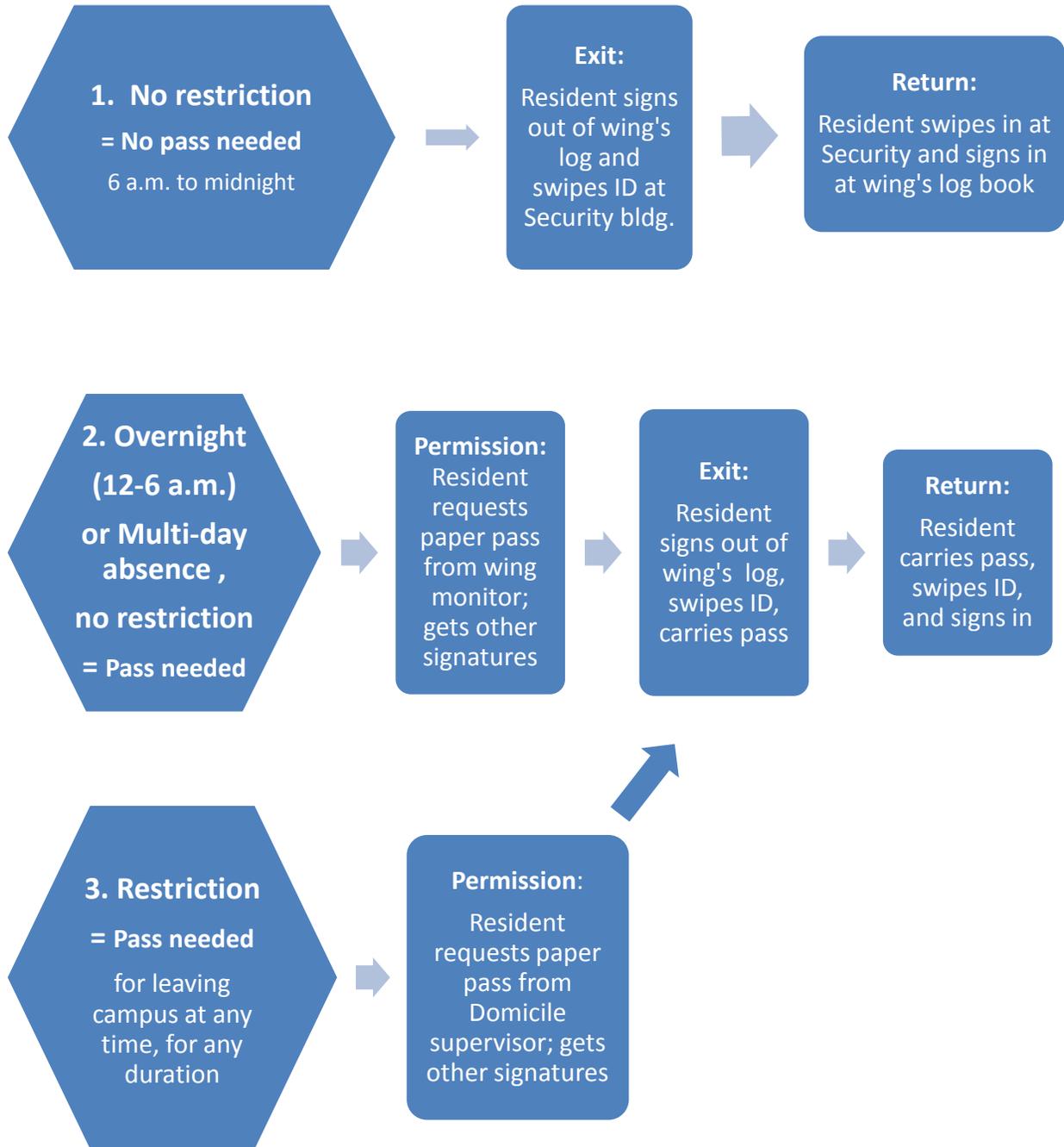
As illustrated, generally a resident who wants to leave the campus for any amount of time from 6 a.m. to midnight can do so without permission if they do not have any restriction on their passage on and off campus. Each resident also is expected to contribute to the upkeep and functioning of the Home to maintain the ability to freely leave campus during non-curfew hours.

A resident must ask for written permission – i.e., obtain a pass – to leave if his or her ability to freely leave campus has been restricted or if the person wants to leave for one or more nights.³² Permission must be given by a Domicile supervisor or wing monitor, respectively. In addition, permission must be acquired (via signature on the pass form) from others, in certain situations:

³¹ According to a Veterans’ Home manager, the federal VA’s inspection includes examination of passes and campus bus transportation lists so they can ensure the census count is precise.

³² The Veterans’ Home staff refer to a resident’s ability to go off-campus as a “pass.” Before the new electronic ID system was instituted in 2013, residents who did not have a restriction and participated in some sort of campus labor (e.g., Veteran Worker program or a small chore) were given a laminated “bus pass” that allowed them to go off-campus.

Figure V-8. Process for Leaving and Returning to the Home for Domiciliary Residents*



*Except for Patriots' Landing and STAR apartment residents.
Source: PRI staff based on review of Resident Handbook.

- B Clinic staff if the person has a medical restriction or is on the Medication Administration Program, where the clinic stores and perhaps administers the person's medication;
- the person's Veteran Worker supervisor, if the person will be missing work; and
- Fellowship House counselor, for that setting's residents.

Restrictions. Restrictions are issued for rule violations and for medical reasons (e.g., if someone recently had a medical procedure and is supposed to be relatively inactive). Generally, someone who has a restriction will be given permission to leave for employment or education reasons, medical appointments, various other appointments (e.g., bank) or to attend to family, but not for leisure activities (except for medical restrictions). A pass is given for a certain amount of time which is dependent on the appointment and expected duration, with up to one hour of travel allowed each way. A person who has a restriction due to a violation generally will be allowed one overnight pass every two weeks.

A resident who has an employment or education commitment that regularly requires the person to leave or return to campus between midnight and 6 a.m. can do so. A work or education paper pass designates the dates and times for passage off and onto campus, and is used in conjunction with swiping the ID card. In order to get this pass, the vocational rehabilitation coordinator verifies the person's vocational engagement and goes with the resident to a Domicile supervisor's office, where the pass is issued.

Extensions and AWOL. A resident who has left the campus and wishes to extend the time off beyond either the midnight curfew (if not on restriction) or the pass's expiration must call a Domicile supervisor for permission. The supervisor may exercise discretion over whether to extend the absence, which usually is approved only if there is an emergency. Those who sound intoxicated or ill are encouraged to return to campus and not issued extensions, according to Home staff. In some cases, documentation like a motor vehicle accident report might be required to show the supervisor or domiciliary care administrator there was an emergency.

If someone chooses to exceed the length of time off-campus without an extension, or to leave campus without an appropriate pass, the person is considered Absent Without Leave (AWOL). Being AWOL is a minor violation unless it extends to four days, either at a time or in a calendar year. At that point, the person is discharged from the Home.

Long-term extended pass. A veteran who wants to leave the campus for a long period of time can get a pass for leaving up to 28 days. This pass generally can only be used once a year. Residents use it to attend to family matters, such as an out-of-state visit or funeral, or as a precursor to voluntarily discharging. If both happen in the same year, the person would be allowed to take a second extended pass.

Morning census. Each morning, the wing monitors count the number of residents present the previous day, noting who is AWOL. They give the counts to an office assistant of the domiciliary care administrator, who reviews and corrects them. The counts are used to develop

the domiciliary care census total, which is the basis for the federal per diem payment that helps support the Home.

Evening check. At the end of the day for the main Residential Facility and Fellowship House, there is “evening bed check” to ensure residents are accounted for, if not out on pass. Between 11 and midnight, residents who are still awake are expected to check in with the wing monitor. The wing monitor also does rounds, walking through the wing rooms to see who is in his or her living space. If, at midnight, someone has not checked in, the wing monitor has not seen the person on rounds, and the person is not authorized to be off-campus past midnight, the wing monitor reports the person’s name to a Domicile supervisor. The supervisor adjusts the person’s ID so if and when it is swiped upon return to campus, Security personnel at the campus gate will inform the resident he or she must see a Domicile supervisor to address the AWOL situation. The supervisor also alerts the administrative assistant who compiles the morning census, which then reflects the resident’s absence. If the person returned overnight, that also is reflected on the morning census.

Room inspections. There are three types of resident room inspections: monthly scheduled and announced inspections; unscheduled; and environmental rounds.



Main Residential Facility room, looking in from the doorway. Each large room is separated into three sections; this is one. Every section has four personal living areas.

1. *Monthly room inspections* are completed by Domicile supervisors. Each living space in a wing is evaluated during the same inspection; wings are inspected on a rotating basis. The inspection schedule is posted monthly in each wing. The supervisors mainly check for prohibited items, cleanliness, electrical cord safety, and easy passage through the rooms.

Living spaces other than the main Residential Facility are also inspected. The STAR living quarters and Fellowship House are included in the monthly inspection schedule, while the Patriots' Landing houses are inspected quarterly. Patriots' Landing inspections are completed by the DVA's director of the Office of Advocacy and Assistance, the domiciliary care administrator, and two staff (a program and a case manager) from the contracted support services agency, Chrysalis Center, Inc.



Left: Main Residential Facility personal living space. Each space includes a bed, dresser, locker area, desk, and desk chair.

2. *Unscheduled inspections* are done daily by Domicile supervisors during weekday rounds. At Fellowship House, the supervisors and House director also routinely do unscheduled inspections, both during the week and weekends. Each weekend, the supervisors randomly choose at least four rooms there to examine as a relapse check and prevention method. Across domiciliary care settings, unscheduled inspections are sometimes done when there is reason to suspect a serious violation or major room order problem in a particular wing or room. These inspections are similar to the scheduled inspections in methods and intent.

3. *Unscheduled environmental rounds* are completed jointly by B Clinic staff and Domicile supervisors. Each month, B Clinic personnel randomly select a wing for examination and within that wing, they choose about ten people's living spaces. The main goal of these rounds is to ensure medication requirements are followed. Medications are expected to be locked, unexpired, and registered with B Clinic.

Substance use testing. Both routine and unscheduled-with-cause alcohol and drug testing is done at the Veterans' Home. The requirements regarding testing are delineated in state regulation.³³ Veterans agree to participate in substance use testing and comply with any resulting treatment recommendations as a condition of admission to domiciliary care, with refusal to test possibly resulting in discharge or non-admission. Incoming residents also agree to complete sobriety while living at the home.

The Veterans' Home uses urine testing for drugs and usually an intoximeter (i.e., Breathalyzer) for alcohol. The on-campus medical laboratory analyzes the samples and delivers the results to the domiciliary care administrator, Fellowship House staff, and B Clinic medical personnel.

Routine testing. Certain main Residential Facility and many Fellowship House residents are routinely tested for alcohol and substances. Routine testing is done every weekday for both

³³ R.C.S.A. Sec. 27-1021(d)-186

settings. A computer program randomly chooses which residents will be tested each day. No resident will be tested more than twice a week.

Routine testing is required of main Residential Facility veterans who have had, within the last two years:

- a confirmed positive test;
- a conviction for illegal drug possession or sale; or
- detoxification or residential rehabilitation treatment.

The testing continues until someone has had two consecutive years of negative tests. Fellowship House residents are tested during their first two years in the House.

Unscheduled testing. A domiciliary care (or Health Care Facility) resident can be required to take a test when:

- the person's primary doctor or APRN at the Home, or the domiciliary or HCF administrator, observes or learns about a behavioral change with no clear cause;
- the domiciliary or HCF administrator believes the person possesses alcohol or substances on-campus; or
- a Security officer, or the domiciliary or HCF administrator, observes at least two of these symptoms of possible intoxication: 1) imbalance; 2) a strong alcohol odor; 3) slurred speech; 4) disorientation; and 5) disruptiveness.

Handling violations. The way in which domiciliary care violations are handled varies depending on the situation. State regulation both prescribes the penalties for violations and gives the administrator some leeway in determining them in specific instances. Major violations generally result in immediate discharge.

For most violations, the first step toward a violation is an incident report, issued by an on-campus Security officer. A resident or staff member may call Security if a violation is suspected. The officer completes the report after talking with the resident(s) involved and observing the place where the incident occurred. If necessary, the officer can talk with other parties. The incident report is logged into a Security database. The Domicile supervisor then prints out the report and completes paperwork for the domiciliary care administrator. The administrator meets with the resident(s) to learn more and decide what should be done.

Typically, Security is uninvolved in minor violations that result from room inspections, except for substantial safety violations as determined by a Domicile supervisor. When a Domicile supervisor discovers a minor violation due to an inspection, the supervisor verbally warns the resident and gives the person time to correct the problem. If the problem persists, the supervisor will issue a written warning, with the domiciliary care administrator's approval. If the problem continues, a violation will be issued.

As shown in the table below, minor violations result in pass restriction and cumulatively can lead to discharge. (See Table V-6 earlier in this chapter to understand which violations are

minor versus major.) The domiciliary care administrator, however, has discretion and may decrease the penalty's severity, taking into consideration the violation's severity, the number of violations earned in the previous two years, the person's ITP, and his or her cooperativeness.³⁴

As the table below indicates, the Home's standard penalties are a little less severe than those prescribed by regulation, for some violations. Furthermore, a first violation's penalty can be reduced (see below), and Veteran Worker suspensions are not used as a violation penalty at all due to potential negative repercussions on Home operations and resident well-being.

| Table V-7. Penalties for Minor Violations (Except Absent Without Leave) | | |
|---|--|---|
| <i># of Violations in a 24-Month Period</i> | <i>Penalties</i> | |
| | <i>Length of Pass Restriction (days)</i> | <i>Length of Work Suspension (days): Not currently done</i> |
| 1 | 15 | --- |
| 2 | 30 | 15 (14)* |
| 3 | 60 (45)* | 30 |
| 4 | 60 (180)* | 180 |
| 5 | Discharge | |
| *Penalty routinely used by the Home is different from state regulation in the way indicated parenthetically. Note: "Work suspension" refers to those residents who are Veteran Workers. Source of data: R.C.S.A. Sec. 27-102I(d)-213. | | |

For first violations, up to about half of the pass restriction penalty (seven of 15 days) can be eliminated through performing various tasks or chores around the Home. Every three hours of work – above and beyond the resident's normal assignment in the Veteran Worker or other program – equates to a one-day reduction in the pass. A resident can choose to work a total of 21 hours to reduce the penalty by seven days. This option is offered by the domiciliary administrator during the meeting with the resident to discuss the violation and penalty; it is not explained in the Resident Handbook. If the resident is interested in working off some of the pass restriction, a Domicile supervisor will assign tasks. These may include monitoring the exercise room or library, or doing janitorial-type work in the resident's wing.

Automatic discharge occurs when there is a major violation, the accumulation of five minor violations within 24 consecutive months, or, as discussed above, the accumulation of four

³⁴ R.C.S.A. Sec. 27-102I(d)-213

days of being absent without leave (either consecutive or within a 12-month period). There is, however, some leeway. When discharge is a possibility, the administrator meets with the person to inform him or her. The administrator then talks with the commissioner to discuss the situation, as well as the resident's history at the Home. The commissioner may choose to offer the resident the ability to remain at the Home if certain conditions are met. (When a person has disappeared and is AWOL, none of these meetings occur.) State regulation gives the administrator the ability to suspend the discharge for a maximum of six months, except for any offense related to illegal substances and paraphernalia.³⁵

Someone who has been discharged due to violation(s) is assisted by a Home social worker in finding another place to stay, such as a shelter or with family. The social worker also will help arrange transportation there, if needed.

Processes for addressing various situations. The Home's staff follows certain procedures when dealing with particular incidents, as described below.

Inspection revealed violation(s). If the violation is minor, the Domicile supervisor tries to remedy the problem without issuing a formal violation. The supervisor asks the resident to fix it and either documents the issue in the Domicile supervisor work log book or gives instructions written to residents with a copy to the next supervisor shift. If a resident is resistant to direction, then the formal violation will be issued.

Alcohol or substance abuse positive test. When a main Residential Facility resident has either a blood alcohol content reading of 0.08 (the state's threshold) or a positive drug test:

1. B Clinic staff are alerted and they check the person's medical record to ensure the cause is not from authorized medicine. If not, the violation process begins.
2. Security is contacted if not already involved and an incident report is completed.
3. A Domicile supervisor asks the person if he or she used alcohol or substances. If the person responds affirmatively, the supervisor completes the violation paperwork and the resident meets with the domiciliary care administrator. If the person replies negatively, the sample is sent to an outside laboratory for verification of the positive result.
4. The administrator informs the resident that the person then must meet with a Fellowship House counselor who, after talking with the resident, recommends a course of action. Usually, either the House's Recovery Education Program or a federal VA substance use treatment program is suggested.
5. The domiciliary care administrator discusses the recommendation with the resident and requires the person to follow it, in order to remain a Veterans' Home resident. She also issues a minor violation, which results in a pass restriction.

³⁵ R.C.S.A. Sec. 27-1021(d)-213(b)2

Once a main Residential Facility resident reaches three positive tests, the veteran is moved to Fellowship House or, if resistant to that step, discharged from the Home to the community. The social worker attempts to help the person enroll in a residential treatment program, if the person agrees.

A Fellowship House resident who has a positive test (which has a lower alcohol positive-test standard) continues in the substance use treatment program and also must simultaneously participate in the Recovery Education Program (REP). A Fellowship House resident who has three positive tests is moved to the main Residential Facility temporarily, until the person can get into a federal VA treatment program from there. The reason for moving a resident to the main Residential Facility is to ensure no negative or regressive impact on current Fellowship House residents working on their own recovery processes. However, someone with a severe relapse but only one positive test may be moved into a federal VA 21-day treatment program that includes detoxification. The federal VA does its own assessment of the appropriate treatment for the person; the Veterans' Home staff cannot directly place people into federal VA substance use treatment programs.

For any resident with a motor vehicle on campus, a substance use violation entails an additional penalty. The first violation yields a 90-day driving suspension and the second leads to revocation of the Home car permit.

Disorderly conduct. Security is called by residents or Home staff when there is a verbal argument involving cursing or threatening. A Security officer interviews participants and witnesses to develop the incident report, which in turn is sent to the domiciliary care administrator. Domicile supervisors complete paperwork, issuing the violation and sending it to the participants along with a notification that each must meet with the administrator. The administrator requires each to meet with the Fellowship House director (a psychologist) to have an individual counseling session on anger management. If after that session the psychologist believes the person needs further work, the person is recommended (though not required) to attend the Fellowship House's anger management group session. Disorderly conduct situations that are severe can warrant discharge; physical altercations always do.

Illegal substance on campus. If an illegal substance or non-prescribed medication is found during inspection or otherwise, the local police are called and the relevant resident(s) is discharged. If there is only suspicion of illegal substances, the resident will be tested for intoxication and the State Police may be called to use canines to conduct a search; this rarely happens, according to Home staff.

Minor violations discovered during room inspection. Domicile supervisors may work with veterans to change behavior, when possible, instead of issuing violations for minor offenses found during a room inspection. In addition, someone who has a psychiatric diagnosis that could result in frequent, repeated violations of the same minor-offense rule may be treated more leniently. For example, a resident with a hoarding disorder may be treated more leniently regarding maintaining a clean and orderly living space. At the same time, the supervisors will immediately work to resolve safety problems like a blocked or overly small pathway through the room.

Appeal. A resident who disagrees with a violation's issuance can appeal to the Commissioner. The resident is to learn about the possibility of appeal through looking at the violation notice and the meeting with the domiciliary care administrator. (The Resident Handbook does not note that a violation can be appealed.) More information on the appeal process (which is rarely used, according to Home staff) will be included in the next report.

West Street houses' rules and consequences. The West Street houses' residents are expected to generally follow the same rules as others living in the Home's other domiciliary settings. These include:

- no alcohol or substances (beyond prescription medication) on the grounds;
- no weapons, ammunition, fireworks, or flammable liquids;
- no pets;
- scheduled periodic (quarterly) inspections by the DVA and the contracted social services provider, "to ensure safety and maintenance"; and
- two vehicles are allowed (but campus permits from Security are not required).

Rules unique to the houses are:

- overnight guests can be hosted with permission from the domiciliary care administrator;
- if residents or visitors cause damage, the veteran resident will be responsible for paying the cost of fixing it; and
- residents may come and go freely. There is no pass system or limit on how long residents may be away from the houses.

Rule violations are to be handled jointly by DVA and Chrysalis Center, Inc. personnel. There is no set of procedures because the current program is relatively new.

Voluntary Discharge

Any resident is free to move out of the Veterans' Home at any time. A resident whose goal is to leave the Home is encouraged to work with the staff to ensure there is a means of financial support (e.g., employment and/or benefits income) and an adequate place to live. The person's assigned social worker will assist in locating and visiting prospective apartments and perhaps applying for certain housing programs (e.g., a regular or veteran-specific Section 8 voucher, disabled housing).

Once housing is secured, the person is urged to complete the discharge form, check in with B Clinic for medication needs, pack, and apply for an extended pass from the Veterans' Home, instead of fully discharging immediately. The pass enables the veteran to re-enter the Home within four weeks without going through the admissions process again, in case the

person's circumstances do not work out. Once the four weeks expire, the person has voluntarily discharged. Some veterans leaving the Home voluntarily decline the extended pass option.

Someone who chooses to leave the Home for more than four days without either officially discharging or taking an extended pass has involuntarily discharged. The distinction in discharge type matters because a veteran who voluntarily discharges is able to re-apply to the Home within one month, while the period is a year if discharged due to rules violation(s).

Resident Concerns and Complaints

There are multiple ways for domiciliary care residents' voices to be heard:

- the residents' council, called the Veterans' Council, which holds open meetings and recently began an anonymous suggestion box;
- community meetings;
- an anonymous tip line; and
- complaints verbally or in writing to DVA staff.

Residents are not consistently surveyed, though the discharging residents' exit forms (completion of which is voluntary) includes a few general questions about staff's helpfulness and progress during their stays.

Veterans' Council. The council meets every Tuesday evening to:

- hear resident complaints and suggestions, for example regarding the smoking policy changes proposed over the last year.
- undertake volunteer-type projects, such as emptying soda cans for recycling; and
- organize and lead programs, like Black History Month in 2013.

In 2012, the council became especially active in conveying and working to address resident concerns. Numerous changes were made to improve resident quality of life, including extending the salad bar availability from weekdays to weekends, lengthening the mail room hours, and showing movies more frequently.

Although there are elected council officers who are chosen by the entire body of residents, any resident is welcome to attend council meetings. Generally, fewer than ten people attend. Often, a Home manager is invited to speak and talk with residents.

Resident concerns are heard during the meetings and through a suggestion box. The box debuted in 2013 and is rotated around campus to various locations. Complaints are reviewed by the council and addressed at the meetings.

The residents' concerns expressed at the council meetings and via the suggestion box are conveyed to Home staff in two ways. First, the meeting minutes are sent to the DVA commissioner and the domiciliary care administrator. Second, the council president or another representative meets weekly with a variety of domiciliary care managerial staff to discuss concerns raised in the last meeting and how to address them.

Although an overall domiciliary care or main Residential Facility council is not required by law, state regulation requires a residents' council for the STAR program.³⁶ There is no such body but those residents are welcome on the existing Veterans' Council.

Community meetings. Community meetings in the main Residential Facility are rare and used to convey important changes or proposals. The meetings are not regularly scheduled; they are as-needed, with perhaps one every year. Topics discussed at the meetings in recent years have been changes in various security procedures, the billing system, and the smoking policy. All domiciliary care residents except those in the West Street houses are invited to attend.

Anonymous tip line. There are small signs posted at various Home locations encouraging anyone with something to report or complain about to call an on-campus, anonymous phone number. The phone number is also included in the Resident Handbook. The message line is checked by the security director, who ensures calls are documented and investigated.

Complaints communicated directly to staff. Residents may complain verbally or in writing to Home and DVA staff, who then are expected to take appropriate action to address the complaint.

There is no formal complaint process advertised to residents. For example, the Resident Handbook does not contain directions on how to communicate complaints, or any information on the Veterans' Council.

State regulation delineates a process under which residents or staff may file a written complaint (called a "petition" in the regulation). The listed process is essentially the same as the appeals process for admissions and discipline decisions, as described earlier in this chapter.³⁷

³⁶ R.C.S.A. Sec. 27-102l(d)-90(c)4(A)iv

³⁷ The main difference is that a complaint must be made within 30 days of the DVA decision or proposed decision in order to be eligible for a hearing or informal conference. (R.C.S.A. Sec. 27-102l(d)-55)

Nursing Care: Health Care Facility

The Veterans' Home offers 24-hour nursing care to veterans in its Sgt. John L. Levitow Veteran's Health Center. (Note: For this chapter, and throughout the report, PRI staff abbreviates the name to "Health Care Facility".) The current building is a stand-alone structure completed in September 2008. The new facility replaced an older building on the Home's campus that was used for long-term care.

The purpose of the Health Care Facility (HCF) is to give sub-acute care to veterans with chronic illnesses or conditions requiring prolonged care and services beyond what the Home's domiciliary care can provide. The facility offers on-site medical and nursing care, rehabilitative therapy, recreation, spiritual care, and respite care for veterans' families. In addition, a clinic in the main Residential Facility is staffed by HCF nursing personnel who provide services to domiciliary care residents.

The Health Care Facility is licensed as a chronic disease hospital (CDH) by the state Department of Public Health. A chronic disease hospital is a long-term care hospital having facilities, medical staff, and all necessary personnel for the diagnosis, care, and treatment of chronic diseases.¹ This is different from a skilled nursing facility, in that a CDH has more medical resources than a nursing home (but fewer than an acute care hospital). Because the federal VA does not formally recognize the differences between a licensed chronic disease hospital and a nursing home, the HCF follows all federal guidelines for nursing homes. This includes the requirement that the administrator have a nursing home administrator license.² As such, the VA treats the facility as a nursing home. Inspections of the facility are conducted by federal VA and DPH staff.³

Facility Capacity and Special Settings

The new HCF was built with a total bed capacity of 125. Recently, one of the facility's rooms was turned into a "sensory room" for residents with cognitive impairments, namely Alzheimer's disease, bringing the total resident capacity to 124. In the old building, there were close to 400 beds in eleven different nursing units. Committee staff was told when the transition to the new facility occurred, the old building was down to five staffed units, each with 22-28 beds – for a useable capacity of 110-140 – due to a mix of fewer residents and less staff.

The HCF is a two-level building with three residential wings on to top level and two on the bottom level. Each wing has 25 beds. Five rooms per wing are private rooms with one bed each. The remaining rooms are semi-private with double occupancy. The single rooms are located at the front part of each wing, and used for residents with spreadable infections, a need for continuous oxygen, and a need for hospice services.

¹ C.G.S. Sec. 19a-535b(a).

² The federal Centers for Medicare/Medicaid Services and the federal VA recognize the Home's chronic disease status for reimbursement purposes.

³ The Department of Consumer Protection does a separate inspection of the Home's pharmacy.



HCF Room with Single Bed

Two full units and all the private rooms have piped-in oxygen. The double rooms have a shared entry and bath, and are separated by a partial floor-to-ceiling wall. A separate special-care unit for residents with dementia is located on the building's lower level. This unit has a private dining room and fenced-in courtyard.

The Health Care Facility has a separate wing for administrative offices and designated space for rehabilitation services. There are two common areas, which are used for recreational activities for the residents. The facility also has a pharmacy, clinic area for certain contracted specialists, small library, mailroom, laundry area, chapel, barber shop, family dining room, and general dining room (used mainly for recreation).

HCF Common Room (used mostly for recreation)



Admissions and Intake

Referrals to the HCF come from various sources, such as veterans' families, local hospitals, federal VA locations in Connecticut, and social workers, according to HCF staff. Sometimes applicants are referred to the HCF if they have been declined admission to the Residential Facility because they need a higher level of care. HCF staff estimates they receive five to fifteen calls a week from veterans' families and others inquiring about the facility. There used to be a staff person solely for admissions, but the position was eliminated at some point after the new HCF opened. Admissions coordination is now the responsibility of a person who has additional responsibilities, including scheduling the appointments for the HCF clinic.

Veterans must complete an application prior to admission to the facility. The application is the same one used for domiciliary care. The admissions coordinator logs all application requests and materials received into a book, gives a quick initial assessment of eligibility, follows up with the applicant as needed, and sends relevant materials to the department's Business Office, which reviews a veteran's ability to pay for care and what payment method(s) will be used.

Once the admissions packet is complete, it is reviewed by an HCF admission team, similar to domiciliary care applications. The team differs, however. For the HCF, it consists of the facility administrator, medical director, Business Office representative, physical therapist, social worker, nursing director, nurse supervisor, and a utilization review staff member. Meetings occur bimonthly, and the team tries to consider only applications with full supporting documentation, including a complete physical and mental health assessment. If someone has dementia or might not be competent based on the information submitted, an evaluation may be requested if the person's application does not show there is a Power of Attorney (POA) agreement or conservatorship. If the person is not found competent, a POA agreement or conservatorship has to be put in place, and then that person can sign the resident into the facility. The HCF requires copies of the POA or conservator designation, which is double-checked by the social worker.

The admissions team does not deny many applications. However, a person might not be accepted if there is evidence of:

- extensive mental health needs beyond dementia;
- wander risk, because the HCF lacks the appropriate alarm system for residents who leave and are not supposed to;
- oxygen requirement and there is no space on a floor with it
- the HCF's level of care is not needed; or
- the Business Office does not approve.

Denials may be appealed to the commissioner, who does overturn them on occasion or refers them back to the HCF admissions team.

The time needed to complete the admissions review and intake processes varies, depending on multiple factors. The review team has completed an admission within a day or two, under certain conditions. Quicker reviews may occur if the veteran is a hospice patient, or has a

100% service-connected disability, in which case the stay will be completely funded by the federal VA (i.e., no examination of financial ability is needed), has no other place to go and whose family is in hardship, or is a terminal patient with family nearby.

Domiciliary care residents. Residents may move from the Residential Facility to the Health Care Facility if additional care is necessary. Usually, the B Clinic notifies the HCF medical director of any domiciliary care resident who they believe needs additional care. Domiciliary care residents may use the HCF for emergency issues, preparation for off-site surgery, and recuperation from major procedures. No new application is required when domiciliary care residents move to the HCF. The annual average number of domiciliary care residents who spent at least some period of time in the Health Care Facility over the last five fiscal years was 45. Domiciliary care residents are admitted to the HCF if they need care or monitoring beyond 96 hours.

Waitlist. Admission to the Health Care Facility is on a first come, first served basis. If someone requires a room for a special purpose (e.g., oxygen) and such rooms are occupied, the person is placed on a waitlist. Until recently, a formal waitlist for prospective residents was not necessary. The facility currently has a waitlist of five people who have been approved for admission but are awaiting a bed. The facility does not estimate how long any applicant will be on the waitlist.

When an appropriate bed becomes available, the first person on the waitlist is called. If that person does not accept admission at that time, the next person is offered the bed, but the first person still stays at the top of the waitlist. This is done because, for example, sometimes veterans refuse a bed but want to stay on the waitlist because they would like to spend more time with their families. If a person is experiencing some type of hardship and has nowhere else to go, they may move ahead on the list. Domiciliary care residents needing short-term physical rehabilitation have placement priority at the HCF because the facility is considered part of the care continuum available to all the Home's residents. If no HCF beds are available, veterans with medical insurance are being triaged to private nursing homes.

Beds reserved for specific reason. The Health Care Facility will hold a bed open for 10 days for any resident who has to go to the hospital. (During that time, a domiciliary care resident might take it for short-term rehabilitation purposes.) The HCF is in communication with the hospital to monitor the veteran's status, and will not use the bed on a long-term basis unless it was clear the hospitalized veteran is not coming back. Committee staff was told the ten-day period is usually sufficient because hospitals now want people to discharge quickly.

HCF personnel also said they try to keep up to nine beds available for domiciliary care veterans who need short-term, sub-acute care because they are recuperating from a physically-debilitating event that prevents them from living at the Residential Facility or they are preparing for an upcoming procedure (e.g., surgery) or unable to maintain their independent living for a variety of other reasons. The reservation of beds for any reason must be balanced with the facility's overall capacity and waiting lists.

Preliminary Admissions and Resident Data

Admissions. An initial review of HCF application and admissions data for FYs 10-14 was made by committee staff. The number of applications received for admission to the facility was only available for FYs 13 and 14. The data show 12 applications were received in FY 13, and 9 were received in FY 14 – a quarter fewer than the prior year.

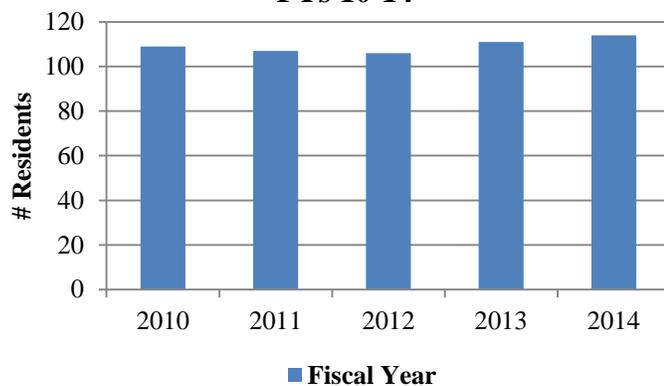
All applications to the HCF for both years were approved for admission. As of August 2014, there was a waitlist of 5 veterans. An additional two veterans were pending financial approval and one veteran was awaiting an on-site visit to determine if the veteran’s needs could be met by the facility.

Occupancy. Resident occupancy for the Health Care Facility for FYs 2010-14 is shown in Figure VI-1. The average yearly number of HCF residents for FYs 2010-12 decreased each year, from 109 to 106 (3 percent). Since then, the average number of residents increased to 111 in FY 13 and 114 in FY 14 (5 percent). The census for FY 14 was at its highest for the past five fiscal years.

Resident characteristics. Residents of the HCF are slightly older than veterans living in domiciliary care. All HCF residents currently are male, though women are eligible for admission. A third – or 38 residents – of the HCF were conserved in FY 14.

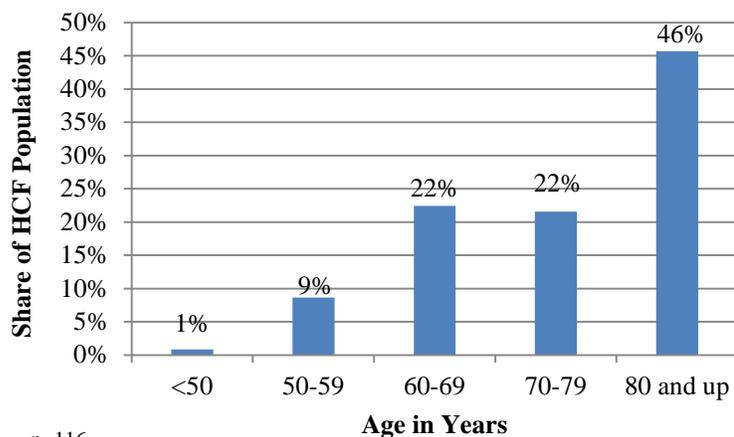
Of the 114 residents, 90 percent of all HCF residents are at least 60 years old, as shown in Figure VI-2. Forty-six percent of HCF residents are in their 80s, with residents’ ages ranging from 38 to 100. Interestingly, there are just as many residents in their 30s or 40s, as there are in their 100s.

Figure VI-1. Nursing Care Residents (Average Yearly Count) FYs 10-14



Source of data: Department of Veterans' Affairs.

Figure VI-2. HCF Residents' Ages, By Share of the Population (2014)



n=116

Source of data: Department of Veterans' Affairs.

Services

Interdisciplinary Treatment Plan. Each veteran admitted to the Health Care Facility for at least seven days receives an Interdisciplinary Treatment Plan (ITP). The ITP identifies a veteran's needs, problems, and concerns, and establishes the goals and services necessary to reach the veteran's highest, practicable level of mental, physical, and psychological well-being.⁴ For a veteran with a terminal condition (life expectancy of six months or less), the ITP must identify appropriate treatment to primary and secondary symptoms if the veteran so desires, establish an aggressive pain assessment and management process, and assess the veteran's psychological and coping mechanisms and appropriate support for the veteran and his/her family. The plans are developed by a team of professionals within the HCF.⁵

A veteran's first Interdisciplinary Treatment Plan must be completed within seven working days of admission to the Health Care Facility, in most cases. ITPs for veterans admitted to the HCF with a current, primary psychiatric diagnosis must be completed within 72 hours of admission.⁶ Thereafter, quarterly reviews of ITPs are to occur. Team meetings are also to take place if the veteran experiences any issues or problems, or if there is a significant change in the veteran's overall condition. Any member of the ITP team may request a meeting of the full team.

Medical and nursing. Medical and professional nursing personnel provide services to HCF residents on a 24-hour basis. According to the department, such personnel are primarily responsible for:

- diagnosing and treating diseases and injuries;
- examining patients for symptoms and signs of injury or disorder;
- actively participating on interdisciplinary committees;
- prescribing medications;
- recommending dietary and activity programs; and
- referring patients to appropriate medical or surgical specialists when necessary.

In-house medical and nursing staffing is supported through the federal VA and outside consultants who come to the Health Care Facility to help care for residents. For example, two federal VA medical doctors come to the HCF once a month to conduct annual physicals for the residents. They typically see five patients each over the course of a day. This is helpful to the HCF because those patients do not need to be transported to the VA for care and it helps relieve the workload of the facility's staff. The VA doctors make referrals for those residents who need the VA for specialist care not available at the Health Care Facility.

Staff. There are two medical doctors on staff; one serves as the facility's medical director. The doctors cover the hours of 8:00 a.m. to 5:00 p.m. on weekdays and nonholidays. Each resident of the Health Care Facility is assigned to one of the doctors, who is responsible for

⁴ DVA Residential Facility Programs and Services Policy and Procedures Manual, October 1, 2013. (The manual also includes the Health Care Facility's Interdisciplinary Treatment Plan policy.)

⁵ Health Care Facility ITP core members are the facility's medical doctor, head nurse, social worker, dietician, and pharmacist.

⁶ "Current" means on medication or presently/recently in treatment.

directing the veteran's care. When there is no doctor at the HCF, the University of Connecticut Health Center provides on-call medical service.⁷

In addition to the medical doctors, there is one director of nursing, three nurse practitioners (APRN), 5 nurse supervisors, 1 infection control nurse, 2 bed utilization nurses, and 1 part-time clinical educator. The nursing staff covers three shifts for the Health Care Facility and two shifts for B Clinic. For direct care staff, the HCF has 16 full-time and 13 part-time licensed practical nurses (LPN), and 20 full-time and 39 part-time (most work four days weekly) nurse aides.

HCF Clinic. There is a small clinic within the HCF that mainly provides certain specialized health care services HCF residents, as well as domiciliary care residents. The clinic also contains a small supply of medicine stocked by the Home's pharmacy.

Services. Optometry, podiatry, and psychiatry are given by consulting, contracted health care practitioners, while a psychologist is on staff. The psychologist is the Home's Fellowship House (residential substance use treatment) director, who sees HCF residents in the clinic as part of her responsibilities. The psychiatrist and psychologist also sometimes treat domiciliary care residents who urgently need behavioral health care. The service availability at the clinic is:

- optometry: one half-day every two weeks;
- psychiatry: at least monthly;
- podiatry: one half-day weekly;
- psychiatry: two days weekly; and
- psychology: one half-day weekly.

The podiatrist, psychiatrist, and psychologist work opposite hours of each other, mainly for space reasons at the clinic. They share a room at the facility that includes an exam table and some podiatry equipment, in addition to typical office furniture. Optometry services are provided in a separate room. If there is an immediate need for services, the HCF will contact the federal VA.

Veterans with a service-connected disability of at least 60 percent can receive their dental care at the federal VA. Veterans not within this category can go to the University of Connecticut Health Center for dental services.

There is also an X-ray service provided to the Health Care Facility through a private mobile x-ray company (Mobile X). The company comes to the HCF three days during the week. If there is an urgent need for an X-ray on another day, the company will also come.

Staff. In addition to the staff described above, an LPN is the clinic's coordinator. She also: shepherds HCF admissions applications through that process; works with hospitals on re-admissions. The scheduler and an LPN work on setting up multiple types of appointments at the

⁷ The contract calls for telephone on-call services from 5:00 p.m. to 8:00 a.m. Monday-Friday, and from 2:00 p.m. to 8:00 a.m. during each weekend and holiday. On rare occasions due to emergency or unexpected illness, DVA may request telephone on-call service be provided outside these times.

federal VA for HCF residents. Veterans travel to the VA for annual exams, off-campus medical appointments, and all VA psychiatric appointments.

Campus-wide emergency medical response. When the telecommunications office receives a call for medical assistance, an on-campus team responds. The team is notified by radio, beeper, and overhead page and assembles at the scene.

Who responds as part of the response team may fluctuate, depending on the time of day and location of the incident. While two security officers and a nursing supervisor always go to any episode, the medical staff and the Domicile supervisor attending vary. A doctor in the HCF responds if it is between 8 a.m. and 5 p.m. on a weekday (except holidays). If the call is received at another time, multiple nurses go and the on-call doctor service (UConn Health Center) is called. A nurse from the B Clinic will respond during first or second shifts. One security officer goes to the HCF to pick up the medical staff, while another proceeds directly to the scene to give first aid and assess the situation. If the person is in crisis, the officer calls 9-1-1.

For domiciliary care residents, the HCF medical staff and security always respond; security will bring a defibrillator and the HCF supervisor will bring the emergency bag (known as “Dr. Quick”). Depending on the time of day, the Domicile supervisor and staff from the B Clinic also may respond. The emergency bag contains shocks, materials to clear an airway, other specialized equipment, and standard first-aid kit components.

For FYs 10-14, the emergency medical response team was used an average of 35 times a year. The team responded to the Health Care Facility an average of 17 times a year, and the Residential Facility an average of 18 times a year.

Rehabilitative Therapies. Physical, occupational, and speech therapy are provided to Veterans’ Home residents at a specifically-designated space at the Health Care Facility. The ultimate goal is to help residents attain maximum independence and mobility.

While most therapy patients are HCF residents, approximately 20 to 30 percent are domiciliary care residents. HCF residents tend to have longer-term therapy needs than domiciliary care veterans. Therapy staff estimate about



HCF: Physical Therapy Room

one-quarter of HCF residents, and one-fifth of domiciliary care residents, are receiving physical or occupational therapy at any given time.

The therapeutic staff shares office space within the HCF and is available from 7:30 a.m.-4:30 p.m. on weekdays (excluding holidays). A referral from a Home or federal VA medical doctor or APRN is necessary for an appointment. Recreation also falls under the “therapy” umbrella, as discussed more below.

Assessments. Every incoming resident is assessed by the physical therapist for ability to move (“transfer”) from one location to another. The evaluation consists of observing the person move among the bed and bathroom to determine whether assistance (in person or equipment form) and therapy are needed. Transfer re-assessment is completed every quarter and when there is a significant change in medical status or a fall. In addition, a speech therapist will assess incoming residents if there is a question of swallowing difficulties.

Treatment. The type of therapy delivered depends on each person’s specific needs. Many residents need strength- and balance-building exercises and stretches. Those requiring occupational therapy for activities of daily living may be treated within their rooms or within the therapy space at the facility, which includes a clothes washer and dryer. Table VI-1 shows the treatment responsibilities and goals of each therapy area, as well as staffing.

| Table VI-1. Occupational, Physical, and Speech Therapy Areas of Responsibility and Staffing | | | |
|--|--|---|---|
| | <i>Occupational</i> | <i>Physical</i> | <i>Speech</i> |
| Goal is to improve resident: | <ul style="list-style-type: none"> • Arms and hands use, comfort • Ability to complete feeding, dressing, bathing • Fine motor function • Organizational life skills | <ul style="list-style-type: none"> • Legs and feet use, comfort • Back and neck use, comfort • Ambulation | <ul style="list-style-type: none"> • Ability to eat • Ability to vocalize and speak |
| Staff | <ul style="list-style-type: none"> - 1 occupational therapist - 1 Certified Occupational Therapy Assistant - 1 shared aide | <ul style="list-style-type: none"> - 1 physical therapist - 1 shared aide (Rehabilitation Supervisor is a licensed physical therapist) | <ul style="list-style-type: none"> - 1 speech therapist |
| Source of data: Department of Veterans’ Affairs. | | | |

In addition to individual therapy appointments, residents may attend group classes that aim to improve strength and balance, in part to reduce falls. These classes include Tai Chi, walking, and circuit training, and unit movement groups.

All classes except circuit training are led by a rehabilitation aide and occur twice weekly. Circuit training is offered twice a week, for a few hours each, and usually the entire therapy department assists the residents.

Equipment. Much of the HCF rehabilitation room's equipment was purchased new when the facility moved to its current building; some additions have since been acquired. The physical therapist orders assistive devices for residents, including splints, walkers, and standard wheelchairs. The Veterans' Home supplies these devices except for customized wheelchairs, which are provided by the federal VA.

Training new HCF staff. Every person who joins the HCF staff (including nursing students) receives certain training from the therapy staff. The physical therapist teaches new staff how to safely transfer and position residents. The speech therapist instructs them in how to feed residents and ensure safe swallowing.

Staff. In addition to the staff shown in the table above, there is a rehabilitation aide who mainly divides her time between physical and occupational therapy, and a consulting physiatrist. The physiatrist sees patients and makes therapy recommendations two days a month. The physical therapist serves as the area's supervisor and is also responsible for the recreation staff.

Recreation. Recreation staff (called "rehabilitation therapists") offer organized recreational opportunities on- and off-campus to all the Home's residents. There are multiple designated recreation areas on campus. Within the HCF, many activities are held in large common rooms.

Activities. Each staff person is responsible for dedicated HCF units, arranging and offering whole-unit and individual resident-specific recreation. Two of the staff alternate arranging HCF-wide activities.

Individual meetings and recreation with residents. A new HCF resident meets with the rehabilitation therapist assigned to that living space (by unit) within the first 14 days on-campus. The person discusses interests and abilities with the therapist, who uses the information to complete a recreational assessment and develop an individualized recreational program. The therapist reevaluates the resident's recreational abilities and needs every quarter, or when there is a significant change in condition (e.g., a nurse contacts the therapist because the person seems lonely or sad).

Every HCF resident has an individualized recreational plan, of which involves one-on-one activity with the therapist (in addition to group activities) for those residents who are cognitively impaired and unable to participate in group activities. All residents are encouraged to attend activities that interest them. Monthly calendars and flyers are posted in each resident's room and on the units for residents to refer to. Overhead announcements also serve as reminders.

Events. The unit and whole-HCF events calendars are posted on bulletin boards in each resident's room and unit. About four days a week, there is a unit-based activity, such as

dominoes or trivia. There is a whole-HCF activity, like horse racing games or Wii Bowling, offered each morning and afternoon during the week.⁸

Some of the on-campus events are regularly scheduled, recurring on certain days of the week at the same time – such as weekly pet therapy in each unit – while others are special events, such as performances by a magician, a barbershop quartet, one of Connecticut’s State troubadours, and a choir.

Recreation staff also attempts to offer off-campus outings specifically for HCF residents twice a month. Sometimes these trips are cancelled due to sudden transportation unavailability from vehicle problems or lack of a properly licensed bus driver. For example, from January to October 2013, all off-campus outings were cancelled. There is no Veterans’ Home vehicle dedicated to recreational trips.

Staff. As described in Chapter V, the recreation staff who serve the HCF and domiciliary care are:

- four full-time rehabilitation therapists who work 35-hour weeks;
- two Veteran Workers who help with daytime games and run evening games for between 25 and 30 hours weekly, and
- one Veteran Worker who staffs the craft room and assists with Bingo for a total of nine hours weekly.

In addition, some individuals and groups run events as volunteers. Usually one or two groups – associated with schools, churches, or veteran organizations – visit each week. Individual volunteers can develop their own programs or just have conversations with veterans.

Respite Care

The Veterans’ Home offers a Respite Care program to veterans and their families when bed availability exists within the Health Care Facility. Respite Care is intermittent care to disabled veterans designed to give a veteran’s primary caregiver a temporary break. The level of disability must require the veteran to rely on a primary caregiver to complete activities of daily living, manage medication, and ensure nutrition.⁹

Veterans are eligible for up to 28 days of Respite Care per calendar year. Veterans using Respite Care must receive the same quality of care and services offered to all HCF residents, although the facility has to be able to meet the person’s care needs.

Respite Care is provided to eligible veterans as a veteran’s benefit and there is no charge. Veterans (or their caregivers) apply to the Home to participate in the Respite Care program using the same application and review process as all nursing care residents. If necessary, veterans must

⁸ There are fewer activities on Sunday, when the chapel worship services often are the only recreation events.

⁹ Regs. Conn. State Sec. 27-102l(d)-108(c)(3)(A)

agree to a visit from professionals at the HCF prior to admission, such as a nurse and social worker.

Capacity. Respite Care capacity fell when the Home’s nursing care transferred to the new Health Care Facility, in 2008. An entire unit in the old hospital was used for Respite Care. The new Health Care Facility, due to more limited capacity, currently tries to keep two beds open for respite (one in the dementia unit and one general bed). Respite care was provided to several veterans at various points in 2013, but not 2014 to date due to space constraints.

Until last spring, the HCF was not accepting applications for Respite Care. Since then, the facility has started to accept applications, although veterans or their caregivers are told there are no Respite Care beds currently available.

Veterans seeking Respite Care use the same application and follow the same review process as veterans applying for full-time admission to the facility. Approved applications are kept on file either until the HCF is asked to remove them or the veteran dies. Veterans using the HCF for Respite Care cannot be transferred to other services or programs offered by the Home unless the veteran applies for admission to the Home and, once admitted, no other veteran is currently on a waiting list.

Table VI-2 shows Respite Care information for FYs 10-14. According to facility staff, the sharp decline in the number of Respite Care applications received, veterans admitted for Respite Care, and total number of Respite Care days beginning in FY 12 was due to a reduction in personnel.

| Table VI-2. Veterans’ Home Respite Care: FYs 10-14 | | | | |
|---|-----------------------------------|--------------------------------|----------------------------|--------------------------------|
| <i>Fiscal Yr.</i> | <i># of Applications Received</i> | <i># Approved Applications</i> | <i># Veterans Admitted</i> | <i>Total # of Respite Days</i> |
| 2010 | 23 | 23 | 23 | 245 |
| 2011 | 21 | 21 | 21 | 204 |
| 2012 | 5 | 5 | 5 | 64 |
| 2013 | 6 | 6 | 6 | 59 |
| 2014 | 1 | 1 | 0 | 0 |

Source of data: Department of Veterans’ Affairs.

Additional HCF Photos



General Hallway

Main Common/Dining Area





View from HCF

Outside Common Area



Areas for Further Development

Over the next two months, program review committee staff will continue to gather information about the Veterans' Home. The next steps of the study will be critical to the goal of producing an evaluation that both assesses current operations and includes recommendations on how the Home can best serve Connecticut's veterans.

Committee staff expects to:

- analyze additional data and records from the Home;
- seek opinions and experiences of residents (beyond the Veterans' Council, with whom staff has met), likely through multiple methods, including a survey;
- interview staff at other Connecticut, national, and federal government organizations that serve veterans – especially those who are homeless or at risk of losing housing;
- talk with additional Veterans' Home and state Department of Veterans' Affairs (DVA) staff (including non-managers), and hold follow-up meetings with key managers; and
- learn about the services and policies of other states' veterans' homes.

The additional information gathered will enable further exploration of these areas:

- 1. The domiciliary's model of care.** A large share of the veterans living in domiciliary care (overall) is long-term residents: Nearly one in two (47 percent) have lived at the Home more than five years, and over one in five (22 percent) for more than ten years.¹ Clearly, some veterans are not exiting domiciliary care promptly in accordance with the Home's mission and its goal of within three years. In addition, the Home is a gated facility located outside of a smaller suburban town – a geographic feature that cannot be easily changed. Although program review committee staff research in this area has been limited so far, other government (and nonprofit) programs seem to put greater focus on more quickly rehousing veterans in the community at large or stabilizing their housing within the community.

- *Given these characteristics, is the Home meeting its mission to “rehabilitate” domiciliary residents and “return as many residents as*

¹ The percentages are from June 12, 2014, and March 22, 2013, respectively. Data from different dates were used because the DVA staff was unable to provide the share of June 2014 residents who had lived in domiciliary care for more than ten years.

possible” to the community as quickly as possible – and can it, with its structure and location?

- *The domiciliary care mission, goal, and model work toward exit by three years while allowing for the possibility of permanent residence at the Home. Is this in line with current thought on how to best serve veterans who need housing stability and other supports? Or, does the state need to shift its paradigm to ensure it provides veterans the most effective service delivery system possible?*
- *Does the model match what today’s veterans are seeking?*

2. Occupancy rate. While the Health Care Facility’s annual average occupancy was at or just above 85 percent from 2010 to 2013 (and stood at 92 percent for 2014, as of August),² the Home’s domiciliary care monthly occupancy rate has not consistently risen above 60 percent since summer 2010.

- *Why is the domiciliary care occupancy rate low compared to recent years, given that there is still a substantial population of homeless and housing-precarious veterans?*
- *Could – and given the model, should – efforts be made to increase occupancy, and if so, what?*

3. Aging in place of domiciliary residents. Reportedly many of the Home’s residents are “aging in place.” – and nearly all are above middle age. Currently, more than half are nearing or beyond 60 years old, and five percent are at least 80.³ The Home has responded by developing a program (Residential Plus Program) that provides a small share of domiciliary residents with some assistance in dressing, bathing, and other daily activities, roughly comparable to “assisted living” programs. However, this program is limited in size, scope, and staffing, and admission recently has been frozen, mainly due to resource issues. As residents become more frail and need constant nursing care, it is possible the nursing facility will need to accept more people from domiciliary care and fewer from the community (which is already a minority of the Home’s nursing care population). Some top state DVA and Home administrators have been mulling what should be done.

- *How can the older veterans living in the Residential Facility best be served?*

² It is state DVA policy to keep nine or ten HCF beds open for domiciliary care residents who need 24-hour nursing care due to injury or illness. At one point recently, all beds in the HCF were taken, due to an unusually high number of domiciliary care residents needing HCF services temporarily. Because it is more common for several of those beds to be vacant, it is unlikely the occupancy rate of the HCF will, on average, ever reach 100 percent consistently.

³ Fifty-eight percent of residents are 60 years old or beyond; of those, 16 percent are aged 70 or above. Only eight percent of domiciliary care residents are under 50 years old. (Data from August 12, 2014, and provided by DVA staff.)

- *If they can best be served at the Home, what changes to the building(s) and services would be necessary – and what would be the resource requirements?*

4. Service quality. The Home operates numerous rehabilitative and basic services for both domiciliary and Health Care Facility residents. The final staff report will offer some data and records analysis in these areas, as well as comparisons to relevant metrics or standards where available. Wherever possible, outcomes will be examined.

- *Are the Home's services high-quality and efficient?*

5. Staff level and balance. There is extensive need for, and use of, overtime and pool (i.e., outside) nursing staff in the Health Care Facility. There is also some overtime use in other departments; both will be analyzed. The Home's state employee labor force has been supplemented by on-campus work performed by domiciliary residents, through the Home's therapeutic Veteran Worker program (which pays minimum wage) and two programs entailing less-involved work, with limited or no pay. Yet, it is unclear if this is a sustainable overall staffing model, given the residents' aging in place and relatively low domiciliary occupancy rate. Between March 2010 and June 2014, the number of Veteran Workers dropped from 146 to 93. The current average age among Veteran Workers is 59 years old. The staff level and balance issues are due in part to a declining number of State-authorized positions.

- *Is the current staffing level adequate to provide quality services?*
- *Is the balance between state employees and resident workers appropriate, and will it be sustainable in the near future?*
- *If staffing changes are needed, what would be the cost?*

6. Therapeutic work program for domiciliary residents. There appear to be a few problems. First, some (not all) managers have had difficulty with Veteran Workers' attendance and work ethic. Yet, generally, those workers are not fired because, state DVA staff seems to mostly agree, the intent of the program is to help the residents acclimate to work and responsibility. Unreliability causes problems for certain managers who rely on the Veteran Workers to get critical tasks done. Second, recently there were a few residents who wanted to join the program but were unable due to a lack of positions. The position shortage is caused by two factors: the ability of residents to hold a Veteran Worker job for an unlimited time, and the requirement (issued a few years ago) that the State's Office of Policy and Management approve any of the program's refills, which slows down refilling when vacancies do occur. Third, program review committee staff heard there sometimes is tension between staff and Veteran Workers because in some cases, the residents perform roughly similar tasks for a lower wage, with

no possibility of a raise. (Veteran Workers can choose to apply for on-campus state employee positions, when those arise.)

- *How is “success” within the Veteran Worker program defined and measured by the Home?*
- *What, if anything, could be done to solve the Veteran Worker program’s challenges, balancing residents’ needs with those of the Home services that rely on the Veteran Workers?*

7. Facilities’ use and conditions. Nearly all the Home’s buildings are nearly 80 years old. Some are used little or not at all. Underuse might be a contributing cause, or effect – or both – of the buildings’ conditions. The most recent thorough review, from 2005, found many buildings needed substantial work. Since then, some renovations have been completed, but conditions might still be fair or poor in many buildings. The current state budget includes \$500,000 for a consultant to assess conditions and consider options for improving or reconfiguring the facilities.

- *How might the levels of building use and condition play into considering the model of care and occupancy rate concerns?*
- *Are there alternative uses for empty buildings that can benefit veterans and/or infuse financial support into the Veterans’ Home?*

8. Respite care. Although state regulation sets out respite care program guidelines, and respite care is advertised in a brochure about the HCF that is online, the Health Care Facility has not yet offered it in 2014, due to the high occupancy rate and low authorized staffing level. Until last spring, applications were not being accepted or reviewed. Currently, caregiver families can apply but will not be offered space.

- *Should the Veterans’ Home prioritize respite care availability? What would be the impacts?*
- *Is the Health Care Facility large enough to adequately meet its three-fold role: 1) long-term care; 2) short-term rehabilitation for domiciliary care residents; and 3) respite care?*

9. Information technology (IT) and management. Some problems are said to have occurred when the DVA’s information technology staff and service provision were transferred to another state agency, but there have been efforts to address the problems. Relatedly, however, the Home’s use of technology (e.g., computers, computer programs) to keep programmatic and resident records, and then use the data for management and planning purposes, could be an area for improvement.

- *How could the Home best use technology to effectively manage its programs?*
- *How have the efforts to improve the IT migration proceeded, and could anything more be done to smooth that effort – or to facilitate the upcoming rollout of residents’ electronic medical records?*

10. Transportation. The Veterans’ Home has three buses to transport residents to medical appointments at the federal VA’s Newington and West Haven health centers, shopping and a local bank, and off-campus recreational activities.⁴ The buses reportedly are old and frequently need repairs – to the point that all scheduled recreational trips off-campus were canceled between January and October 2013. Recently some managers have begun to advocate for additional vehicle capacity.

- *What resources would be needed to adequately fulfill veterans’ health and recreational needs?*

11. Connections with the federal Department of Veterans Affairs (VA). The federal VA’s health centers work with the Veterans’ Home staff on co-management of residents’ healthcare. (Prior to the early 2000s, residents’ health care was largely provided at the Home.) Co-management affords the residents medical care continuity and the opportunity to navigate the federal VA with some level of independence. From the state’s perspective, the arrangement pushes many of residents’ medical costs onto the federal VA. However, it also requires the Home to perform and fund seemingly complex, costly logistical arrangements that involve much staff time, handicapped-accessible buses, and fuel. The federal VA also refers veterans to the Home and oversees contracted inspections of all states’ veterans’ homes.

- *Could anything be done to ease the logistical and cost burden of co-management, without sacrificing residents’ quality and continuity of care or impeding efforts to foster resident independence?*
- *What are the federal VA’s standards or expectations regarding domiciliary model of care, programs, and staffing?*

12. Other states. Every other state has at least one veterans home, but services, scope and policies vary. It is unclear whether any other state has domiciliary care capacity that equals or exceeds Connecticut’s.

- *Should the Connecticut State Veterans’ Home adopt any other state homes’ policies, rules, or programs that seem to work well (from among those others that will be examined)?*

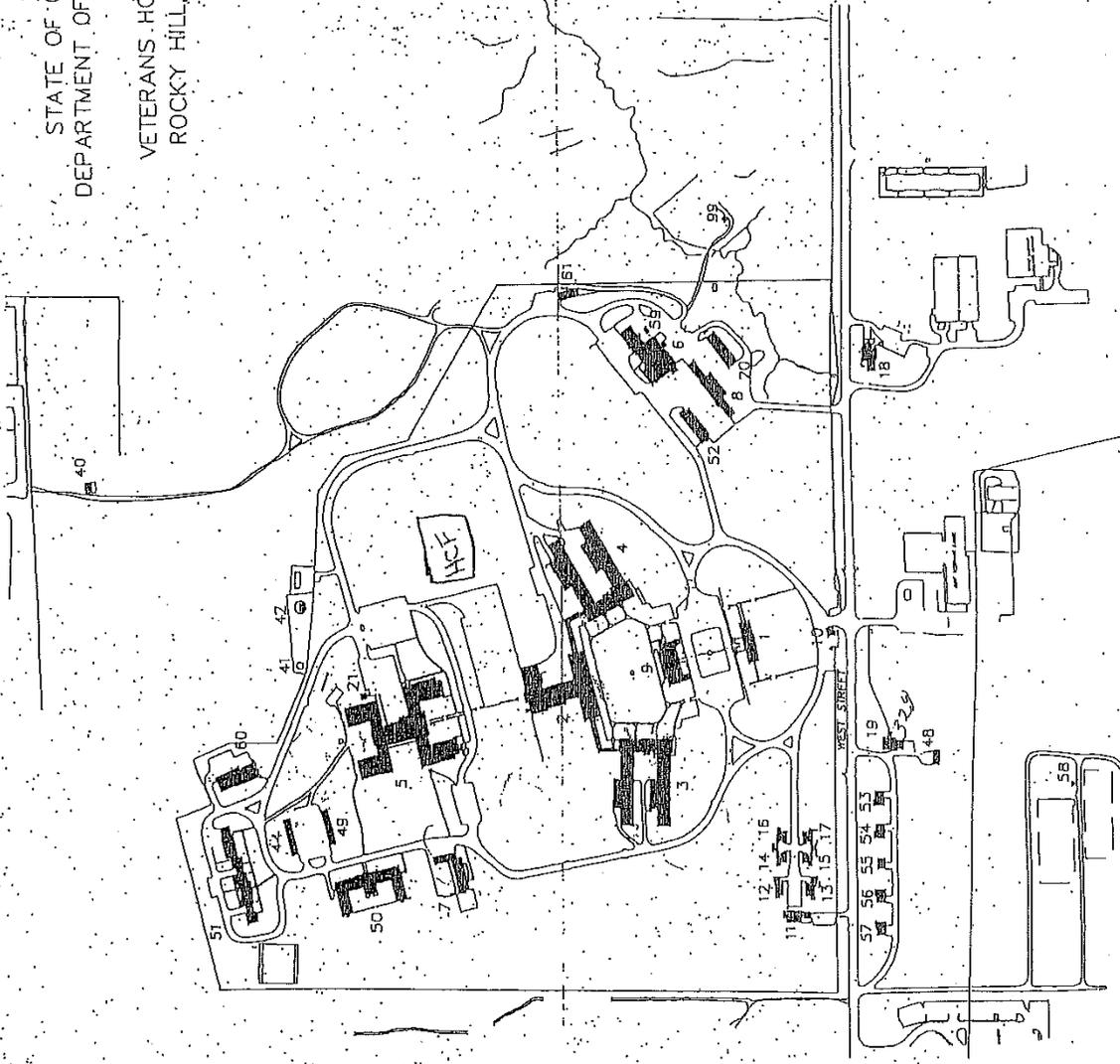
⁴ Small passenger cars (driven by state employees or Veteran Workers) also are available to transport residents to important appointments (e.g., a court date).

STATE OF CONNECTICUT
DEPARTMENT OF VETERANS AFFAIRS

VETERANS HOME & HOSPITAL
ROCKY HILL, CONNECTICUT

FACILITY BUILDING NUMBER AND NAME

- 1 - ADMINISTRATION
- 2 - COMMISSARY
- 3 - WEST DOMICILE
- 4 - EAST DOMICILE
- 5 - HOSPITAL
- 6 - POWER PLANT
- 7 - VETERANS SERVICES
- 8 - PHYSICAL PLANT
- 9 - ASSEMBLY
- 10 - GATE HOUSE
- 11 - STAFF RESIDENCE
- 12 - STAFF RESIDENCE
- 13 - STAFF RESIDENCE
- 14 - STAFF RESIDENCE
- 15 - STAFF RESIDENCE
- 16 - STAFF RESIDENCE
- 17 - STAFF RESIDENCE
- 18 - DAY CARE CENTER
- 19 - ALTERNATIVE LIVING RESIDENCE
- 20 - MAINTENANCE SHOP
- 21 - OXYGEN STORAGE
- 22 - PUMP HOUSE
- 41 - WATER TANK (50,000 GAL)
- 42 - WATER TANK (300,000 GAL) & VALVE PIT
- 44 - GARAGE
- 48 - GARAGE
- 49 - GARAGE
- 50 - VETERANS RECOVERY CENTER
- 51 - STAFF APARTMENTS
- 52 - TRANSITIONAL LIVING RESIDENCE
- 53 - ALTERNATIVE LIVING RESIDENCE
- 54 - STAFF RESIDENCE
- 55 - ALTERNATIVE LIVING RESIDENCE
- 56 - ALTERNATIVE LIVING RESIDENCE
- 57 - ALTERNATIVE LIVING RESIDENCE
- 58 - CEMETARY TOOL SHED
- 59 - STORAGE
- 60 - STAFF APARTMENTS
- 61 - INCINERATOR
- 99 - SLUDGE BED



OCTOBER 10, 1996

Appendix B

Veterans' Home Buildings

| Table B-1. Veterans' Home's Buildings: Current Use and, According to 2005 Master Plan, Condition and Cost to Renovate | | | | | | | |
|--|----------------------|---|-----------------------------|---------------------------------------|-----------------------|---|--|
| <i>Map #</i> | <i>Name</i> | <i>Current Use</i> | <i>At or near capacity?</i> | <i>Consistently used? (Currently)</i> | <i>2005 Condition</i> | <i>2005 Est. Cost to Renov. To "Excellent" Condition*</i> | <i>Recent/Fall 2014 Renovations</i> |
| None | Health Care Facility | Nursing care | ✓ | ✓ | NA – New in 2008 | | --- |
| 1 | Administration | State DVA administration | ✓ | ✓ | Fair | \$2,366,816 | --- |
| 2 | Commissary | Domiciliary dining hall, kitchen, food inventory, wheelchair repair area | NA | ✓ | Fair | \$14,409,216 | Air conditioning in kitchen |
| 3 | West Domicile | Domiciliary rooms and administration | No | ✓ | Poor to Fair | \$27,040,500 | Air conditioning |
| 4 | East Domicile | Domiciliary rooms and B Clinic | No | ✓ | Poor to Fair | \$17,520,624 | Air conditioning; fall 2014: asbestos floor tile removal |
| 5 | Hospital | 3 of 5 floors used: Mail room, volunteer office space, 40 extra (empty) beds in case of emergency, Dept. of Correction offices, HCF storage, HCF maintenance office | No | ✓ | Poor | \$47,929,683 Hospital replacement recommended (and done) | --- |
| 6 | Power Plant | Generate electricity, hot water, heat | ✓ | ✓ | Good | \$16,418,886 | --- |

| Table B-1. Veterans' Home's Buildings: Current Use and, According to 2005 Master Plan, Condition and Cost to Renovate | | | | | | | |
|--|-------------------------------------|---|-----------------------------|---------------------------------------|-----------------------|---|-------------------------------------|
| <i>Map #</i> | <i>Name</i> | <i>Current Use</i> | <i>At or near capacity?</i> | <i>Consistently used? (Currently)</i> | <i>2005 Condition</i> | <i>2005 Est. Cost to Renov. To "Excellent" Condition*</i> | <i>Recent/Fall 2014 Renovations</i> |
| 7 | Veterans Services | VFW and American Legion offices | No | ✓ | Poor | \$2,789,514 | --- |
| 8 | Maintenance / Physical Plant | Automotive and craft shops, offices | ✓ | ✓ | Poor | \$3,929,270 | --- |
| 9 | Assembly | Auditorium, chapel | NA | ✓ | Poor | \$4,515,660 | --- |
| 10 | Gate House | Gate security | NA | ✓ | Fair | \$396,308 | --- |
| 11 | Staff Residences (i.e., Sugar Hill) | Occasional (<weekly): Trustee meetings, family visiting hospice patients, media and Governor meetings, HCF staff housing when roads close, out-of-state visitors attending Stand Down | No | No | Poor | \$442,804 | --- |
| 12 | Sugar Hill | Spanish American Legion office | ✓ | ✓ | Poor to fair | \$265,287 | --- |
| 13 | Sugar Hill | See Bldg. 11 | No | No | Poor to fair | \$302,549 | --- |
| 14&16 | Sugar Hill duplex | See Bldg. 11 | No | No | Poor to fair | \$469,791 | --- |
| 15 & 17 | Sugar Hill duplex | See Bldg. 11 | No | No | Poor to fair | \$469,791 | --- |
| 18 | ESGR / Day Care Center | Vietnam Veterans office | No | No* | Good | \$314,238 | --- |
| 19 | Alternative Living Residence | No longer in use | No | No | Fair | \$595,775 | --- |
| 20 | Grounds Shop/ | Maintenance shop | NA | ✓ | Poor | \$240,176 | --- |

| Table B-1. Veterans' Home's Buildings: Current Use and, According to 2005 Master Plan, Condition and Cost to Renovate | | | | | | | |
|--|---|--|-----------------------------|---------------------------------------|-----------------------|---|-------------------------------------|
| <i>Map #</i> | <i>Name</i> | <i>Current Use</i> | <i>At or near capacity?</i> | <i>Consistently used? (Currently)</i> | <i>2005 Condition</i> | <i>2005 Est. Cost to Renov. To "Excellent" Condition*</i> | <i>Recent/Fall 2014 Renovations</i> |
| | Maintenance Shop | | | | | | |
| 40 | Pump House | Water pumps | ✓ | ✓ | Good | \$38,931 | --- |
| 41 | Water Tank | Used when need to service other (larger) tower | No | No | Not covered in plan | | --- |
| 42 | Water Tank | Water tank (tower) | NA | ✓ | Not covered in plan | | --- |
| 44&49 | Garage | Equipment and materials storage | ✓ | ✓ | Poor | \$150,960 58 rec. for demolition | --- |
| 48 | Garage | Equipment and materials storage | ✓ | ✓ | Not covered in plan | | --- |
| 50 | Veterans Recovery Center (Fellowship House) | Substance use treatment: Residential, limited outpatient (for certain Home residents), AA/NA meetings, staff offices | No | ✓ | Poor | \$13,050,728 | --- |
| 51 | Staff Apartments | STAR housing (4 apartments) and American Legion offices (1 apartment) | No | ✓ | Poor | \$6,367,718 | --- |
| 52 | Transitional Living Residence | Storage and electrical shop | ✓ | ✓ | Poor | \$3,426,772 | --- |
| 53 | Alternative Living Residence | Patriots Landing | ✓ | ✓ | Poor | \$169,959 Rec. replacement with row | Renovated |

| Table B-1. Veterans' Home's Buildings: Current Use and, According to 2005 Master Plan, Condition and Cost to Renovate | | | | | | | |
|--|------------------------------|--|-----------------------------|---------------------------------------|-----------------------|---|-------------------------------------|
| <i>Map #</i> | <i>Name</i> | <i>Current Use</i> | <i>At or near capacity?</i> | <i>Consistently used? (Currently)</i> | <i>2005 Condition</i> | <i>2005 Est. Cost to Renov. To "Excellent" Condition*</i> | <i>Recent/Fall 2014 Renovations</i> |
| | | | | | | housing for Bldgs. 53-57 | |
| 54 | Staff Residence | Patriots Landing | ✓ | ✓ | Poor | \$160,155 | Renovated |
| 55 | Alternative Living Residence | Patriots Landing | No | ✓ | Poor | \$148,233 | Renovated |
| 56 | Alternative Living Residence | Patriots Landing | ✓ | ✓ | Poor | \$160,155 | Renovated |
| 57 | Alternative Living Residence | Patriots Landing | ✓ | ✓ | Poor | \$156,510 | Renovated |
| 58 | Cemetery Tool Shed | Cemetery tool shed | NA | ✓ | Fair | \$6,600 | --- |
| 59 | Storage | Storage for powerhouse materials | ✓ | ✓ | Not covered in plan | | --- |
| 60 | Staff Apartments | Empty; used by State Police for training | NA | ✓ | Poor | \$2,757,216 | --- |
| 61 | Incinerator | Trash compactor and storage | NA | ✓ | Poor | \$177,904 | --- |
| <p>*In unadjusted (2005) dollars. **Meeting room is used weekly by Vietnam Veterans; they also rarely use the building's office space. Sources of data: "Veterans' Home Master Plan Study," Friar Associates Inc., July 2005, and Department of Veterans' Affairs.</p> | | | | | | | |

Other Services

There are multiple Veterans' Home services that support the core rehabilitative, nursing, and residential care offered to residents. This chapter briefly describes those services, which are Security, Food Services, Laboratory, and Pharmacy. Central administrative services – the Business Office, Human Resources, the Commissioner's office, and information technology – are explained in Chapter II.

Spiritual Care

The Veterans' Home offers a range of chaplain services to interested residents, including worship opportunities. There are two Sunday worship services in the HCF chapel every Sunday (one each Roman Catholic and Protestant), open to both domiciliary and nursing care residents, and two services in the HCF Alzheimer's unit. There are also periodic Sunday services in the domiciliary care chapel, located below the auditorium near the main Residential Facility, and holiday worship services.



Domiciliary care (left) and Health Care Facility (right) chapels

The chaplains also provide:

- weekly Bible study in the main Residential Facility;
- weekly conversations in Fellowship House with veterans participating in residential substance use treatment;
- individual counseling and support; and
- funeral services for Veterans' Home residents.

Staff. Two part-time chaplains are on staff, one Roman Catholic and the other mainline Protestant.

Security

Activities. The mission of the security department is to ensure safety and security on the Veterans' Home campus. Some of the tasks used to fulfill the mission are described further below; others are:

1. patrolling the campus and its buildings;
2. enforcing motor vehicle rules;
3. responding to incidents like theft, vandalism, and rule violations and generating an incident report (see Chapter V for more information);
4. intervening – often with the Domicile supervisors – when there are heated resident arguments;
5. training staff on what to do in certain emergency situations (e.g., active shooter training, which is done collaboratively with the nurse training coordinator);
6. responding to fire reports;
7. monitoring the campus through closed circuit television, excluding personal living and working spaces; and
8. transporting residents unable to walk to other campus locations.

Monitoring campus exit and entry. Security officers posted in a small building at the campus's only entrance follow certain procedures to track all arrivals and departures. For example, domiciliary care residents must swipe their identification cards and, if needed, show a special pass, inside the building. Officers also are to visually inspect all resident packages and vehicles. That policy was adopted 2012, upon a security consultant's recommendation, after one resident brought weapons onto the campus. Staff and visitor packages and/or vehicles may also be searched when security staff determines there is a need.

Controlling vehicle permits. Staff and domiciliary care residents may be issued parking permits by Security personnel. Resident vehicle permits are reissued annually to ensure the car insurance and registration, as well as driver's license, are current.

Attending to on-campus requests for urgent medical assistance. When there is a medical call, two officers should respond. One goes with a vehicle to the Health Care Facility to pick up a doctor (if on duty) and a nurse. The other travels directly to the scene and then assesses what should be done. If the person is in crisis, the officer dials 9-1-1; if not, the officer administers first aid. All security vehicles are equipped with an automatic external defibrillator (AED), oxygen, and emergency first aid materials.

Additional role. Beyond its core role of ensuring safety on the Home's campus, the security department plays a part in ensuring evacuation preparedness for any accident at

Connecticut's only nuclear power plant, Millstone Power Station in Waterford. There is an annual drill inspected by the Federal Emergency Management Agency.

Powers not held. There are some limitations on what Security staff may do, since they are not police officers (though many were prior to working at the Home). The staff cannot: 1) search a resident's person; 2) search a resident's personal belongings without permission except on the day a new resident moves in (at the campus gate);¹ or 3) arrest anyone. In addition, Security officers do not carry weapons.

Security staff sometimes call the local Rocky Hill Police Department and/or State Police for assistance when an arrest might be necessary or if additional help is needed, including for incidents beyond the Home's jurisdiction. For example, if someone threatens to harm another person or him or herself, the state and local police are summoned. In addition, the Rocky Hill Fire Department is called when needed.

Staff. There are 16 Security officers and a director. One of the officers has training responsibilities.

The campus's two telecommunications staff, as well as two Veteran Workers, also report to the Security director. The staff is phone operators who receive and handle calls to the general Veterans' Home phone number, as well as on-campus calls for urgent medical response.

Food Services

Activities. The Veterans' Home's Food Services department prepares and serves three meals daily, every day of the year, to residents, staff, and visitors. It also oversees stocking of the main Residential Facility's Winners Circle lounge.

Determining appropriate meals. The Home's dietician meets with each new resident to learn about the person's food preferences, restrictions, and needs (e.g., non-solid diet). Then, the dietician enters that information into the person's profile in the computer program used for meal planning, GeriMenu. GeriMenu is also used to generate the individual serving slips (called "meal tickets" by Home staff) necessary for plating HCF residents' food.

When a domiciliary care resident has dietary restrictions due to medical problems, B Clinic staff and the dietician meet with them to educate the person on why there are restrictions and what should be eaten. The resident, however, ultimately chooses what to eat.

Preparing and serving meals. Meals are prepared in a central kitchen, located in the main Residential Facility. Generally the same fare is eaten in the HCF as in the domiciliary dining room, which is adjacent to the central kitchen.²

¹ Domiciliary care residents agree at admission to have their belongings, living spaces, and motor vehicles subject to inspection.

² The dining hall is open from 6-8:30 a.m. for breakfast, 11 a.m. to 12:30 p.m. for lunch, and 4-6 p.m. for dinner.



Dining hall for domiciliary care residents



Dining hall service areas

Before each meal period, food to be eaten in the Health Care Facility is delivered to a smaller kitchen in that building. There, the meals are plated according to each resident's (and any visitor) dietary requirements and preferences. At that point, the meal trays are arranged on carts and delivered as necessary. Both kitchens are equipped with dishes, flatware, and a dishwasher.

On average recently, about 404 people are served per meal. This total includes:

- 238 domiciliary care residents;

- 124 Health Care Facility residents;
- 20 staff meals provided per union contracts; and
- 18 to 25 other staff, domiciliary care residents' visitors, and volunteers, who generally purchase their meals for \$4 and, unlike residents, are limited to an entrée (hot or sandwich bar), the salad bar, dessert, and a drink.

Although non-resident meals usually come at a price, there are some exceptions for Home residents' guests. For example, domiciliary care residents can have one visitor eat free every month, and two free guest meals on Christmas and New Year's.

Purchasing food and supplies. Staff survey the current stock before ordering goods for the next week's meals and nourishments (e.g., "Ensure" for some HCF residents), working off the inventory list and doing an actual examination as well. They order a combination of fresh and frozen food, though frozen food has not yet been cooked or otherwise prepared in any way. Ice cream and coffee for the domiciliary care lounge, the Winners Circle, is also handled by Food Services. Goods are acquired from the State of Connecticut's vendors, after Fiscal department review of purchase orders.³

Receiving and incorporating meal feedback from residents. The director and supervising chef gather residents' likes and dislikes by:

- attending Veterans' Council meetings frequently;
- doing rounds to solicit and receive opinions, which is sometimes done in the main dining room by the supervising chef, and done every weekday by a dietary technician in the HCF, who updates residents' GeriMenu pages with the information gathered; and
- making it known that residents are welcome to come into their offices, which are adjacent to the dining area, at any time.

Arranging for equipment repair when needed. The Home draws upon both its own campus-wide maintenance staff for a limited number of equipment repairs. If the in-house staff cannot fix the problem, the Food Services managers call the two maintenance and repair vendors. One is contracted to complete a monthly review of equipment condition, during which certain maintenance may be done.

³ The State's vendors are selected and overseen by a cross-agency food service advisory committee, on which all the agency food service directors sit.



One area of the main kitchen

Staff. Currently the Food Services operation is made up of:

- 26 staff and managers (including the director, whose title is “Supervising Chef”), who oversee and prepare meals, as well as meal clean-up;
- a dietician;
- a dietary technician;
- a storekeeper, who is the lead on inventory and stocking the Winners Circle; and
- an administrative assistant.

There are also about 15 veteran workers, evenly spread among the central kitchen, the dining room, and the HCF.

Medical Laboratory

Activities. The medical laboratory, located in the main Residential Facility next to B Clinic, performs a variety of tests for the care of domiciliary and HCF residents. It is equipped for hematology, clinical chemistry, urinalysis, therapeutic drug monitoring, and toxicology. The most common tests performed at the lab are complete blood count, alcohol and drug screens (which are required for some domiciliary care residents), and the basic and comprehensive metabolic panels.⁴ The DVA Business Office bills Medicaid and, less frequently, Medicare for covered tests the lab handles.

Samples are obtained onsite by laboratory staff. Domiciliary care residents’ samples are taken in the main Residential Facility, either in the B Clinic, when a lab phlebotomist is needed, or in the lab. Health care facility residents’ samples are taken in that building.

Certain tests are performed off-site by a contractor, Quest Diagnostics. These are tests that the lab’s director has determined as more cost-effective to contract out than to perform on-site, given the equipment needed. The cost analysis is monitored annually by the director, who

⁴ According to data provided by lab staff, for the period of February 2013 through January 2014.

then may work to adjust which tests are sent out. Currently the laboratory sends out samples for bacteriology, syphilis, coagulation studies, and blood typing. When such a test is needed, the sample is obtained by lab staff or delivered to the lab and picked up by Quest. Quest sends the results to the lab staff electronically.

Staff. Two full-time staff perform testing in the laboratory, which is open weekdays from 7:30 a.m. to 3:00 p.m. Staff are on-call for urgent and emergency situations during weeknights and during weekend days. There also are two part-time staff: a temporary phlebotomist/medical assistant, there during weekdays, and an office clerk with limited hours in the laboratory. The lab's director is the DVA Director of Planning, who holds a doctorate in hospital administration and is board-certified in healthcare management.

Pharmacy

Activities. The pharmacy's main task is to fill prescriptions ordered by the Home's doctors and APRNs. Accordingly, the pharmacy orders medications (maintaining an inventory), dispenses them, and prepares the carts used to deliver medications to the HCF units. The pharmacy piggybacks off the federal VA's pharmaceuticals contract with McKesson. It also acquires over-the-counter medications via purchase order with the DVA Business Office.

On average, from 300 to 400 prescriptions are filled daily. A four-week supply is given for each long-term medication, and the average HCF resident is taking approximately 12 of them – as well as 10 as-needed medicines. About 30 percent of the pharmacy's volume is prescriptions for domiciliary care residents. Domiciliary residents may use the pharmacy at no cost to them in any of three situations:

1. they are not covered by federal VA insurance, which in June 2014 was only a few residents;
2. the Home's medical staff has given them a prescription; or
3. they refuse to travel to the federal VA to see a healthcare provider.

The pharmacy also:

- supplies and rotates out an additional, limited amount of all its medications which are kept the HCF's locked medication rooms, located in each unit and in the HCF clinic;
- supplies and rotates out a small number of medications in the domiciliary care medical clinic (B Clinic);
- reviews HCF residents' medication charts monthly to ensure: 1) there are no irregularities in dosages, combinations, or interactions; and 2) the federal VA's electronic medical records regarding medications match the Home's records;

- approves domiciliary care residents' prescription renewals every 90 days (before B Clinic staff alerts the federal VA doctor that a refill is needed), which is not required but done for liability reasons; and
- conducts a quarterly study, focusing on a particular issue (e.g., ensuring a multivitamin is only prescribed when certain criteria are met), to improve medications that patients receive.

Particular medicines are delivered by a contractor, PharMerica Corporation. It provides:

1. intravenous drugs for hospice patients that the pharmacy cannot obtain from the wholesaler;
2. emergency delivery of time-sensitive medications when either: 1) the pharmacy has run out of them; or 2) the HCF medication rooms' supply has been exhausted and the pharmacy is not open, which is anytime outside of 8 a.m. to 3:30 p.m. on weekdays (except State holidays); and
3. certain specialty medications (e.g., eye or heart) that are not on the federal VA formulary.

The pharmacy recently began billing for some of its medications. Those costs used to be paid by the state DVA, as a Veterans' Home expense. Practically, there was some subsidization by the federal VA through: 1) whole-care payments for residents with a disability that is at least 70 percent service-connected; and 2) per diem payments for all other HCF residents. There also is subsidization through Medicaid and other revenues received by the Home's nursing care side. Since July 1, 2014, the pharmacy has been billing the federal VA for medications it fills for HCF residents whose disabilities are less than 70 percent service-connected, or who are not technically disabled at all. The change saved the Home \$21,000 in the first month, according to staff. The pharmacy does not directly bill Medicaid (e.g., for domiciliary care residents' prescriptions) or residents.

Staff. The pharmacy staff is composed of a pharmacist (35 hours weekly), a temporary pharmacist who was recently hired (25 hours weekly), and two pharmacy technicians (one for 30 hours weekly and the other for 35). In addition, two pharmacy students at a local college are unpaid interns (7 hours weekly for two), and there will be an additional short-term, full-time intern for half of the Fall 2014 semester.