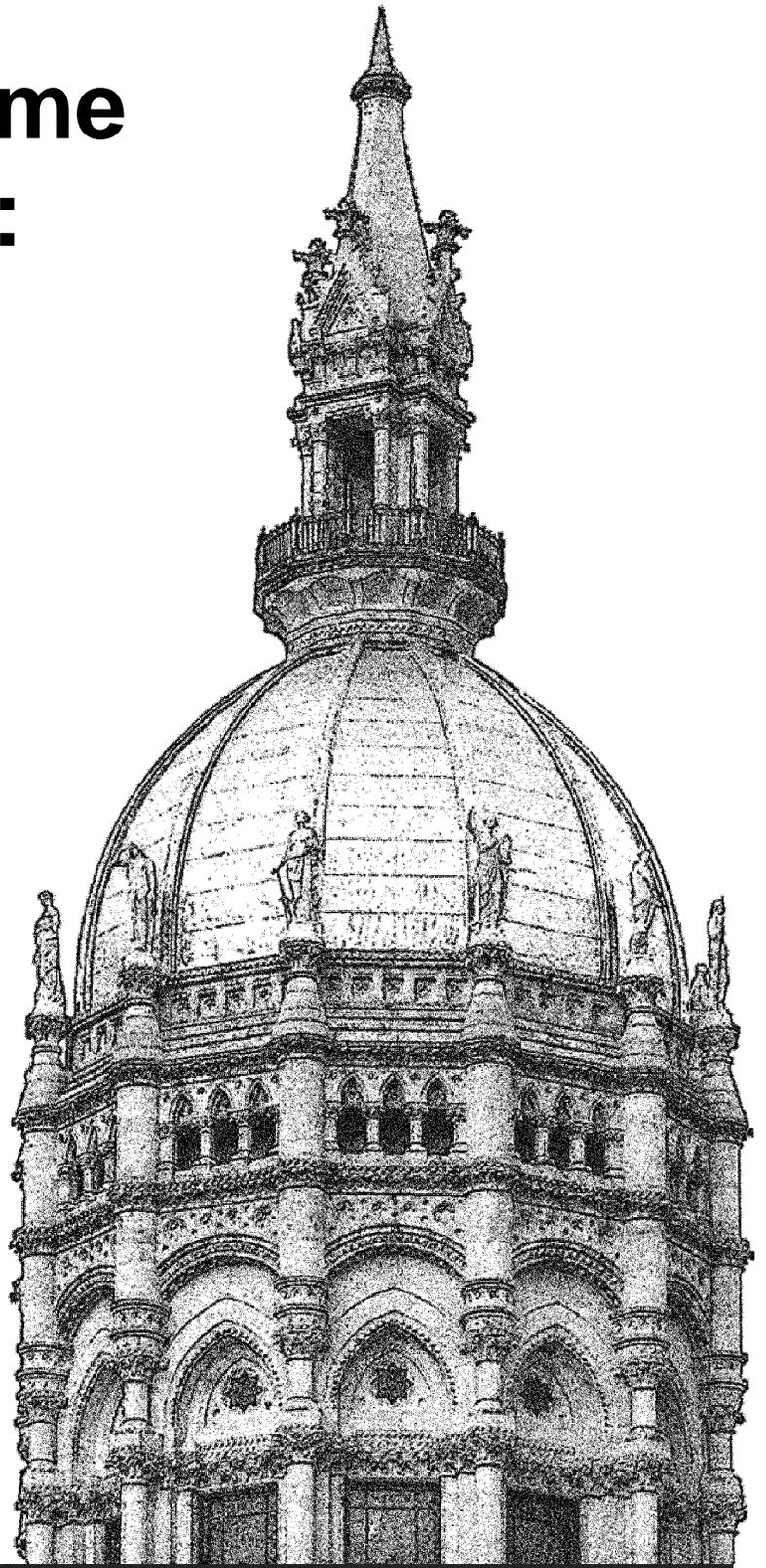


Veterans' Home at Rocky Hill: Residential Services

December 2014



PRI

**Legislative Program Review and
Investigations Committee**

Connecticut General Assembly

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a bipartisan statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and in 1985, it gave the committee the authority to raise and report bills. In 1977, the committee also acquired responsibility for “sunset” (automatic program termination) performance reviews. The state’s sunset law, however, was amended in 2012; PRI is still involved, but the legislature’s subject matter committees have roles as well.

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& INVESTIGATIONS COMMITTEE

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Residential Services

DECEMBER 2014

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Veterans' Home at Rocky Hill: Residential Services

Background

In May 2014, the program review committee authorized a study to evaluate the Connecticut State Veterans' Home's operations and effectiveness.

The Home offers veterans 24-hour nursing care (similar to a nursing home) as well as domiciliary care. Domiciliary care consists of shelter, food, and services intended 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.

Most domiciliary care residents live in the main Residential Facility. Others participate in a residential substance use treatment program with separate housing, live somewhat independently in campus apartments for a short time, 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). It accounted for 97 percent of the department's budget in FY 14, with a total cost of nearly \$28 million.

To complete this study, the committee's staff: interviewed Home and DVA personnel; obtained residents' views, mainly through surveys and public hearings; observed certain Home staff meetings and a DVA Board of Trustees meeting; reviewed a variety of documents and websites; analyzed data provided by DVA and the federal Department of Veterans Affairs (VA); communicated with several other state agencies' staff, multiple VA personnel, and some managers of other states' homes; toured a few other veteran housing options; and interviewed a number of advocates, researchers, and service providers involved with veteran housing / homelessness issues at the state and national levels.

Main Findings

The Home's major domiciliary care program has the goal of helping residents successfully move to independent housing, but not the features needed to support that goal. For example, currently there is one full-time equivalent social worker for every 96 residents at the Home, when the generally accepted ratio is 1:25. Only about 10 percent of residents are satisfied with how well the Home staff has helped them try to find employment or housing.

Domiciliary care has become permanent housing for many residents, but its rules approach, accommodations, and services are inadequate for permanent supportive housing. Roughly 60 percent of residents have lived at the Home longer than three years; overall about half have been there at least five years. About one-quarter of the residents do not intend to leave. They must live with the same restrictive rules and lack of personal space (12-person rooms) as the short-term residents.

Demand is low for the Home's domiciliary care, for many reasons. The federal VA has boosted resources to prevent homelessness, which combined with its policy shift toward permanent housing, may be translating into fewer referrals from VA staff. Others may not want to live there because of strict rules and/or the campus's institutional feel. The recent upswing in the economy may mean fewer veterans need the Home.

The Home's Health Care Facility's quality is strong. The facility performed well on recent federal and state inspections, which are more thorough than for domiciliary care (due to being a long-term care facility). Residents generally are satisfied. Recent direct care staffing changes, however, could impact quality, and need to be closely monitored.

The Home has been isolated and deficient in oversight, program monitoring, public relations, and vision. The Home's shortcomings have gone largely overlooked due to limited attention to performance by the Board of Trustees and the legislature. Antiquated data systems and other data problems have also contributed.

PRI Recommendations

Many recommendations are made to strengthen the Home's services and sustainability, as well as improve residents' lives. The recommendations, centered around five key goals, would:

1. **Transform the Home's domiciliary care into transitional and permanent supportive housing**, in terms of program design, staffing, rules, responsibilities, fees, and accommodations;
2. **Ensure the Home's substance use treatment services are high-quality and possibly accessible to more veterans;**
3. **Maintain quality at the Health Care Facility; and**
4. **Improve collaboration, oversight, program monitoring, and opportunities for residents' views to be heard.**

Acronyms

CMS	Centers for Medicare and Medicaid Services
CY	Calendar year
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DVA	(State) Department of Veterans' Affairs
FFY	Federal fiscal year
FY	(State) fiscal year
GPD	Grant and Per Diem
HCF	Health Care Facility
HPPD	Hours per patient day
HUD-VASH	U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing
PHA	Public housing agency
PRI	Program Review and Investigations Committee
PSH	Permanent supportive housing
RAP	Rental Assistance Program
RBA	Results-Based Accountability
RPP	Residential Plus Program
SSVF	Supportive Services for Veteran Families
VA	(Federal) Department of Veterans Affairs
VIP	Veterans Improvement Program

Recommendations

Veterans' Home at Rocky Hill: Residential Services

Domiciliary Care Overall

1. The Department of Veterans' Affairs should replace its current general domiciliary program at the State Veterans' Home with two separate programs that resemble transitional housing and permanent supportive housing.
2. The Department of Veterans' Affairs should determine the number of staff needed to fully implement the recommended programs, including case managers / social workers, employment specialists, and behavioral health staff. The department should consider partnering with staff from other state agencies and nonprofits. The DVA should then pursue the necessary resources.
3. All current residents of the Veterans' Home's domiciliary care (except for those in the Patriots' Landing program) should be fully assessed and given the option to move out of the Home via a federal Department of Veterans Affairs program. Those who choose to stay at the Home should decide whether they would like to be in its transitional housing or permanent supportive housing program. Once the programs are active, the residents would need to comply with the applicable program rules.
 - a. Home residents should actively participate in an assessment process, which should be done in-person by a team of contracted case managers who work for the VA and/or nonprofit agencies offering case management services to homeless veterans. Each resident should have an assigned case manager.
 - b. The assessment should be based on a common information gathering tool. The tool should include:
 - i. education, work history, and particular skills, licenses, certifications, or training;
 - ii. financial resources;
 - iii. overall physical and mental health, including any diagnosed disabilities;
 - iv. ability to complete activities of daily living, including the ability to self-administer medication;
 - v. external supports;
 - vi. current length of stay at the Home; and
 - vii. housing preferences, after first receiving: a) an in-person, one-on-one explanation of federal VA transitional and permanent supportive housing options; b) a description of the Home's new programs; and c) the results of the assigned case manager's recommendations.

- c. The assigned case manager should recommend to the resident the type of VA program for which the person is best-suited and which of the Home's new programs is appropriate for the person (transitional housing or permanent supportive housing). Using this information, each resident should choose his or her living arrangement.
4. New applicants to the Veterans' Home should submit a modified version of the assessment for current residents (in addition to an admissions application), including a program preference (for either transitional housing or permanent supportive housing). Based on the assessment, the Home staff should recommend the most appropriate program to the resident. As part of the admissions process, and on the Home's website, the DVA should also give the applicants information on federal VA housing options.
5. The DVA should consider what behavioral health and other staff resources may be necessary in order for the Veterans' Home to accept applicants with more-recent psychiatric problems. The DVA should communicate closely with the federal Department of Veterans Affairs and the Connecticut Department of Mental Health and Addiction Services to develop an analysis. The analysis should be delivered to the Board of Trustees and the legislative committees of cognizance by June 1, 2015.
6. Each Veterans' Home domiciliary resident should have a semi-private or private room, with the room's own door. If semi-private rooms are done, residents should be assessed for compatibility and their personal preference (e.g., if the person would like to have a certain resident as a roommate) and then grouped accordingly.
7. The Department of Veterans' Affairs should eliminate the Veteran Worker and Detail programs. Prior to the elimination, the DVA should assess the overall need of each position currently in the programs. The DVA should consider working with the Department of Administrative Services and/or the Office of Policy and Management, or a contracted firm, to conduct the analysis. The analysis should determine which positions will be:
 - a. Converted to state employee positions through a standard, public recruitment process that gives a hiring preference to current Veteran Workers;
 - b. Converted to time-limited paid state internship or apprenticeship-type positions, for the Home's transitional housing participants, with the expectation of attendance and a limited amount of sick time; or
 - c. Eliminated, possibly through assigning small tasks to all Home residents (e.g., up to one or two hours weekly).
8. Regarding the Veterans' Home's current "program fee" and DVA's Institutional General Welfare Fund, which houses the program fees, the Department of Veterans' Affairs should:

- a. Beginning in the 2015 calendar year, a new resident's first month at the Home should remain free. The fee should be applied for every month thereafter. Veterans who are admitted to the Home before 2015 will continue to have a free first three months.
 - b. For transitional housing residents:
 - i. Specify that the fee is a "resident care fee" and maintain the current level of \$200 for the 2015 calendar year.
 - ii. Effective January 1, 2016, the transitional housing resident fee level should be annually adjusted for inflation. A fee waiver can be requested at any time, based on the Home's current waiver process, and a waiver should be approved if a resident's income falls below three times the fee level. Each waiver is valid for six months.
 - c. For permanent supportive housing residents, replace the program fee with an income-based resident care fee, effective January 1, 2016. The income should be determined after subtracting for taxes and court-ordered payments. The fee should be 30 percent of adjusted income.
 - d. Provide transparency regarding the Institutional General Welfare Fund by formally sharing with all residents a semiannual, plain-language summary of how the Fund is used in accordance with state law (to "directly benefit veterans or the Veterans' Home").
 - e. Provide the opportunity for residents to make suggestions on projects for which they would like to see the Institutional General Welfare Fund used. Residents' input should be requested at least semiannually.
9. The Veterans' Home should frequently and routinely (e.g., weekly) offer classes on life and vocational skills, such as establishing a bank account, budgeting, searching for jobs online and through networking, navigating federal VA services, interviewing for jobs, and cooking. The Home should consider opening these classes to veterans in the general public, and assess its equipment to determine whether additional resources are needed. The Home should also seek out volunteers to conduct the classes.
 10. The Veterans' Home should offer and publicize increased volunteer opportunities for the public on-campus, including at the main Residential Facility, and for veterans in the community.
 11. The Veterans' Home should make the following changes to its security procedures for domiciliary residents:
 - a. Domiciliary residents who intend to leave the campus should sign out using a log in their building each time they leave campus, noting whether they intend to return that day or a following day. No permission should be needed to leave the campus.
-

- b. The Home should transition to a swipe-card door-locking system for its main Residential Facility and Fellowship House. Upon the transition, a resident should no longer be required to swipe a Home identification card at the campus entrance security building, in order to leave or return to campus, and the identification card should open the vehicle gate.
 - c. The Home should discontinue the mandatory visual package and vehicle inspections done when a resident re-enters campus. An inspection may be done when there is reason to believe a resident is bringing a prohibited item onto campus. Written guidelines should be established by DVA regarding what constitutes “reason to believe” and then distributed to each resident.
 - d. Residents should be allowed to use their personal vehicles from their first day at the Home. Permits should be issued within a resident’s first week at the Home and remain valid until the person moves out of the Home.
12. The pass restriction system for handling rule violations should be replaced with the following system as of January 1, 2015:
- a. The first violation should result in an immediate meeting (within one working day) between the resident and his or her case manager / social worker and employment specialist. The meeting should involve discussion of the incident, the underlying reason(s) the incident occurred, consequences for subsequent violations, and the resident’s plan to avoid or correct the behavior.
 - b. The second violation should result in a similar meeting as the first, but include the domiciliary care administrator and the staff should emphasize that the third offense results in immediate discharge.
 - c. The third violation should result in discharge, appealable to the DVA commissioner. As is current practice, staff should assist the resident in locating a place to live.

Transitional Housing Program

13. The Veterans’ Home’s new transitional housing program should have the following components to ensure a focus on successfully discharging residents to independent living and encouraging personal responsibility:
- a. New residents should have a stay limit of nine months in the transitional program.
 - i. If a resident reaches the seven-month point, there should be a meeting with the person’s case manager / social worker, the employment specialist, and B Clinic personnel to determine what steps need to be taken should the person reach the nine-month stay limit. All options, including entirely independent housing, federal VA programs, and the Home’s programs, should be fully discussed and considered. The resident should select two

preferences and, working with the case manager, aggressively pursue them.

- ii. If, at the nine month point, alternative housing has not been found, a three-month stay extension is possible upon resident request to the program director. The program director should solicit staff opinions from each supportive services area when making the decision.
- b. Current residents in the transitional housing program should have a two-year stay limit.
- i. If, by the twentieth month in the program, a resident is employed and/or enrolled in education or training for at least 30 hours per week, the resident should have the ability to stay in the transitional program for an additional year.
 - ii. If a current resident reaches the 21-month point, there should be a meeting with the person's case manager / social worker, the employment specialist, and B Clinic personnel to determine what steps need to be taken should the person reach the 24-month stay limit. All options, including entirely independent housing, federal VA programs, and the Home's programs, should be fully discussed and considered. The resident should select two preferences and, working with the case manager, aggressively pursue them.
- c. A veteran may participate in the transitional housing program twice, either consecutively or at two separate times. If a veteran is approaching the time limit of a second round in the transitional housing program, and prefers to stay at the Home, the resident should move to the permanent supportive housing program.
- d. Discharge planning should begin on the day of admission, including meetings with the person's case manager / social worker and employment specialist.
- e. There should be clear, unified messages from all staff that the resident will leave the program at the specified time limit and needs to spend the time in the program finding employment, pursuing education and/or training, acquiring benefits (including housing benefits), and locating housing options, as appropriate. Staff should project a positive attitude regarding living independently in the community and not use the time limits in any negative manner against residents.
- f. Each resident should meet at least weekly with the person's social worker / case manager. There should be a maximum ratio of one social worker / case manager for every 25 residents. Each resident should also meet at least weekly with an employment specialist if not enrolled in education or training. Those who are enrolled should meet at least monthly with the employment specialist.
- g. There should be a monthly meeting for each resident that includes the person's social worker / case manager, employment specialist, and B Clinic nurse; the

resident must attend. The first such meeting should occur within the person's first week.

- h. When veterans move to independent living, the social worker / case manager should remain in contact and open to assisting the former resident for up to one year. At minimum, the social worker should collect information every three months (including at 12 months after discharge from the Home) on employment and education status, treatment services, and housing type.
- i. Upon discharge for a violation, or upon voluntarily leaving the Home to avoid a third offense, a resident should be allowed to re-enter the program after three months have passed, if the person has not previously participated in the transitional housing program.

Permanent Supportive Housing Program

- 14. The Veterans' Home's new permanent supportive housing program should have the following components to recognize the long-term nature of some residents' stays and encourage independence:
 - a. Each resident's social worker / case manager should reach out to the veteran at least weekly; participation in supportive services is the resident's personal choice. The social worker / case manager should monitor the person's well-being and assist in improvement. The social worker / case manager should encourage the resident to attend life skills classes and apply for independent housing programs, such as HUD-VASH and other options. There should be a maximum ratio of one social worker / case manager for every 35 residents.
 - b. The Home should work to place these residents in a separate building(s) from transitional housing residents (e.g., one side of the main Residential Facility); at minimum, in the short-term, they should be on separate floors. In the long-term, the Home should place its permanent supportive housing residents in studio or one-bedroom apartments.
 - c. Once the permanent supportive housing residents are in a separate building(s), all rules not involving building and personal safety should be eliminated. There should be a set of rules specifically for residents of the program, mirroring a typical apartment or house lease agreement. A process should be established for eviction if rules are seriously or repeatedly broken. The DVA should develop guidelines for what offenses or accumulation of offenses may result in eviction. Evictions should be appealable to the Board of Trustees. Readmission should be allowed once, no earlier than six months later, for those required to leave.
 - d. There should be a tenants' association, which should meet monthly, to: review program rules and offerings; make suggestions on rules, program offerings, accommodations, and other aspects of the permanent supportive housing program;

and receive complaints from residents. The tenants' association should provide a detailed annual report of its activities to the Board of Trustees.

- e. Residents should be encouraged to attend group recreational activities designed to meet their interests, and may choose to use the Home's on-site medical services (B Clinic) as well as its Dining Hall. Once a permanent supportive housing resident has access to a kitchen with a working stove, the person can choose to use the Dining Hall as a guest, which should include payment.
- f. The Home should consider starting a compensated work therapy program, modeled after the best practices of such programs, for its permanent supportive housing residents.

Substance Use Treatment Services

- 15. The Department of Veterans' Affairs should develop and implement a plan by January 1, 2016, to improve its substance use treatment services, as currently provided at the Veterans' Home's Fellowship House.
 - a. As part of the plan's formulation, DVA should work intensively with the Department of Mental Health and Addiction Services, the Department of Public Health, the federal Department of Veterans Affairs, veteran organizations, and substance use recovery organizations.
 - b. The plan should be based on evidence-based and best practices for substance use treatment.
 - c. The plan should consider:
 - i. all aspects of the Home's residential substance use treatment program;
 - ii. how the Home can best serve its many residents who are in recovery but do not live in Fellowship House; and
 - iii. whether DVA should offer any substance use treatment to Connecticut veterans in the community who may wish to participate in veteran-specific substance use treatment, and the resources that would be required to take that step.
 - d. The plan should also include:
 - i. Clear missions for all substance use treatment programs envisioned;
 - ii. Performance measures, including but not limited to participant satisfaction and outcomes, for all programs; and
 - iii. How the program staff will collect data on the performance measures.

Health Care Facility

16. The Health Care Facility should continue to track its overall performance and work toward continuous improvement regarding resident care and safety. The DVA commissioner and Board of Trustees (and regulators) should carefully monitor direct care staffing levels at the facility to ensure its performance is not compromised in any way as a result of cost reduction measures.
17. The Department of Veterans' Affairs should conduct a full needs assessment of its long-term care program to determine if action is necessary to help alleviate capacity concerns and increase the availability of respite care at the Health Care Facility. At minimum, the assessment should examine whether the use of off-site short-term rehabilitation services for domiciliary care residents offers a pragmatic solution. The department should present its findings to the Board of Trustees by July 1, 2015.

Leadership

18. DVA should fully coordinate and collaborate with key stakeholders who focus on veteran issues, particularly affordable housing for veterans, to identify ways to continually improve the Veterans' Home's services using evidence-based approaches and best practices. As part of this effort, the department should develop a stronger working relationship with the federal VA in Connecticut to better understand the VA's housing programs for veterans, while providing the VA an opportunity to more fully understand the Home's programs.

Residents Aging in Place

19. The Department of Veterans' Affairs should work with its Board of Trustees on devising a strategy and program to address the issue of residents who are aging in place. A well-designed plan should be developed by October 1, 2015. A summary of the plan should be forwarded to the department's legislative committees of cognizance, and included in the board's 2015 annual report. If needed, additional resources should be requested of the legislature.

Performance Oversight and Monitoring

20. The Board of Trustees should be strengthened in the following ways:
 - a. All current and new board members should fully understand and work toward their role to advise and assist the commissioner on the Home's programs, services, and administration. Members should request the necessary information from the department to appropriately monitor the Home's overall progress towards meeting its missions and the department should provide the information in a timely manner.

- b. The board should develop (and submit to the legislature and governor) an annual report by February 15 of its previous calendar year's activities. At minimum, the report should include the Home's progress in fulfilling its mission based on programmatic outcomes.
 - c. A full complement of members should be appointed to the board by March 1, 2015. The appointing authorities should continue to ensure members are appointed in a timely way when vacancies occur.
 - d. The governor should appoint a chairperson, other than the DVA commissioner, from among the members of the board. The chairperson should have the authority to call meetings of the board, as should a majority of the board membership.
 - e. Beginning January 1, 2015, any board member who fails to attend three consecutive meetings or who fails to attend 50 percent of all meetings held during any calendar year should be deemed to have resigned from the board.
 - f. Board membership should include one veteran from each of the Home's permanent and transitional housing programs, and long-term care facility. The members should be elected yearly, or upon a member's resignation, by fellow residents, and serve in a non-voting capacity on the board.
 - g. All meeting notices, minutes, and reports of the board should be prominently posted on the department's website (and provided in accordance with all current statutory requirements). The information should be kept current, with meeting minutes posted to the website within seven days after each board meeting (with an indication that they are considered "draft" until approved by the board). Any historical information pertaining to the board – dating back to at least January 1, 2012 – also should be posted.
21. The Department of Veterans' Affairs should establish an internal workgroup to examine the overall capacity of the department's management information system. The workgroup should include agency leadership, program managers, and the Department of Administrative Services. The group should review the program data currently collected by program managers and the system(s) used to collect the data. The group should develop appropriate measures to gauge programmatic implementation and outcomes and ensure the data necessary to support such examination is collected and maintained. Once the workgroup's review is completed, it should report its findings to the department's Board of Trustees.
22. Beginning January 1, 2016, and annually thereafter, the department should develop an annual Results-Based Accountability-style report card to fully capture its performance based on RBA principles. The report card should be promptly distributed to the Board of Trustees and the legislature's committees of cognizance, and posted on the department's website.

Veterans' Home at Rocky Hill: Residential Services

The Connecticut State Veterans' Home provides domiciliary and 24-hour nursing care to eligible veterans on its 90-acre Rocky Hill campus.¹ Domiciliary care generally consists of housing, food, day and evening outpatient nursing care when needed, and some social services. Within domiciliary care, the Home has three distinct programs, including a residential substance use treatment program.² Long-term nursing care is delivered by the Home's Sgt. John L. Levitow Health Care Center, also known as the Health Care Facility (HCF). The facility is a state-licensed Chronic Disease Hospital, and similar to a skilled nursing facility in many ways. The Home's federally-authorized domiciliary capacity is 488 residents, and the HCF's capacity is 125.³

The Veterans' Home is operated by the state Department of Veterans' Affairs (DVA). It is, by far, the agency's largest expenditure, costing \$27.9 million (97 percent of DVA's \$28.8 million total budget) in FY 2014. The DVA's other programmatic expenditures are the State Veterans' Cemeteries and the Office of Advocacy and Assistance, which were not reviewed in this study. The department's main administrative office is located on the Home's grounds. The Veterans' Home is funded by the state and federal governments, its residents, and private donors.

The Rocky Hill home was the first state veterans' home in the country. Currently, each state has a home, and there are 149 nationally.⁴ Among them, 140 offer nursing home-like care, 54 provide domiciliary care, and two have adult day programs.^{5,6}

Study Scope

In May 2014, the Legislative Program Review and Investigations Committee (PRI) voted to evaluate the Veterans' Home's operations and effectiveness. The original intent of the study

¹ The statutory eligibility criteria are: 1) serving actively in the Armed Forces; and 2) exiting service honorably or "under honorable conditions." Active service means full-time duty in the U.S. Army, Navy, Marine Corps, Coast Guard, Air Force, and/or the Connecticut National Guard. Reserves are included, as is service with wartime allies. Types of full-time duty that do not qualify are training, cadet service, or training service during which the person was injured, according to U.S. Code. Due to the wording of the state statutes, Connecticut residency does not seem to be required. See C.G.S. Sec. 27-108(a), with reference to C.G.S. Sec. 27-103(a). Connecticut residency is addressed in C.G.S. Sec. 27-108(b), which involves veterans who are entitled to Armed Forces retirement pay, but not the admissions criteria for the Home.

² One of the programs, Patriots' Landing, does not offer food and nursing care to inhabitants. This program is new and very small, limited to residents of five single-family houses located across from the main campus (the West Street Houses).

³ Although the authorized domiciliary capacity is 488, the actual capacity based on the facilities currently used is slightly smaller, at 456.

⁴ Including the District of Columbia and Puerto Rico.

⁵ Delanko, JoAnne, and Parker, Valerie, "2014 State Veterans Homes – VA Survey Deficiency Overview," U.S. Department of Veterans Affairs Office of GEC Operations, presentation at the 2014 National Association of State Veterans Homes (NASVH) summer conference (July 27-August 1) in Charleston, South Carolina. <http://www.nasvh.org/Conferences/conferenceLinks.cfm> (accessed August 26, 2014).

⁶ Adult day programs offer group care for people who need some assistance but not full-time nursing care.

was to assess many aspects of the Home, including its admissions, complaint, and discipline processes, overall performance, and occupancy. A committee staff update report in October 2014 included relevant background information in many of these areas (see Appendix H for the entire update). However, as the study progressed, more fundamental, pressing issues became clear to the program review committee, particularly on the domiciliary side of the Home. Thus, while current operations remained of significant interest, the committee determined to focus its time on more fully identifying and addressing those critical issues.

Research Methods

This study relied on many sources. To learn about operations and conditions at the Home, committee staff had numerous conversations with the Home's staff, requested and analyzed data, examined various documents, and reviewed:

- 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).

Committee staff discussed the study with more than 30 DVA and Veterans' Home managers, staff, and union leaders. Home personnel provided data, policies and procedures manuals, federal and state inspection results, and program-related documents. Committee staff observed Home admissions decision meetings, one each for domiciliary care and nursing care, and the DVA's 2014 Stand Down event.⁷ Discussions with personnel from Chrysalis Center, Inc., the nonprofit agency contracted by the Home to provide services to residents in a small domiciliary program, also occurred.

Committee staff spoke with numerous Home residents, mainly at a meeting to explain a domiciliary care survey the residents would soon receive, during resident council meetings, and at survey collection times. Home resident views were also elicited through two public hearings held by the committee (including one at the Veterans' Home) and original surveys, including in-person, on-site discussions with HCF residents.

Tours of the Home's buildings were provided to committee staff and committee members (staff also toured unoccupied buildings). Staff observed a DVA Board of Trustees meeting and spoke with several board members. Discussions with personnel at the state Departments of Public Health, Labor, Mental Health and Addition Services, and Consumer Protection, as well as with federal VA staff, also helped provide information for the study.

⁷ 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 attend. The services range from dentistry to a traffic "court". Some donated goods are also distributed by collecting nonprofits.

To understand the Veterans' Home's outreach, perception among Connecticut providers of services related to veterans and/or housing, and how the Home fits within the context of those other services, committee staff interviewed personnel from:

- four veteran service organizations (American Legion, Vietnam Veterans of America, Disabled American Veterans, and Veterans of Foreign Wars);
- three housing and homelessness organizations (Connecticut Coalition to End Homelessness, Connecticut Housing Coalition, and Partnership for Strong Communities);
- CT Heroes Project;
- Homes for the Brave/ABRI, which provides transitional and permanent supportive housing for veterans through federal programs;
- Community Renewal Team, which provides transitional housing for veterans via a federal program, among many other social services; and
- Errera Community Care Center (part of the federal Department of Veterans Affairs, or VA, behavioral health services in Connecticut), including VA homeless services.

Committee staff also:

- had discussions with the point-person of the Governor's Working Group charged with examining the Veterans' Home;
- toured permanent supportive housing at Victory Gardens, an affordable housing development on the campus of the Newington VA Medical Center;
- toured two buildings offering transitional housing for veterans, Homes for the Brave in Bridgeport and Veterans' Crossing in East Hartford; and
- surveyed Connecticut municipal veteran contacts via an online survey method.

To understand national programs related to housing veterans and the state veterans' homes, committee staff spoke with people from:

- two advocacy organizations (the National Alliance to End Homelessness and the National Coalition for Homeless Veterans);
- the National Center on Homelessness Among Veterans, which is a federal VA organization that researches veteran homelessness and federal veteran homelessness programs, and also disseminates best practices;
- the federal VA's state homes inspection management unit and government liaison office; and
- multiple previously mentioned organizations.

The federal VA government liaison office and the federal VA in Connecticut shared some data regarding the state veterans' homes and federal veteran housing programs.

To learn about other states' veterans' homes, committee staff selected the ten largest-capacity domiciles (as well as another, due to its proximity to Connecticut) and researched them. For several states, sufficient information was located on the Internet. For others – certain homes

in Massachusetts, Minnesota, and Pennsylvania, as well as Rhode Island's sole home – committee staff had telephone conversations with high-level personnel.

It should be noted there was a change in DVA commissioners during the course of the committee's study. The change occurred in late September 2014, when the current acting commissioner (who had been the deputy commissioner) took over from the previous commissioner, who headed the agency since 2003.

Report Organization

This report has five chapters and eight appendices.⁸ Chapter I explains the federal programs for housing veterans and discusses approaches to housing homeless people to help provide context for how Connecticut operates its Veterans' Home's residential services. Chapter II assesses the Veterans' Home's domiciliary care, including comparisons to relevant federal programs and other states. Chapter III presents recommendations to overhaul domiciliary care at the Home. Chapter IV provides findings and recommendations for the Home's nursing care facility, which intend to ensure quality care continues to be provided. Chapter V describes some problems that impact both domiciliary and nursing care at the Home, and issues recommendations to solve them.

The report's appendices are: (A) information on Housing First, an approach to housing homeless people; (B and C) Connecticut-specific data for two federally-funded programs for homeless veterans; (D and F) methods and results of the program review committee staff surveys of domiciliary residents and town veterans' issues liaisons; (E) domiciliary resident rules; (G) some information on other states' domiciliary care; and (H) the committee staff's October update on study progress, which includes relevant background information about the Veterans' Home.

Agency response. It is the policy of the Legislative Program Review and Investigations Committee to provide agencies studied by the committee with an opportunity to review and comment on committee findings and recommendations prior to publication of the final report. A written response was solicited from the state Department of Veterans' Affairs. The department's formal comments are provided in Appendix I.

⁸ Nearly all photographs in the report were taken by PRI staff with the permission of DVA personnel; the remaining few photographs used were from other sources (a consultant's study of the facilities' condition, and a DVA brochure), and those instances are noted.

Veteran Housing: Federal Approach

To help provide context for how Connecticut operates its Veterans' Home and for the committee's assessment and recommendations regarding the Home's domiciliary care provided in Chapters II and III, this chapter discusses the current federal government's approach to housing veterans who are either homeless or at risk of homelessness. The federal approach for housing homeless veterans – and homeless people, generally – is moving away from the traditional time-limited “housing readiness” strategy. That model focuses on treating the underlying cause(s) of a person's homelessness, such as mental illness, substance use, unemployment, or physical disability, while the person is in “transitional housing.”¹ Once the issue(s) has been addressed, the goal is for the veteran to move to permanent housing, either with or without supportive services.

In contrast, the new federal approach, based on what is called the Housing First model, offers quick placement in permanent housing – or support to maintain such housing – without any preconditions.² It is generally paired with the short- or long-term services necessary to maintain independent living. This policy shift was signaled by the passage of two federal acts in 2009.³ The two laws placed greater emphasis on homelessness prevention and rapid re-housing of people into permanent housing. The laws also underscore that homelessness services should view independent housing as the first goal, not as something that needs to be earned.

The goal for most people is to live independently. For individuals who want to live on their own but still need long-term social services, “permanent supportive housing” (PSH) is an alternative. This option combines permanent housing with permanent supportive services to help enable independent living. Permanent supportive housing is offered in single-site housing, whereby residents live and receive services in a particular building(s), and individual scattered-site apartments in the broader community.⁴ Single-site PSH can involve either private rooms with shared kitchens or personal apartments.

Permanent supportive housing, based on the Housing First model, became a national strategy in 2010, when *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* was put forth.⁵ The plan, which includes the federal VA's roadmap for ending

¹ The length of time someone can stay in transitional housing varies; there is 24-month maximum stay for veterans in transitional housing under VA requirements.

http://www.va.gov/HOMELESS/docs/GPD/GPD_Final_Rule_38CFR61_02-25-2013.pdf (accessed November 16, 2014).

² Additional description of the Housing First approach is provided in Appendix A.

³ Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH), and the stimulus law, which included the Homeless Prevention and Rapid Rehousing Program (HPRP).

⁴ While basic tenant rights are afforded participants, personal accountability is expected, such as paying rent on time and abiding by landlord rules. If a tenant does not fulfill those responsibilities, sanctions may be imposed, including eviction.

⁵ Connecticut has adopted the federal goal of ending homelessness among veterans. See:

<http://www.governor.ct.gov/malloy/cwp/view.asp?A=4010&Q=539758> (accessed November 4, 2014).

homelessness among veterans by 2015, specified “the research is clear that permanent supportive housing based on a Housing First approach is the primary solution for helping people experiencing chronic homelessness.”⁶ Permanent supportive housing and Housing First are considered evidence-based practices for eliminating homelessness.^{7,8}

Despite the federal government’s embrace of this new approach, not all service providers agree the strategy can, by itself, eradicate homelessness. Some contend the traditional “housing readiness” approach is a necessary supplement to the newer Housing First strategy, and is more appropriate for certain people.

The federal VA has three major housing programs that use either the Housing First or the housing readiness models, and these are described below. Two of the programs – HUD-VASH and Supportive Services for Veteran Families – follow the newer Housing First model to quickly house veterans,⁹ while the third program – Grant and Per Diem (GPD) – is a long-standing VA program operating on the traditional housing readiness model.

HUD-VASH

The VA and the federal Department of Housing and Urban Development (HUD) have combined efforts to create a program for homeless veterans – including those with severe psychiatric issues, substance use disorders, and/or physical disability – and their families to move them from homelessness to permanent supportive housing.¹⁰ The program’s overall purpose is to help the most vulnerable and chronically homeless veterans, including those in shelters, emergency rooms, and inpatient mental health treatment programs, obtain and retain permanent supportive housing.

What is it? The HUD-VA Supportive Housing program gives veterans HUD’s Housing Choice Vouchers (i.e., “Section 8”) for rental assistance, as well as case management and clinical services through a local VA medical center. Rental vouchers are distributed by HUD to individual public housing agencies (PHAs). The PHAs number of vouchers is determined

⁶U.S. Interagency Council on Homelessness, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, Washington, D.C., 2010. http://usich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf (accessed October 22, 2014).

⁷Evidence-based programs have strong research demonstrating repeated success at reaching specific outcomes across a variety of settings or locations (See: Hannah G, McCarthy S, Chinman M. (2011). *Getting To Outcomes in Services for Homeless Veterans: 10 Steps for Achieving Accountability*; and National Center on Homelessness Among Veterans. http://www.va.gov/homeless/nationalcenter_additional_information.asp, accessed November 4, 2014).

⁸Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Permanent Supportive Housing: The Evidence*, 2010. <http://www.samhsa.gov> (accessed November 2, 2104); and United States Interagency Council on Homelessness, *Housing First*. http://usich.gov/usich_resources/solutions/explore/housing_first (accessed November 4, 2014).

⁹Montgomery, AE., Hill, L., Kane, V., Culhane, D., *Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-VASH*. The National Center on Homelessness Among Veterans, March 2013. http://works.bepress.com/cgi/viewcontent.cgi?article=1153&context=dennis_culhane (accessed November 14, 2014).

¹⁰ The program officially began in 1992, releasing just under 1,800 vouchers. It remained relatively stagnant until 2008, when it began distributing thousands more vouchers (and using a Housing First approach instead of the previous “housing readiness” model); over 60,000 vouchers currently exist nationwide.

through a collaborative effort between HUD and VA that relies on specific data to calculate geographic need.¹¹

HUD-VASH uses a somewhat modified Housing First approach. The program does not require a set period of sobriety or engagement in any sort of treatment prior to receiving a voucher, but it does require participants to agree to case management.¹² The other eligibility criteria are that the veteran must:¹³

1. meet the federal definition of homelessness;¹⁴
2. not be on the state's lifetime sex offender registry;
3. be able to perform activities of daily living and live independently; and
4. be eligible for VA healthcare.

Eligibility determination is a joint effort between the VA medical center and public housing agency serving the veteran applying for the voucher.¹⁵ Once in the program, veterans are expected to participate in case management and use the support services, treatment recommendations, and assistance needed to successfully maintain recovery and sustain housing in the community. The program attempts to maintain a 1:25 ratio of case managers to veteran households.¹⁶

The voucher, and any accompanying supportive services, is considered permanent unless the veteran voluntarily relinquishes it, dies, or otherwise is forced to surrender it due to not following the program's requirements, including refusing case management services without good cause.¹⁷ Families may be offered a "regular" Housing Choice Voucher, if one is available, instead of the HUD-VASH voucher, as a way to free-up the HUD-VASH voucher for another veteran. The supportive housing vouchers for veterans are portable, within certain guidelines. Veterans receiving HUD-VASH can live in various types of housing, including private-market, housing owned by non-profit agencies, or public housing.

¹¹ The data used are: HUD point-in-time data on homeless veterans needing services in the area, VA medical center data on the number of contacts with homeless veterans, and performance data from the housing agencies and medical centers. See: U.S. Government Accountability Office, *Veteran Homelessness: VA and HUD Are Working to Improve Data on Supportive Housing Program*, June 2012. <http://www.gao.gov/assets/600/591906.pdf> (accessed November 10, 2014).

¹² Veterans Healthcare Administration Handbook, HUD-VASH Program, September 14, 2011. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2446 (accessed November 14, 2014).

¹³ U.S. Department of Veterans Affairs: HUD-VASH Eligibility Criteria. http://www.va.gov/homeless/hud-vash_eligibility.asp (accessed November 18, 2014).

¹⁴ Generally, federal law defines chronic homelessness as someone homeless for a full year or at four different times over a three-year period. For the full definition: <https://www.hudexchange.info/resources/documents/HomelessAssistanceActAmendedbyHEARTH.pdf> (accessed November 18, 2014).

¹⁵ The VA first evaluates a veteran's homelessness status, VA healthcare eligibility, and whether the veteran agrees to receiving case management services. Public housing authorities then assess a person's income and sex offender registry status prior to voucher approval.

¹⁶ U.S. Interagency Council on Homelessness, *Case Management*. http://usich.gov/usich_resources/toolkits_for_local_action/using_hud_vash_to_end_veterans_homelessness/case_management/ (accessed November 25, 2014).

¹⁷ VHA HUD-VASH Handbook, Department of Veterans Affairs. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2446 (accessed November 20, 2014).

How effective is it? HUD-VASH was administered on a very small scale until 2008, and specific research on the program’s effectiveness since then is limited but promising. One study released in 2013 showed veterans who participated in HUD-VASH under the program’s Housing First framework established that year had less time to housing placement, were more likely to stay housed, and used the emergency room less, compared to veterans in a “housing readiness” model.¹⁸ The study, however, indicated more rigorous research is needed to further evaluate the effectiveness of the using the Housing First model to end homelessness among veterans. To that end, VA and HUD have joined efforts to further study the program to more fully determine ways to improve its effectiveness. That study’s release is anticipated in early 2015.¹⁹

Use in Connecticut. Table I-1 shows 63 HUD-VASH vouchers are currently available to Connecticut veterans, or nine percent of the 679 vouchers allocated to the state since Federal Fiscal Year (FFY) 08.²⁰ Currently 11 general vouchers and two project-based vouchers remain.²¹ Of the 54 new vouchers allotted to Connecticut in FFY 14, only four are being used. According to stakeholders interviewed by committee staff, the number of new HUD-VASH vouchers is anticipated to remain relatively steady in the coming years.

Table I-1. HUD-VASH Voucher Activity in Connecticut: FFY 08-14*			
<i>Fiscal Year Allocated</i>	<i>Total Vouchers</i>	<i>Vouchers In Use</i>	<i>Available Vouchers</i>
2008-2013	610	599 (98%)	11 (2%)
2011 (Project-based only)**	15	13 (87%)	2 (13%)
2014	54	4 (7%)	50 (93%)
Total	679	616 (91%)	63 (9%)

*As of November 21, 2014.
 **Vouchers are intended to be tenant-based, meaning they can be used to lease a private-market rental unit. Some vouchers are project-based, meaning they are tied to a specific development and do not move with the veteran. Although PHAs receive both types of vouchers, most are tenant-based because project-based vouchers are capped at 20 percent of the PHA’s tenant-based voucher budget.
 Source: PRI staff analysis of Department of Veterans’ Affairs data.

Although the state may see limited new HUD-VASH vouchers, there are other efforts to continue to make permanent supportive housing available to veterans. There is attention in the state on helping voucher holders achieve permanent housing independent of the rental assistance voucher. This would potentially allow more voucher turnover, increasing the number homeless

¹⁸ The National Center on Homelessness among Veterans, *Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-VASH*. Montgomery, A.E., Hill, L., Kane, V., Culhane, D. March 2013. http://works.bepress.com/cgi/viewcontent.cgi?article=1153&context=dennis_culhane (accessed November 10, 2014).

¹⁹ Department of Veterans Affairs, National Center on Homelessness Among Veterans: 2013 Annual Report. <http://endveteranhomelessness.org/sites/default/files/VA%20National%20Center%20Homelessness%20Among%20Veterans%202013%20Annual%20Report.pdf> (accessed November 22, 2014).

²⁰ See Appendix B of this report for a listing of vouchers by VA medical center.

²¹ Vouchers are intended to be tenant-based, meaning they can be used to lease a private-market rental unit. Some vouchers are project-based, meaning they are tied to a specific development (i.e., single-site) and do not move with the veteran. Although PHAs receive both types of vouchers, most are tenant-based, not project-based, since project-based are capped at 20 percent of the PHA’s tenant-based voucher budget.

veterans served. In addition, the state recently announced the immediate release of 50 state-funded Rental Assistance Program (RAP) vouchers for veterans, with the potential for 50 additional RAP vouchers in early 2015. The initiative is to assist veterans who want to move from permanent supportive housing to housing without supports but still need assistance with rent payments. As a result of the RAP vouchers, 50 more homeless veterans could be provided access to permanent supportive housing through federally-subsidized HUD-VASH vouchers, when those vouchers are turned over.

Supportive Services for Veteran Families

What is it? The federal VA's Supportive Services for Veteran Families (SSVF) program provides grants to selected non-profit organizations to prevent and end homelessness among very low-income veterans.²² The program helps veterans who are in danger of becoming homeless to remain housed, and rapidly rehouses veterans who become homeless. It was not originally intended for people experiencing chronic homelessness, but has begun providing assistance to a cross-section of homeless veterans. The program became fully operational in 2012 and uses a Housing First approach. It is offered both to families and individuals.

The program provides financial help (generally for three to six months) and case management services to assist with financial, employment, legal, and benefits issues. Recently, the VA has begun encouraging SSVF providers to work with state veterans' home domiciliary care residents.

Individual grantees determine whether a veteran family is eligible for SSVF assistance, using a screening tool approved by VA. The form requests information to determine whether a veteran meets the program eligibility requirements:

1. member of a "veteran family," meaning the individual is a veteran or a member of a family whose head of household, or the spouse of the head of household, is a veteran;
2. very low income; and
3. literally homeless (according to the federal definition) or imminently at risk of becoming homeless.²³

Grantees collect other information to help assess the veteran's overall level of need, including the number of times the person has moved in the past 60 days, reason(s) for recent housing loss, number of dependents and their ages, and whether rent payment is in arrears. Each

²² Very low-income is defined as household income not exceeding 50% of area median income. See: U.S. Department of Veterans Affairs - Supportive Services for Veteran Families (SSVF) Program: Program Guide, Last updated March 31, 2014). http://www.va.gov/HOMELESS/ssvf/docs/SSVFUniversity/SSVF_Program_Guide_March31_2014.pdf (accessed November 18, 2014).

²³ Meets the federal definition of homeless, and: 1) is scheduled to become a resident of permanent housing within 90 days pending the location or development of housing suitable for permanent housing; or 2) has exited permanent housing within the previous 90 days to seek other housing that is responsive to the very low-income Veteran family's needs and preferences. (Veterans may live in permanent housing and still receive SSVF services.)

assessment item is associated with a number; the larger the final number, the more the person is considered in need of SSVF services. In areas where there is more demand than funding, higher-need veterans are prioritized.

How effective is it? Studies specific to the overall effectiveness SSVF are short-term, given the program only recently began, but the research is promising. Strong majorities of program participants are avoiding homelessness or getting housed.

For example, in a nationwide follow-up of SSVF participants after their exit from the program over a two-year period, only a small minority of veterans experienced an episode of homelessness over an extended period of time.²⁴ The study showed just above nine percent of all veteran families exiting the program after receiving rapid rehousing assistance experienced homelessness within one year, and 16 percent over two years. For single veterans, the rates were 16 and 27 percent respectively. Of veteran families participating in SSVF prevention assistance, seven percent experienced homelessness one year following SSVF exit and 11 percent after two years; the rates for single adults were 10 percent after one year and 18 percent after two years.

Another study, limited to veterans who exited the SSVF program in FFY 12, showed most (86 percent) had a successful outcome (i.e., left to permanent housing).²⁵ Specifically, 90 percent of veterans with children and 81 percent of individual veterans exited to permanent housing. Among veteran households at risk of homelessness, 90 percent avoided homelessness.

The concept of “rapid rehousing” as a method to address homelessness – which is a primary component of SSVF – has been used effectively since the late 1980s to end homelessness for individuals and families.²⁶ Although large-scale rigorous evaluations have not been completed, findings of program-specific evaluations are fairly consistent. These have often reported that 90 percent or more of heads of households served remained housed after one or more years, and that very few returned to shelters.²⁷ In fact, one study specific to Connecticut showed 95 percent of families had not returned to shelters, three years after being rapidly rehoused through a federal initiative.²⁸

Use in Connecticut. Three community-based non-profit agencies throughout the state were awarded SSVF program grants in FFY 14 totaling almost \$3.3 million, or roughly 1 percent

²⁴ Byrne, Thomas, Culhane, Dennis, Kane, Vincent, Kuhn, John, and Treglia, Dan, *Predictors of Homelessness Following Exit from the Supportive Services for Veteran Families Program*. VA National Center on Homelessness Among Veterans, U.S. Department of Veterans Affairs, Research Brief, October 2014. <http://www.endveteranhomelessness.org/content/predictors-homelessness-following-exit-supportive-services-veteran-families-program> (accessed December 11, 2014).

²⁵ “Effectiveness of Permanent Housing Program FY 12.” http://www.va.gov/HOMELESS/docs/SSVF/Effectiveness_of_SSVF_Program_Report_FY2012.pdf (accessed November 18, 2014).

²⁶ U.S. Interagency Council on Homelessness, *Rapid Rehousing*. http://usich.gov/usich_resources/solutions/explore/rapid_re_housing (accessed November 22, 2014).

²⁷ *Ibid*

²⁸ Connecticut Coalition to End Homelessness. “Where are they now? Three years later, did rapid re-housing work in Connecticut?” http://www.cceh.org/files/publications/NEW_RRH_works_in_CT_FINAL_2013.10.10_CCEH.pdf (accessed November 18, 2014).

of that year's nationwide SSVF funding.²⁹ As a part of their awards, grantees estimate they would serve 715 households statewide at the completion of the grant year. Comparing award amounts with the estimated number of people the grantees anticipate serving, the cost per participant ranges from just under \$3,000 to \$5,235; the estimated average per-participant cost among the three grantees is \$4,563.

Federal funding for SSVF has increased significantly in the program's short existence, signaling commitment to the program. During the program's first year of operation (FFY 12), funding totaled \$60 million to 85 nonprofit grantees.³⁰ Over the next two years, funding grew five-fold, to \$300 million distributed to 319 grantees.³¹

It is unclear if the current funding level will be sustained. During its interviews with key stakeholders nationwide and in Connecticut, committee staff was told that SSVF funding is expected to continue in the near future, but the program's long-term financial outlook is less certain.

Grant and Per Diem

The federal VA's Homeless Providers Grant and Per Diem (GPD) program is a long-established transitional housing program for veterans. This is the only major VA program that continues to operate using a "housing readiness" approach to prepare veterans to live on their own.

What is it? The GPD program provides per diem payments³² and construction-related grants to selected community-based providers of transitional housing for veterans.³³ Providers receiving GPD funding are expected to serve mostly veterans.³⁴ Community-based transitional housing programs are selected by VA through an application process.

To meet GPD eligibility requirements, veterans must be:³⁵

²⁹ See Appendix C for a listing of the grantees and their award amounts.

³⁰ Department of Veterans Affairs - Supportive Services for Veteran Families (SSVF) Program: Program Guide, Last updated March 31, 2014.

http://www.va.gov/HOMELESS/ssvf/docs/SSVFUniversity/SSVF_Program_Guide_March31_2014.pdf (accessed November 12, 2014).

³¹ In January 2014, the VA released a Notice of Funding Availability for the SSVF program. Program funding was designated in two ways: 1) up to \$300 million to renew existing grants; and 2) up to \$300 million in one-time grant funding over the next three years to 78 communities with the highest need based on factors including current level of unmet service needs, level of veteran homelessness, levels of Veteran poverty, and the overall size of the veteran population. (See: Federal Register, Vol. 79, No. 9, Tuesday, January 14, 2014, Notices, and subsequent corrections to original notice.)

³² The per diem rate is federally-determined, and the current maximum rate is \$43.32. The rate is paid for each day an eligible veteran occupies an authorized bed.

³³ The grant portion of the GPD program provides funding for up to 65 percent of projects involving the construction, acquisition, or renovation of facilities offering transitional housing to homeless veterans. It can also be used to purchase vans to provide outreach and services to homeless veterans.

³⁴ Up to 25 percent of bed capacity in a transitional housing arrangement may be used for non-veterans, without payment.

³⁵ VA Connecticut Healthcare System: Errera Community Care Center, "Transitional Housing: The Homeless Grant and Per Diem Program," March 2014.

1. homeless (according to the federal definition) or in imminent risk of losing housing;
2. referred by the veteran's primary clinician;
3. be in treatment for mental health, medical, and/or substance abuse issues (including compliance with toxicology screens); and
4. actively working towards a plan of independent living.³⁶

Individual GPD programs may have their own requirements for residents. Based on committee staff's discussions with providers in Connecticut, some programs require a period of sobriety before admission. If a veteran has income, programs may charge rent, and some do. Programs may choose to give meals to residents.

GPD programs provide supportive services, with a focus on case management. Services are geared toward helping the veteran become ready for independent living (with or without supports), and generally include assistance with VA benefits, connection to mental health and substance use treatment services, financial guidance, education counseling, employment-related assistance, and aid in finding permanent housing.

Veterans are limited to a 24-month stay in a GPD program, with a maximum of three separate stays in any combination of programs. Once in GPD housing, in Connecticut, the VA has been urging programs to focus on successful exits (i.e., into permanent housing) by six to nine months. In fact, the average length of stay in Connecticut GPD programs is around five months, with about two-thirds moving to permanent supportive housing.

Extensions may be granted beyond two years on an individual basis if permanent housing for the veteran has not been located or if the veteran requires additional time to prepare for independent living. The VA's GPD liaisons make those decisions.³⁷ GPD liaisons are also responsible for monitoring programs' operations and results, as well as conducting annual facility inspections.

How effective is it? There is debate at the national level and in Connecticut as to the overall necessity and effectiveness of transitional housing. A known limitation of the approach is that a majority of those who are chronically homeless, even those who have participated in treatment or transitional programs intended to prepare the person for permanent housing, may not be able to meet the housing preconditions.³⁸ Others are not in favor of transitional housing due to its time-limited nature, which means it is, by definition, temporary, and there is a lack of independence for residents. Advocates of transitional housing, however, say it provides a better place for those experiencing homelessness to live than emergency shelters, while allowing them to work on the issues contributing to their homelessness and toward permanent housing.

³⁶ Although veterans in transitional housing for longer than 90 days are no longer considered "chronically homeless" under the HEARTH Act, they are still eligible for HUD-VASH vouchers if they have high vulnerability and need the case management services to successfully sustain permanent housing. <http://100khomes.org/blog/mythbusters-using-hud-vash-to-house-homeless-veterans#sthash.NyREx25h.dpuf>

³⁷ No more than half of a provider's residents may exceed the 24-month limit at any time.

³⁸ Caton, Carol, Wilkens, Carol, Anderson, Jacquelyn, *People Who Experience Long-Term Homelessness: Characteristics and Interventions*. 2007. <http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/> (accessed on November 23, 2014).

Research on transitional housing and the GPD program results is scant. The VA's National Center on Homelessness Among Veterans' website references one study from 2007 (making it relatively dated) that determined 79 percent of those leaving GPD facilities were permanently housed one year after discharge.³⁹

As noted above, the VA's approach to homelessness is shifting from transitional housing to a Housing First model. GPD providers in Connecticut told committee staff the federal VA is placing increased emphasis on provider accountability and quicker placement in permanent housing. Multiple national associations on homelessness also told committee staff that while funding for the federal GPD program has not declined, the approach of early prevention and rapid rehousing of homeless veterans is getting more attention at the federal level (as discussed earlier). In addition, modifications to the traditional GPD program are being tried, including Transition in Place, a program whereby beds in transitional housing programs become permanent for the veterans living there.

Use in Connecticut. Table I-2 highlights GPD program activity in Connecticut for FFYs 12-14. In FFY 14, there were 16 GPD providers throughout the state, offering 167 beds to veterans, generally the same as the previous two fiscal years. The average time veterans remained in GPD transitional housing was the same for FFYs 12 and 13 (149 days), and decreased somewhat in FFY 14, to 145 days (possibly as a result of VA's emphasis on shorter stays in GPD programs). The average occupancy rate dropped between FFYs 13 and 14, from 79 percent to 76 percent. The percent of veterans discharged to permanent supportive housing increased from FFYs 13-14 – from 61 to 66 percent.⁴⁰ At the same time, information about the length of time veterans remain permanently housed before becoming homeless again is not formally tracked. Annual federal GPD funding to Connecticut averaged almost \$1.8 million.

³⁹ Department of Veterans Affairs, http://www.va.gov/homeless/nationalcenter_additional_information.asp (accessed November 20, 2014).

⁴⁰ The VA noted its data was collected differently for FFY 12, as shown in Table I-2.

Table I-2. Federal VA Grant and Per Diem Program Activity in Connecticut: FFYs 12-14			
	<i>FFY 2012</i>	<i>FFY 2013</i>	<i>FFY 2014</i>
Number of providers	16	15	16
Number of total beds	(not available)	160	167
Average occupancy rate	(not available)	79%	76%
Average length of stay (days)	149	149	145
Percent discharged to Permanent Supportive Housing (PSH)	58% (data collected differently)	61%	66%
Total federal funding in Connecticut*	\$1,650,917	\$1,853,083	\$1,873,938
<p>Note: The data provided by VA-CT led to additional questions. Due to time constraints, committee staff was unable to follow up.</p> <p>*May not have all been spent; could have been returned to VA (but would likely have been a small amount, if any).</p> <p>Source: PRI staff analysis of Department of Veterans' Affairs data.</p>			

Domiciliary Care Assessment

The Connecticut State Veterans' Home's domiciliary care, which is based on the "housing readiness" approach, needs improvement. General domiciliary care in the main Residential Facility has a "rehabilitation" mission that implies both a transitional housing program and permanent supportive housing, but it does not adequately provide either, based on the committee's analysis. It lacks the necessary case management intensity, employment services, and day-one emphasis on successfully moving on to independent living to qualify as transitional housing. General domiciliary care also has a population of medium- and long-term residents, some of whom do not intend to ever move out from the Home. However, the Home does not offer those residents the services, accommodations, rules, and responsibilities of permanent supportive housing.

The Home's other main types of domiciliary care – transitional housing in free-standing houses, and residential substance use treatment – are challenging to assess. The first type is a new and very small program, so this study chose to focus most resources elsewhere. The second type, residential substance use treatment, has unclear goals and poor data. It was not possible within the study's time constraints and scope to thoroughly explore how the program compares to others. There are some indications that the Home's residential substance use treatment program could be strengthened.

This chapter assesses all three settings for performance on the program goals, occupancy (as an imperfect proxy for quality, outreach, and/or need in the community for the service), and participant satisfaction. Evaluating any of the domiciliary settings using data is difficult. The Home does not have the data to monitor and assess some of its key services and outcomes; in some cases, it is hindered by an antiquated data system. The program review committee staff surveyed domiciliary residents (except those in the new, small program) and found that, overall, about half are satisfied with the Home, and the vast majority generally felt safe. Some respondents were dissatisfied with staff services, especially those geared toward helping residents move on to independent living, and with the available avenues for registering complaints. Survey methods and full survey results are found in Appendix D.

Overview of the Home's Domiciliary Care

The mission of the Veterans' 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."¹ Domiciliary care is provided by the Connecticut Department of Veterans' Affairs (DVA) in multiple settings on the Home's campus, outlined below in Figure II-1. The largest setting is the main Residential Facility. It is made up of multiple connected buildings and often

¹ Connecticut State Department of Veterans' Affairs. *Residential Facility Programs and Services Policy & Procedures Manual*. 2013.

Figure II-1.

Veterans' Home Domiciliary Care

Main Residential Facility



- General population
- 362 capacity
- Multi-person rooms

Fellowship House



- Residential substance use treatment
- 75 capacity
- Single-person rooms

STAR Apartments



- Working full-time off-campus and seeking to move into the community
- 12 capacity*
- 5 apartments with 3 private bedrooms each

West Street Houses



- 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; and PRI staff.

called “the Domicile” or “the Dom.” The STAR apartments are considered an extension of the main Residential Facility, for the purposes of this report. As of December 8, 188 veterans were living in the main Residential Facility and STAR, and another 35 in the Home’s residential substance use treatment program, located in Fellowship House.

Nearly all domiciliary care residents have access to a range of on-campus 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 are in unique accommodations for a special program, as described below. The Home’s domiciliary care is reviewed annually by the federal Department of Veterans Affairs (VA), as a condition of the Home’s federal funding.

There is no fee for the first three months of domiciliary care. Thereafter, the monthly fee of \$200 may be waived upon monthly application and approval by DVA.

West Street Houses (Patriots’ Landing)

Since early 2014, the five fully-furnished houses across West Street from the bulk of the Home campus have hosted mainly families as transitional housing, in line with the Home’s housing readiness approach. The families receive case management services from a contracted nonprofit, Chrysalis Center, Inc., and are limited to two years in the houses.² The nonprofit is expected to meet specific performance measures and expected outcomes, such as no clients exiting to homelessness.

How effective is it? Because the Patriots’ Landing program is new and small, it is difficult to assess effectiveness.

- **Program goal:** *Success in reaching the program goal cannot be determined at this early stage.* Because the program has been running for less than a year, with a “successful exit” (to permanent housing) deadline of two years, it is unfair to judge the program based on this goal.
- **Occupancy:** *Demand seems high, relative to the Home’s other domiciliary settings.* The houses largely have been full. One family left a few months ago and the program administrators from both DVA and Chrysalis Center, Inc. have been interviewing prospective tenants.
- **Resident satisfaction:** *Participant satisfaction is unknown.* This aspect of the program was not assessed by the program review committee, due to the small number of program participants. However, some level of satisfaction may be inferred from the low turnover rate to date.

How does it compare? The Patriots’ Landing program is similar to a standard transitional housing program, with a few exceptions. The table below shows how the program’s

² Chrysalis Center, Inc. is contracted by the Connecticut Department of Mental Health and Addiction Services (DMHAS), which in turn has a Memorandum of Understanding with DVA for reimbursement. The agreement covers a 28-month period ending June 30, 2016.

rules, discharge time frame, and level of case management services match transitional housing. The program differs in its single-family house setting and population. Most transitional housing is for single people and gives private or semi-private rooms in a large house or building. Due to the setting and population, some of the Patriots’ Landing rules are more relaxed than standard transitional housing. For example, there is no curfew, and overnight guests are allowed with permission requested in advance. None of the twelve veterans’ homes in other states researched by program review committee staff offers transitional housing for families with children.

Table II-1. Comparison of Home’s Patriots’ Landing to Standard Transitional Housing		
	<i>Patriots’ Landing</i>	<i>Standard Transitional Housing: Federal VA’s Program (GPD) in CT</i>
Exit deadline (goal)	2 years	2 years
Case manager staff: client ratio	1:10-20	1:25
Alcohol prohibited	Yes	Yes
Accommodations	Single family house	Private or semi-private room in large building or house
Curfew	No	Yes
Monthly cost	\$200* Meals not included	\$0-300, generally Meals may be included
*Free for the first three months. Sources: PRI staff research, including: interviews with DVA personnel, GPD providers, and federal VA staff; review of the federal VA handbook for the GPD program; and review of the VA-CT brochures for the GPD program.		

Fellowship House: Residential Substance Use Treatment

Fellowship House, also known as the Veterans Recovery Center, hosts residential treatment for people with substance use disorders. It contains 75 single-occupant rooms (with shared bathrooms), group meeting rooms, and a few recreational areas. To be eligible for admission, someone must have been substance-free (“clean”) for at least 21 days and meet the other Home requirements. (The federal Department of Veterans Affairs has a 21-day detoxification program in West Haven.)

The main treatment program – the Recovery Support Program – consists of group and individual therapy, as well as 12-step group meetings. Group therapy is more intensive during the first four to six months (Phase I). In the second six months (Phase II), participants are to address employment and legal issues, as well as take a leadership role in a 12-step group. Those who complete a year in Fellowship House may choose to apply for up to two additional years living there, called Alumni Year (second year) and Recovery In Motion (third year). The House also offers outpatient relapse education to any domiciliary care resident (except those in Patriots’ Landing) through its Recovery Education Programs. In addition, the House’s Alcoholics Anonymous/Narcotics Anonymous meetings are open to anyone living at the Veterans’ Home and the public.

How effective is it? For multiple reasons, assessing the effectiveness of Fellowship House’s main residential treatment program is difficult. However, residents of Fellowship House seem satisfied with the substance use treatment services they are receiving.

- **Program goal:** *Success in reaching the residential treatment program goal cannot be determined with certainty due to the lack of a clear goal, as well as data shortcomings.* Until 2014, program staff considered someone to have successfully completed the residential treatment program when the person reached 12 months there. Starting this year, staff changed the definition of “completion” to mean completing the “core” group therapy courses featured in Phase I. The change was made because the staff considers the core group therapy courses the most intensive component of the program. Completion of these groups can take four to six months.

However, new entrants into the program are not told there is a specific treatment or program completion point. Instead, they are told about the different stages of the program, and the ability to stay at the Fellowship House for two years. As such, it is possible some residents may not be wholly focused on their treatment or working toward life after Fellowship House, knowing they could stay there for multiple years.

While Fellowship House staff were responsive in compiling data requested by program review committee staff, there were multiple data inconsistencies that could not be adequately resolved. Consequently, committee staff limited their analysis to the first twelve months of Fellowship House residence, the portion of the data for which there were fewer problems. In addition, critical information – what happened to people once they left Fellowship House – could not be determined within the time frame of the study. This is true even for those Fellowship House veterans who completed residential treatment and then moved to the main Residential Facility.

Keeping in mind data limitations, it appears that over five recent fiscal years (FYs 2009-13), 71 percent of the 204 people who began the residential treatment program completed at least Phase I. A very small share (three percent) of those who had completed Phase I had chosen to leave within six months. By the twelve-month mark, 57 percent had successfully lived at Fellowship House for that long or left after completing one or both phases of the program. The table below shows there is some variation in completion rates, from year to year, due in part to the small number of veterans beginning the program.

Table II-2. Residential Treatment Program Completion at Six and Twelve Months, FYs 09-13*					
<i>FY Cohort</i>	<i># Began Program</i>	<i>% Completed At Least Phase I (4-6 Mos.)**</i>	<i>% Completed Phase I <u>and</u> Had Left House Between:</i>		<i>% Completed Phases I and II, or Had Left the Home After Completing At Least Phase I, By 12 Months***</i>
			<i>4-6 Months</i>	<i>4-12 Months</i>	
2009	58	69%	5%	22%	59%
2010	31	71%	0%	16%	65%
2011	34	65%	0%	24%	53%
2012	44	75%	2%	25%	59%
2013	37	73%	5%	14%	49%
Total, FYs 09-13	204	71%	3%	21%	57%
<p>*FY 14 data was unavailable because persons in that cohort could have entered the program anytime from July 2013 to June 2014. Consequently, the six- and twelve-month points would not have been reached for some portion of the cohort, by the time of data request (July 2014).</p> <p>**The data indicate the share of the cohort that was either still living at Fellowship House six months after admission or had chosen to leave the House after completing Phase I.</p> <p>***Excludes those who had left against Fellowship House staff advice.</p> <p>Source: PRI staff analysis of Department of Veterans' Affairs data.</p>					

Reasons for leaving. There are multiple reasons why people left the residential treatment program, other than successful program completion. Most of those who left for other reasons (29 percent who entered the program in Fiscal Years 2009-13) departed due to relapse, as displayed by Table II-3.³ Some (9 percent) exited because they required medical care, while smaller shares left for other program violations – including being absent without leave, which may indicate relapse – or choosing to leave against the advice of treatment staff.

Table II-3. Shares of Residential Treatment Program Participants Who Left in the First 12 Months, For Reasons Other Than Successful Completion, FYs 09-13				
<i>FY Cohort</i>	<i>% Significant Relapse*</i>	<i>% Other Violations**</i>	<i>% Chose to Leave Against Treatment Advice</i>	<i>% Needed Medical Care (Non-Relapse)</i>
2009	36%	2%	2%	2%
2010	19%	0%	10%	6%
2011	32%	3%	0%	12%
2012	18%	7%	2%	14%
2013	35%	3%	0%	14%
Total, FYs 09-13	29%	3%	2%	9%

*Includes only those living in Fellowship House. First and second relapses generally result in the person participating in the Home’s Recovery Education Program, while the third results in discharge from Fellowship House. The program staff have some discretion in handling relapses.
 **Examples of “Other Violations” are non-compliance with the program/treatment plan and violations of the Home’s general rules for domiciliary residents (e.g., someone absent without leave).
 Source: PRI staff analysis of Department of Veterans’ Affairs data.

Relapse rates. It is difficult to assess any substance use treatment program’s effectiveness based on relapse rates. Limited data are available overall, and particularly for residential programs. Furthermore, it is generally accepted by researchers, treatment professionals, medical personnel, and persons in recovery that substance use disorders are a chronic condition; many people with any chronic condition – from 30 to 70 percent – experience relapse(s).⁴

Keeping these caveats in mind, information on relapse rates for Fellowship House residents is provided below, for relapses resulting in treatment program discharge – which generally means the person has relapsed three times. Among Fellowship

³ First and second relapses generally result in the person participating in the Home’s Recovery Education Programs, while the third results in discharge from Fellowship House and, once alternative accommodations (preferably a treatment program) have been found, from the Veterans’ Home. The program staff have some discretion in handling relapses.

⁴ National Institute on Drug Abuse. *Principles of Drug Addiction Treatment; A Research-Based Guide, 3rd Ed.* U.S. Department of Health and Human Services, 2012. http://www.drugabuse.gov/sites/default/files/podat_1.pdf (accessed November 12, 2014).

House residents, the 12-month significant relapse rates ranged from 18 to 36 percent across fiscal years, averaging 29 percent. Former participants who had left Fellowship House before a year for reasons other than relapse are excluded from these rates.

Table II-4. Residential Treatment Program Participant Significant Relapse* Rates, FYs 09-12				
<i>FY Cohort</i>	<i>0-6 Months</i>	<i>6-12 months</i>		<i>0-12 Months</i>
		<i>% of Cohort</i>	<i>% of Those Who Were Still in Program, at 6 Months</i>	
2009	26%	10%	16%	36%
2010	13%	6%	9%	19%
2011	21%	12%	18%	32%
2012	9%	9%	13%	18%
2013	14%	22%	32%	35%
Total, FYs 09-13	17%	12%	17%	29%

*Includes only those living in Fellowship House. First and second relapses generally result in the person participating in the Home's Recovery Education Program, while the third results in discharge from Fellowship House. The program staff have some discretion in handling relapses. Source: PRI staff analysis of Department of Veterans' Affairs data.

Data not analyzed. Information on participation, completions, and discharges for the Alumni Year (year two) and Recovery in Motion (year three) programs was provided by the Home but not analyzed, due to data quality issues. In addition, the Home does not collect data on what happens to residents once they leave Fellowship House. Therefore, longer-term outcomes regarding substance use, housing, and other areas of interest are unavailable.

- **Occupancy:** *Fellowship House has not been full in several years, if it ever was.* The average annual occupancy rate has fluctuated since FY 10, rising from 60 percent to 76 percent in FY 12, before falling to 57 percent in FY 14. The number of new House residents has also varied. Although 58 veterans were admitted in FY 09, in the next four fiscal years, between 31 and 44 began the program annually.

If residents could not extend their stays (upon application) by an additional one to two years, it is likely the House would regularly be less than half full. In early November 2014, 25 of the 75 rooms (33 percent) were occupied by first-year residents (seven in Phase I, and 18 in Phase II). Another 10 rooms (13 percent of rooms, and 29 percent of the occupied rooms) housed residents in their second and third years (two and eight residents, respectively).

- **Resident satisfaction:** *Residents appear satisfied with the program.* All 13 Fellowship House residents who submitted a program review committee staff survey indicated they were either very satisfied (62 percent) or satisfied (38 percent) with how well the Veterans’ Home staff helps them “deal with substance use issues.” Satisfaction surveys administered by Fellowship House staff several years ago (2005 and 2007) also gave favorable feedback; no such surveys have been done recently.

How does it compare? Fellowship House’s residential treatment program is quite different from the vast majority of residential substance use treatment programs in Connecticut. It is longer, has an option for maintaining housing in the same location post-completion, and is considerably less costly than standard private residential programs, as the table below shows. It also uniquely serves veterans. There are some residential treatment programs funded by the Department of Mental Health and Addiction Services (DMHAS) that are relatively lengthy, like the Home’s, but those programs are also different in key ways.

Table II-5. Comparison of Home’s Fellowship House to Other Residential Treatment Programs			
	<i>Fellowship House</i>	<i>Standard Private Residential Program</i>	<i>DMHAS-Funded Program Slots</i>
Number of days of abstinence required before admission	21	Varies; as little as a few days	5 to 7
Program length	Not clearly defined. Most intensive phase is 4-6 months; but see below	28 days	Varies by program; from 3-4 weeks to 6-9 months
Post-program housing in same location	Yes	No	No
Accommodations	Private rooms	Private rooms	Mainly shared rooms
Mix of group and individual counseling	Yes	Yes	Yes
Integrated substance use and mental health treatment	No	Varies	Yes
Monthly cost (all include meals)	\$200*	Health insurance might cover, in part, if insured; if not, likely several thousand dollars	Free**
*Free for the first three months. After three months, fee may be waived if income is below a certain threshold. **DMHAS funds some programs that accept non-DMHAS clients, who may be charged. Source: PRI staff analysis.			

Other states. Just one of the twelve other state veterans' homes' websites examined by program review committee staff (Minnesota's Hastings home) specifically mentioned assisting residents with substance use treatment. That home has two psychologists, a lower-level mental health professional, and a weekly consulting psychiatrist, for about 160 residents. The psychologists' caseloads are about 20 clients apiece. It does not offer residential-level substance use treatment, but does have some group counseling sessions around substance use issues.

Federal VA. The federal VA has some residential substance use treatment programs in other states. The closest ones are in Providence, Rhode Island, and Northport (Long Island), New York. These programs mainly have general staffing and programming requirements, with the federal VA requiring at least two licensed (not certified) practitioners and adherence to evidence-based practices for treating substance use disorders.⁵

Overall. The quality of the Veterans' Home's residential substance use treatment program is unclear, but a few circumstances suggest there may be room for improvement:

- *The program is not currently licensed by the Connecticut Department of Public Health, which sets and maintains standards for private and some state residential substance use treatment facilities. The Department of Veterans' Affairs explored licensing the program, in the past, but decided against it. However, the agency seems to be reconsidering. The program is not accredited by an outside agency (e.g., The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities).*
- *Program staff have not communicated with the Connecticut Department of Mental Health and Addiction Services or the federal Department of Veterans Affairs regarding what makes a high-quality residential treatment program, based on program review committee staff interviews.*
- *Because residents receive mental health care off-campus from the federal VA, substance use and mental health treatment is not optimally integrated. Although Fellowship House staff can communicate with the federal VA providers (with permission from the patient), treatment is not integrated in terms of substance use treatment staff or the treatment program content.*
- *The program review committee is unsure whether it is wise to extend the option of living in Fellowship House past 12 months (for a possible total of 36 months), as is currently done. There is a general recognition in the field of substance use treatment that establishing recovery supports in a person's home community is critical. What is effectively up to a three-year residential program (with "light" program services in the second and third years) at Fellowship House may inhibit someone from achieving full recovery potential over the rest of the person's life.*

⁵ Department of Veterans Affairs. *VHA Handbook 1162.02: Mental Health Residential Rehabilitation Treatment Program*. 2010. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2354 (accessed November 20, 2014).

General Domiciliary Care: Main Residential Facility

The vast majority of Veterans' Home residents live in the main Residential Facility. They reside in the East and West Domiciles, sharing large rooms (divided into three sections, or "bays") that can host up to 12 people each. Services offered are an on-site medical clinic (B Clinic), social work, vocational rehabilitation, and recreational activities. The main Residential Facility also contains a dining hall and kitchen, which prepares and serves food to the Home's residents, including transporting it to the Health Care Facility, which gives long-term care. The main Residential Facility services are also available to STAR apartment and Fellowship House residents.

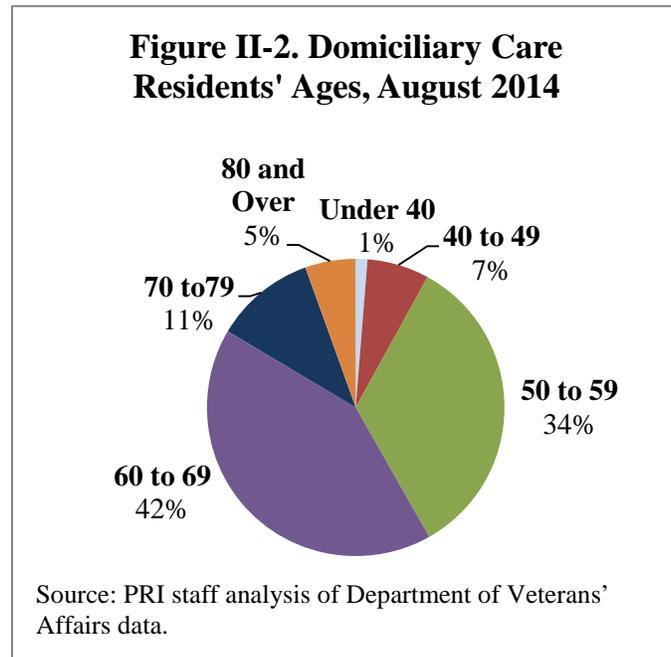
The STAR apartments are designated for domiciliary residents who have obtained employment and plan to leave the Home within six months, with a possible six-month extension. STAR residents have more relaxed rules. During the latter part of their stay in STAR, residents are required to purchase and prepare their own food, and cannot use B Clinic. Due to the low number of participants (two as of early December), they are included in this discussion of regular domiciliary care.

An entering resident is expected to meet separately with an assigned social worker (one of the Home's four) and the vocational rehabilitation coordinator within the first five days. Both meetings involve discussion of the resident's goals and how the staff can assist the resident in reaching them.

Three months after a new resident has arrived, the social worker, vocational rehabilitation coordinator, and substance use treatment director meet with the resident to develop a discharge plan. The Home's goal is for the resident to successfully leave to independent housing within two years, but some residents have a three-year goal while others are working toward leaving sooner.⁶ Some choose not to participate in discharge planning, initially or at a later point. The team then is supposed to work with the resident to make the plan happen, and adjust the plan when necessary; this is called the Veterans Improvement Program (VIP). The resident and service team are to meet every three months. In between, as-needed meetings and communication can occur among the service staff and resident. There are expectations of monthly written, phone, or in-person contact with a social worker for those actively working toward successful discharge and, for every resident, a meeting every three months with the person's social worker.

⁶ The domiciliary care policies and procedures manual states the program goal is two years, but data produced by the Home at its staff's own initiative (before a data request had been received) set the short-term length of stay at three years. In addition, domiciliary staff conveyed in multiple ways throughout the study that the goal is flexible and can extend to three years.

Resident characteristics. Domiciliary residents (including those in Fellowship House) generally are middle-aged, or seniors, and dealing with a range of health issues. Most residents are in their 50s or 60s (76 percent combined), with small shares under 50 (8 percent) and 70 or beyond (16 percent), as shown in Figure II-2.⁷



Both mental and physical health challenges are common.⁸ More than half of residents have a psychiatric and/or substance use diagnosis. The most common psychiatric diagnoses among residents are depression (estimated at 55 percent), post-traumatic stress disorder (about 19 percent) and anxiety (approximately 17 percent).⁹ Roughly three-quarters have heart disease or a precursor, about half have diabetes, and almost one-third have cognitive impairments.¹⁰

Most (70 percent) domiciliary residents are White. Just over one-quarter (27 percent) are Black, and a very small share (3 percent) identify primarily as Spanish, Hispanic, or Latino.¹¹

How effective is it? Unclear goals, a wide range in residents' lengths of stay, and limited data availability hampered the program review committee's attempt to fully assess the effectiveness of the Veterans' Home's regular domiciliary care.

- **Program goal – Length of stay:** *If the goal is for new residents to successfully leave within two to three years, the Home is falling short.* Nearly half (47 percent) of domiciliary care residents in a recent month had lived at the Home for more

⁷ August 2014 residents.

⁸ The program review committee staff is not fully confident in the preciseness of the psychiatric and medical condition data in this paragraph. The June 2014 data gathered by the Home that provided information in these areas, which was presented in the committee staff's October update report, conflicted somewhat regarding age with more reliable age data given by the Home for August 2014 residents. Upon committee staff's request, the Home produced more specific psychiatric diagnosis data in October 2014, but there was a considerable swing from June 2014 in the percent of residents with a psychiatric diagnosis. All health condition data provided by the Home – March 2013 data analyzed in the update report, June 2014 data, and October 2014 data – were produced using the same methods. Consequently, committee staff chose to give estimated data, based on as many of the three data points as possible. Committee staff also no longer believes that the Home's data is sufficiently strong to show that the domiciliary population has growing medical needs and is aging rapidly, conclusions that were provided in the October update report.

⁹ October 2014 residents.

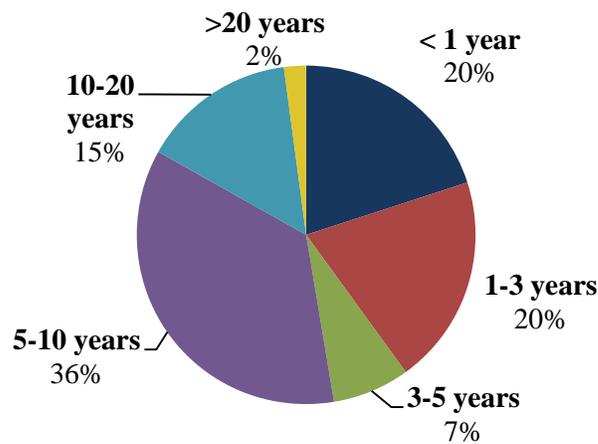
¹⁰ Rough estimates based on Home data for March 2013 and June 2014 residents.

¹¹ August 2014 residents.

than five years. Another 11 percent had resided there for between three and five years.¹²

DVA was unable to provide detailed information on length of stay (due to data system limitations), but the program review committee staff survey provides a glimpse. Although not all domiciliary residents completed the survey – 96 of 223 residents (43 percent) did so – the respondents’ median age (61 years) nearly matched that generated by the Home (62 years), so it may be somewhat representative. Figure II-3 shows that one-fifth of survey respondents had lived at the Home for less than one year, and another fifth had been there for one to three years.

Figure II-3. Domiciliary Residents' Length of Stay, Per PRI Staff Survey, 2014



Source: PRI staff analysis of Department of Veterans' Affairs data.

If, however, the goal is to be available to house veterans for an extended period of time, the Home is accomplishing it. The figure to the left indicates that many veterans are long-term residents of the Home. One-third (36 percent) of survey respondents had lived at the Home five to ten years, and another one-sixth (17 percent) had been there at least ten years. Overall, 60 percent of residents

responding to PRI staff’s survey had lived at the Home beyond the outlying goal of three years. Nearly one-quarter (24 percent) of respondents indicated they want to stay at the Home permanently.

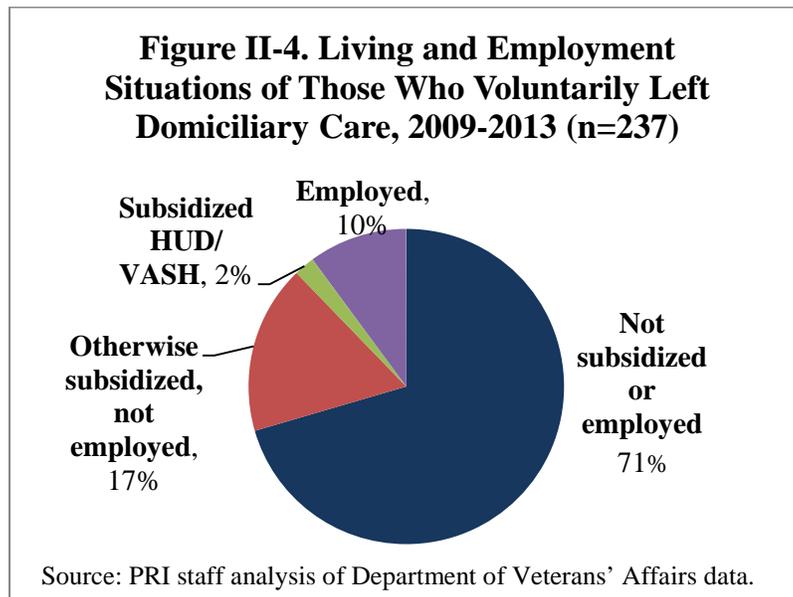
Limited program data from the Home supports the idea that a large share of residents lives there long-term. Eight out of every 13 residents (62 percent, or 141 residents) have either chosen to withdraw from discharge planning (via the Veterans Improvement Program) or have been designated as needing some extra assistance with daily living activities.¹³ Nearly half (47 percent) of the committee

¹² As of June 2014, according to data provided by the Department of Veterans’ Affairs.

¹³ As of October 24, 2014, according to data provided by the Department of Veterans’ Affairs. The resident counts per program level were: 82 (36 percent) in Standard (expected stay of six to 24 months); 128 (57 percent) have withdrawn from discharge planning and therefore have a program status of Extended; 13 (6 percent) in the Residential Plus Program, the Home’s version of an assisted living program; and three (one percent) in the STAR

staff's survey respondents did not know what level of the VIP program they were in, or if they had withdrawn from the program.

- **Program goal – Independent housing:** *Some residents leave the Home for independent housing.* For calendar years 2009 through 2013, 237 veterans exited the Home (including Fellowship House and regular domiciliary care) to independent housing in the community. Most (70 percent) left for unsubsidized housing without employment, as conveyed by the chart below.¹⁴ Home staff indicated that many of those residents pay for housing via Social Security Disability, VA benefits, and/or private pensions.

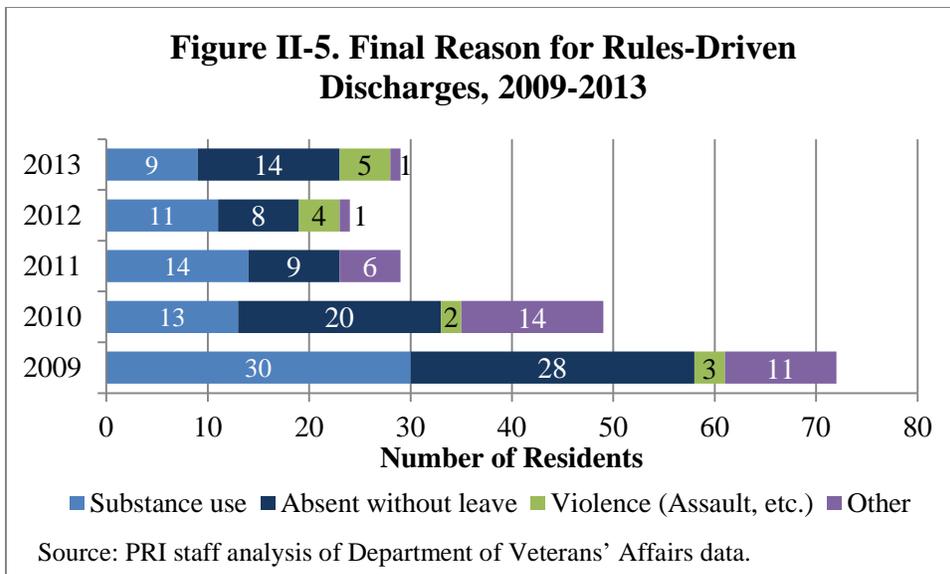


Some (19 percent) moved into subsidized housing. A small share (10 percent, or 24 residents) left for their own housing with employment.

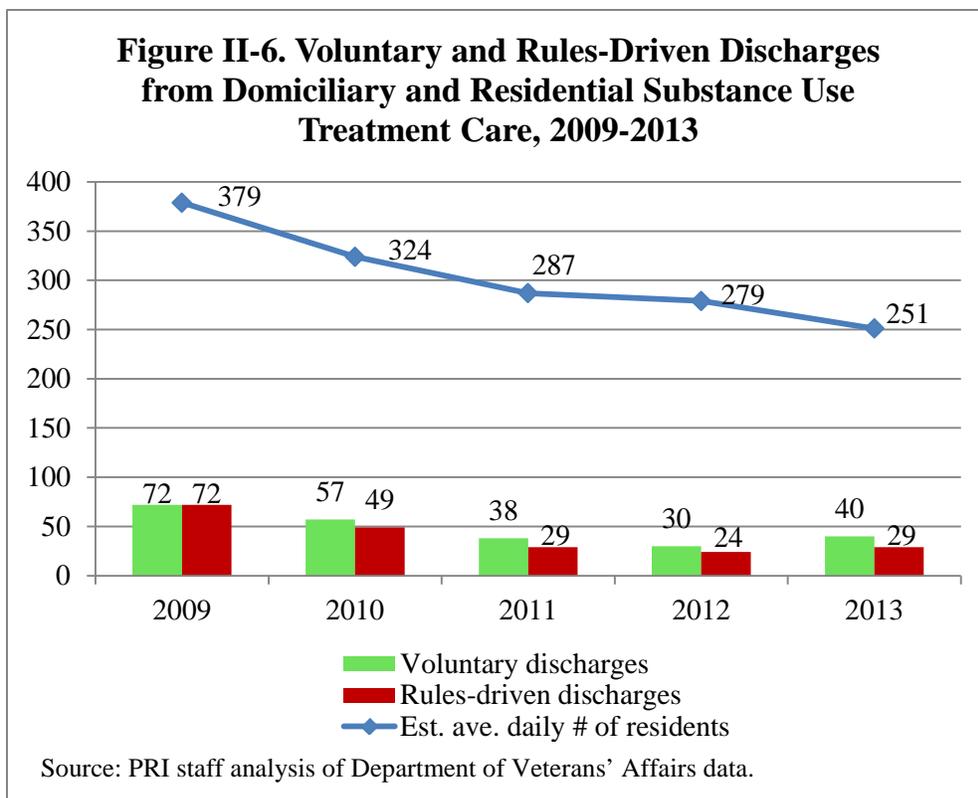
Rules-driven exits. Other residents are involuntarily discharged for breaking the Home's rules (listed in Appendix E), while some choose to leave to avoid a rule violation penalty (i.e., voluntary discharge for rules-related reasons). Most (77 percent, or 156) of rules-related discharges from 2009 through 2013 ultimately were due to being off-campus without permission (absent without leave, at 39 percent) or substance use (38 percent), as Figure II-5 conveys. A small portion (7 percent of involuntary discharges) were due to violence, while some (16 percent) were due to other reasons, such as theft, being arrested and held, or the person choosing to leave to avoid a penalty. Those who leave the Home for penalty-related reasons are offered assistance in finding somewhere to live or take shelter.

accommodations, which means a current expectation of departing within one year. It appears no residents were in the Accelerated level of the program, which is for new residents with community employment who intend to leave within six months.

¹⁴ The number of unduplicated residents for each of several recent years was requested but unable to be provided by Department of Veterans' Affairs staff.



Since 2009, the share of discharges that are rules-driven has declined. Figure II-6 indicates there was an equal number of rules-driven and voluntary discharges in 2009, but since then, the ratio has fallen from 4:4 to about 3:4. Between 2009 and 2013, rules-driven discharges fell from 19 percent of the estimated average daily number of residents to 12 percent.



- **Program goal – Employment progress:** *Some residents engage in education or training, or obtain employment, while living at the Home.* Since 2010, on average 17 residents per semester (about 6 percent of the average daily census) have been enrolled in postsecondary education or training. Fourteen residents earned a certificate or degree while there, and another three obtained a Commercial Driver’s License. Four to fifteen people per year acquired a job, with a median wage of \$12 per hour. It is unclear to what extent Veterans’ Home staff assisted these particular residents in making vocational progress.

Coordination. *There is no coordination between the state Department of Labor’s Office for Veterans’ Workforce Development and the Veterans’ Home’s vocational rehabilitation coordinator.* The state labor department has representatives in six offices who do similar tasks as the Home’s vocational staff person, and they generally do not work with Home residents. The Home’s vocational staff person does not work with that office on job developing, but does collaborate at times with job developers at the federal VA to assist specific residents in finding jobs.

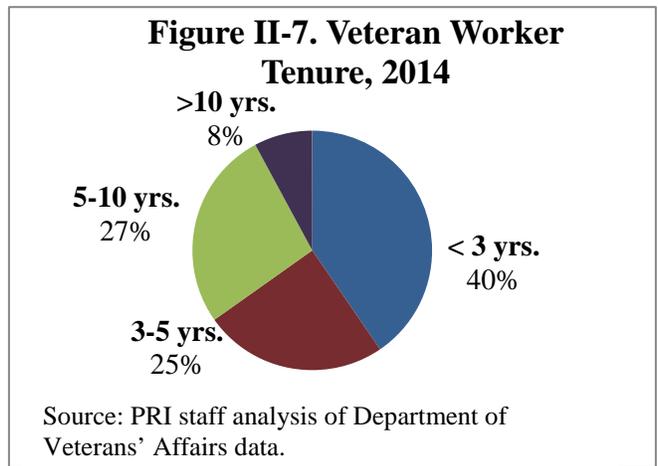
Veteran Worker program. *Thirty-eight percent of residents (93) participates in the on-campus Veteran Worker program, which is intended to be therapeutic for residents.*¹⁵ It involves working at the Home for minimum wage, with no possibility of advancement or a raise. Common positions include maintainer/janitor, food service worker, and wing monitor (roughly similar to a resident assistant at a college), but Veteran Workers support nearly every department on campus.

Another 45 percent of residents receives \$3 an hour for up to ten hours weekly of less-intensive work, like sweeping, through the Detail program. All domiciliary care residents must have either a Veteran Worker or Detail position, or an uncompensated, minimal chore, to live at the Home.

The overarching goal of the Veteran Worker program is to “assess an individual’s ability to return to gainful employment within the community,” according to the program manual, which continues that the work is to be “of a therapeutic nature.” In more practical language, the intent is to deliver multiple benefits to participants: self-esteem; recent work experience; increased work skills; an employment reference; and income in return for work. These are all attributes that could assist residents in living and working independently. The DVA staff reported that in recent years, a majority of residents who became employed off-campus first participated in the Veteran Worker program.

Yet, the program’s key goal of helping the resident become employed in the community is not being met in a timely way. The majority of participants (60 percent) have been Veteran Workers for more than three years, as shown in Figure II-7, and about one-third of them for longer than five years.

¹⁵ As of June 27, 2014.



Employment of more than three years for such a large share of participants does not seem to indicate the program is effectively moving people toward employment in the community. Instead, the program may be encouraging at least some people to remain Home residents because they feel tied (practically or emotionally) to their work there. The program may be encouraging

complacency with living at the Home instead of motivation to seek work outside it.

If Veteran Worker participants are remaining in their same positions for many years, there are limited opportunities for new Home residents to engage in the program. Although data were unavailable, Home staff acknowledged there has been relatively little turnover in positions recently. This problem has worsened, according to Home staff, due to complicated logistics involving reclassifying (by the Department of Administrative Services) long-held positions when they become vacant, which is a lengthy process.¹⁶

While the program's goals may be sound, the Veteran Worker program has dampened morale and created tension between the resident participants and state employees. Many residents with whom committee staff spoke complained bitterly of working alongside state employees who do similar work for better pay, sometimes for many years. Many state employees at the Home interviewed by committee staff spoke about the program acknowledged the resentment and tension it has created.

The Veteran Worker program critically supplements the Home's contingent of state employees. All staff and residents with whom program review committee staff spoke about the program noted that the Home relies on the Veteran Workers to run. A few managers discussed problems with some participants' work ethic and attendance, but most talked favorably about their experiences with the Veteran Workers.

- **Program goal – Safe environment:** *Half of resident survey respondents indicated they always felt safe at the Home; over one-third (38 percent) reported feeling safe most of the time.*

¹⁶ Veteran Workers are non-classified workers but the State's pay system requires each worker to have a classification in order to get compensated.

Assault. As noted in Figure II-5, annually there were five or fewer violence related incidents by domiciliary residents resulting in discharge at the Home from 2009 through 2013. More assault-related incidents – 15 on annual average – were reported to Safety and Security (for 2012 and 2013) than incidents resulting in discharge, although only three reports of assault have been made so far for 2014. The discrepancy between reported incidents and violence-related discharges may be due to resulting investigations determining the reports were false.

Property. The trend in missing property / theft is down recently, as Table II-6 shows. At the same time, prohibited items like weapons and illegal substances have been more frequently discovered in 2014 than in the two previous years. Both types of property-related infractions are relatively rare.

Table II-6. Domiciliary Care Property-Related Incidents: Number of Incidents and Rough Estimate of the Share of Residents Experiencing Them, 2012-2014*				
	#	2012 (per-resident basis)	2013	2014
Theft / missing property	7	(2.5%)	4 (1.6%)	3 (1.3%)
Weapon possession	3	(1.1%)	2 (0.8%)	5 (2.1%)
Illegal substance possession	2	(0.7%)	1 (0.4%)	4 (1.7%)
*2014 data are through mid-November. Number of incidents includes those reported by staff and residents. Some incidents may have been experienced by staff, not residents. Includes all domiciliary care: main Residential Facility, Fellowship House, STAR, and Patriots' Landing. Per-resident basis was calculated using the average daily census for the year. Source: PRI staff analysis of Department of Veterans' Affairs data.				

Rules. There are numerous rules intended to maintain personal and community safety on campus. The rules address a variety of subjects, from behavior to personal possessions and living space. Residents who break the rules may be required to leave (involuntarily discharged, as described above) if the offense is severe, or have their ability to leave campus be restricted (i.e., pass restriction). The residential director judges the evidence and determines whether a violation occurred and if a penalty is issued. She may choose to give a warning instead of a penalty, if the resident acknowledges the error and agrees to corrective action.

The annual number of rule violation incidents on an approximate per-resident basis has fluctuated between one for every two residents and one for every 1.6 residents, since 2009. In 2013, there were 150 incidents that could have resulted in a violation; of these, 69 percent did. In the past several years, fewer incidents have resulted in violations (versus warnings).

Some residents are dissatisfied with the process for determining whether there has been a violation and how it should be treated. Although a slim majority of respondents (52 percent) reported they felt fairly treated during rule violation

situations, only 13 percent thought they were *always* treated fairly then – and 33 percent indicated feeling they were only sometimes or never treated fairly. Fifty percent of survey respondents thought violations are issued about the right amount of time, given the rules; 42 percent think they are given too frequently.

Regarding the rules themselves, the survey respondents are about evenly split between thinking the rules are too strict (47 percent) and about right (50 percent). They did not consistently write in any particular rule as their top three they think should be changed or eliminated. The three rule changes most frequently listed by the survey respondents were:

- relaxing substance use (not possession) screening or threshold policies (26 percent);
- relaxing or eliminating pass restrictions (20 percent); and
- stopping the relatively new visual inspections the campus's Safety and Security personnel perform of all resident packages and vehicles, upon re-entry to campus (16 percent).

Assistance with living tasks. The Home's Residential Plus Program assists about one dozen domiciliary residents who need some help with activities of daily living (e.g., dressing). One to two nurse aides staff the program between 6:45 a.m. and 11:15 p.m. The program began in January 2014, in response to growing needs of several long-term residents. Admissions to it, though, have been frozen since June 2014. The DVA reported it is attempting to figure out how to match the program to Department of Public Health regulations.

The establishment of this program is indicative of a larger problem facing the Home, discussed in Chapters IV and V: how to properly serve domiciliary care residents who are aging in place. These residents, who are growing in number according to Home staff, need assistance beyond what is generally provided for the Home's domiciliary veterans, but do not need the level of care offered at the Health Care Facility.

- **Program goal – Substance-free environment:** The Home takes multiple steps to ensure certain residents abstain from alcohol and illegal substances entirely, and to keep others from returning to campus intoxicated. (Residents may not have alcohol or other substances on the Home's campus.) Veterans in the residential treatment program have weekly zero-tolerance screens for their (first) two years at the Home.

Screening. Residents of the main Residential Facility and STAR apartments may be Breathalyzed upon re-entering campus, if Safety and Security or other staff observe signs of possible intoxication. All Fellowship House residents are required to have a Breathalyzer upon return to campus, as are all residents who are considered to be absent without leave.

Between 2012 and 2014 (as of mid-November), roughly 18 percent of residents were screened (with 108 screens across the years).¹⁷ The screens indicated intoxication at the state-defined level 43 percent of the time, meaning that roughly 7 percent of residents had a positive screen – about 15 residents per year.

Those who test positive receive at least a violation and need staff permission to leave campus for a certain amount of time (which lengthens depending on the number of violations recently received); they are also subjected to random screening and may lose a Veteran Worker position. Twelve percent of main Residential Facility residents in October 2014 were required to comply with random screening due to not having two “clean” years at the Home.¹⁸ The results of the residents’ random screens were unavailable due to time constraints.

Medication assistance. The Home assists some residents in taking medication. More than one-third (37 percent) of domiciliary residents received this help, in October 2014. Of particular interest, thirty-three residents (15 percent) were on injectable medication, which must be stored at the Home’s domiciliary clinic, and 42 (19 percent) were receiving assistance in taking psychiatric medication.¹⁹

- **Program goal – Other outcomes:** *Major data shortcomings impede a more complete assessment of the Home’s challenges and successes.* For example, DVA staff was unable to develop cohort data to help program review committee staff understand what happened to all residents who entered in a particular year. On a programmatic level, DVA staff could not produce some requested data, like the number of residents in a year a Home social worker had helped reconnect or improve relationships with family members.

Neither was any information available on how former residents fared after departing the Veterans’ Home. Recently, however, the Department of Veterans’ Affairs agreed to become part of the Homeless Management Information System (HMIS), which tracks persons who use homelessness services in Connecticut. That step should enable the Home to understand whether its former residents return to homelessness, as discussed in Chapter V.

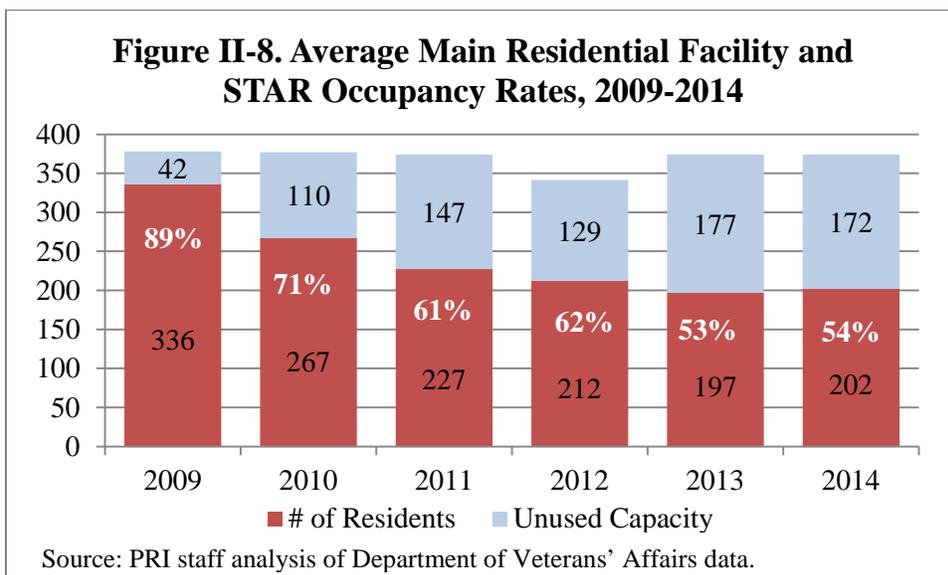
Home staff similarly could not provide information on the number or share of residents that had repeatedly been admitted to the Home, but nearly one-quarter (24 percent) of respondents to the committee staff survey had lived at the Home at least once before. Of these, three percent had previously resided there two or more times.

¹⁷ The estimate is rough because it is based on the average daily census divided by the total number of screens, not on the actual, unduplicated number of residents who were screened.

¹⁸ Includes those who had a rules violation and those who moved from Fellowship House to the main Residential Facility before two clean years there.

¹⁹ A resident may receive assistance with both injectable and psychiatric medication, and such a person would be included once in each figure here. No resident was receiving assistance only with psychiatric medication, at the time this data was produced (October 2014).

- **Occupancy:** *The main Residential Facility and the STAR apartments collectively are just over half full (54 percent occupancy). The average number of residents has dropped by 40 percent since 2009, to 202 residents in 2014 – the lowest level over the last six years. The decline was sharp from 2009 to 2011; the number of residents dropped once more in 2013, as displayed in Figure II-8 below.*



On average in 2014, there has been room for another 172 veterans in regular domiciliary care. It is unclear why the Home's occupancy rate has fallen so precipitously. Possible reasons include:

- the expansion of federal Department of Veterans Affairs programs to help homeless veterans;
- perhaps fewer referrals from the VA as it shifted to a Housing First philosophy for most of its major veteran housing programs;
- maybe lower need among people generally for housing as the recent recession eased; and
- less interest among veterans in the accommodations, rules, and services that come with living at the Veterans' Home.

Admissions criteria naturally affect occupancy, and it is possible the Home's criteria could be reconsidered. Home staff and those outside the Home believe that many, if not most, application denials are due to mental health disorder severity. The Home staff appears to be especially wary of admitting persons who might be at risk of suicide.

The Home may be overly restrictive in this respect and there could be steps to make the DVA more comfortable with admitting veterans with psychiatric illnesses. The steps could include on-site behavioral health staff (aside from

Fellowship House personnel) and suicide risk assessments. The Home is considering requesting permission (and funding) to hire a psychiatrist, which potentially could help address the issue.

The Home does not formally collect data from its potential and actual applicants that could provide valuable information on how people learn about it and why some people choose not to apply. Home staff believe most successful applicants originally learned about the Home through federal VA personnel in Connecticut and Massachusetts.

The Veterans' Home does not actively publicize or promote domiciliary care availability to veterans who may be in need of housing. No staff at the Home or the DVA are tasked with reaching out to nonprofit homeless services providers and their staff who directly work with homeless people. Nonprofit case managers and personnel at veterans service organizations told program review committee staff that they rarely refer veterans to the Home, in large part because of the restrictive admissions and living rules.

Similarly, it seems that town veteran service contacts – with whom the DVA's Office of Advocacy and Assistance is in touch – seldom point veterans toward the Home's domiciliary (or nursing) care. Only five of the 33 respondents to program review committee staff's web-based survey of the contacts indicated they had referred people there in the last two years. Just over half of the respondents (53 percent) indicated they did not know enough about domiciliary care at the Home to have an opinion about it. Roughly one-quarter (27 percent) had a favorable opinion, and only a few (9 percent) held a negative opinion.²⁰ Few (6 percent) marked that DVA or the Home had encouraged them to refer people to the Home or given them basic information on the Home (12 percent). The survey's methods and results are provided in Appendix F.

- **Resident satisfaction:** *About half (49 percent) of program review committee staff survey respondents were very satisfied or satisfied with living at the Veterans' Home. One-third (33 percent) were neutral, while just over one-sixth (18 percent) were either dissatisfied or very dissatisfied.*

About one-quarter (26 percent) of survey respondents reported dissatisfaction with how well the Veterans' Home staff help them achieve [their] goals to move off-campus. Seventeen percent were very dissatisfied, 9 percent were dissatisfied, and only 21 percent were some level of satisfied. Most (61 percent) of survey respondents reported wanting to live outside the Home "within a year or two." The lowest levels of satisfaction with staff services were for the specific services that would directly aid in accomplishing that goal: finding off-campus employment (10 percent satisfaction) and locating off-campus housing (11 percent satisfaction). The highest satisfaction level was for on-site medical care, at 49 percent.

²⁰ The remainder of respondents (12 percent) was neutral toward the Home's domiciliary care.

Most survey respondents were overall satisfied or neutral toward the condition of the Home, with the Dining Hall receiving the worst marks (24 percent dissatisfied). At the same time, about four out of five residents (81 percent) indicated they would like their own private living quarters.

The Home does not regularly survey its residents to understand residents' satisfaction or learn how they think the services and facilities could be improved. The only routine effort involves collecting minimal, non-specific feedback from veterans who are leaving the facility and choose to complete a discharge form. The questions on the form ask about overall staff helpfulness and the share of the departing residents' goals met. There has not been a survey of residents in recent years. The Home gets some feedback from its veterans through a residents' council, but it has several deficiencies, as discussed below.

Staff fairness. *A substantial share of residents feels they are not treated fairly by the Home's staff.* Several residents shared this sentiment with the program review committee and its staff, publicly and privately, throughout the study. The survey results show that about one-quarter of respondents (26 percent) believed they are treated fairly all the time, and another one-third (33 percent) thought treatment is fair most of the time. Two of every five respondents (40 percent) believed they are treated fairly half the time or less.

Complaints. *A large share of residents does not feel there is a safe, effective way to voice complaints.* There are two main ways to complain: to staff, or to the residents' council. More than two in five (43 percent) indicated they are uncomfortable with bringing complaints to the staff, and about one in four (27 percent) felt they had been treated worse by staff after complaining. Among those who have not complained to staff in the last two years, one in four wrote they had not done so because they were afraid of staff retaliation, and an approximately equal number stated the reason was because they did not think anything would change.

The residents' council, however, is not viewed as effective. Just one in six (17 percent) marked they were satisfied with the council's ability to get results for residents. Of those who had not complained to the council recently, about one in three wrote the reason for their silence was their belief that no change would result (35 percent). The same share stated they had not complained because the council seemed too close to the staff or administration (32 percent).

A majority of respondents who had complained to staff and/or the residents' council within the last two years did not feel attention was paid to the complaint (58 and 59 percent, respectively).

How does it compare? *Regular domiciliary care at the State Veterans' Home does not resemble either standard transitional housing programs or permanent supportive housing.* The Home has a stated goal of helping veterans move out to independent housing within two to three years, which is similar to transitional housing, as previously discussed. Veterans can choose,

however, to remain at the Home permanently, which is not allowed in transitional housing.²¹ The Home does offer some supportive services to veterans who are long-term residents. Yet, the Veterans' Home's case management services, accommodations, some rules, and other features do not look like either transitional housing or permanent supportive housing.

If the Veterans' Home is attempting to provide transitional housing, as it appears, the Home falls quite short of the federal VA's standards for its transitional housing program providers. The Veterans' Home's services to help residents successfully navigate life are much less intensive and the Home's exit goal is up to four times longer. Table II-7 notably shows:

- The Home's case management staffing level is less than one-third what transitional housing providers are expected to maintain, and its case management expectations are minimal in comparison; and
- Discharge planning at the Home begins three months after a veteran enters, compared to the first day in transitional housing funded by the VA.

During the committee's research, transitional housing provider personnel and people who work for housing-related organizations were asked to comment on the Home's case management staffing levels and time frame for beginning discharge planning. Each person had the same response: *To most effectively give every veteran a chance at a successful, independent life, the Home must dramatically intensify case management and begin discharge planning on the day of admission.*

²¹ The federal VA is working toward converting some of its contracted transitional housing capacity to permanent housing, when the unit resembles an apartment setting, through the Transition in Place program. The idea is that persons who may be suitable for transitional housing enter the unit, receive services for up to 24 months, and then assume the lease for the unit. Services do not continue past the leasing point; it is not permanent supportive housing. See: http://www.va.gov/HOMELESS/docs/GPD/PDO_Transition_in_Place_Guide_09192012.pdf (accessed December 2, 2014).

Table II-7. Comparison of Home's Regular Domiciliary Care Services and Goals to Federal VA's Transitional and Permanent Supportive Housing Services

	<i>Home's Regular Domiciliary Care</i>	<i>Transitional Housing: Federal VA's Program (GPD) in CT</i>	<i>Permanent Supportive Housing: Federal VA's Program (HUD-VASH)</i>
Exit goal	2-3 years	6-9 months	Not applicable
Exit deadline	None	2 years; small percentage of provider's clients may get extension	None
When discharge planning begins	3 months into the stay	First day	Not applicable
Case manager staff: client ratio	1:96*	Varies; generally not above 1:25 and may be as low as 1:10	1:25
Case manager contact required	Monthly for those looking to move out; every three months otherwise	Weekly, typically	Monthly
Monthly cost	\$200**	\$0-300; one requires 20% of income and 60% of income to savings. May charge up to 30% of adjusted income***	30% of adjusted income

*From June through mid-September (3.5 months), the number of social workers serving nearly all residents at the Veterans' Home, including the Health Care Facility but not Patriots' Landing, was two instead of the normal four. One social worker had left employment at the Home and another was temporarily on leave. During those months, the ratio was about 1:177. The worker who was on leave has returned at half-time; the person will switch back to full-time in April 2015. At that point, the Home will again have four full-time social workers, lowering the ratio to roughly 1:77, depending on the number of residents.

**Free for the first three months. After three months, the fee may be waived if income is less than three times the fee and the resident's monthly waiver request is approved by DVA.

***Can charge up to 30 percent of income after deducting medical expenses, child care expenses, and any court-ordered payments; must not exceed federal Department of Housing and Urban Development's Fair Market Rent. Sources: PRI staff research, including: interviews with DVA personnel, GPD providers, providers of case management at a single-site project that includes HUD-VASH veterans, and federal VA staff; review of the federal VA handbook for the GPD program; and review of the VA-CT brochures for the GPD and HUD-VASH programs.

There are a few similarities, and a couple of key differences, between the Veterans' Home's rules and transitional housing, illustrated in Table II-8. The Veterans' Home's rules related to alcohol and other substances, as well as curfew, align with transitional housing program rules. However, the Home's rule forbidding vehicle use in a resident's first three months is dissimilar and may be overly restrictive, particularly given the somewhat isolated setting of the Home. The Home sits on a large campus with extremely limited public bus service. There is transportation provided by the Home but it, too, is limited.

Another contrast with transitional housing (and permanent supportive housing) is that the Home’s approach to rules violations mainly seems punitive – to restrict the person from easily traveling off-campus. The Home is a much larger operation than Connecticut transitional housing, which generally is contained to a single building, so a pass restriction is less harsh. At the same time, the philosophy underlying the penalties might not be helpful to residents, or respectful of them. *Transitional housing providers view non-violent violations as a signal to immediately figure out how to better help the person, which is likely to be a more productive response than the Home’s current method.*

Table II-8. Comparison of Home’s Regular Domiciliary Care Rules to Federal VA’s Transitional and Permanent Supportive Housing Rules			
	<i>Home’s Regular Domiciliary Care</i>	<i>Transitional Housing: Federal VA’s Program (GPD) in CT</i>	<i>Permanent Supportive Housing: Federal VA’s Program (HUD-VASH)</i>
Alcohol prohibited on grounds	Yes	Yes	No
Alcohol screening if appear intoxicated	Yes	Allowed	No
Random screening for alcohol	For some	Allowed	No
Length of sobriety required	About six months*	0-90 days Average: 30 days Median: 17.5 days	None
Vehicle allowed	After first 3 months, if have complied with rules and campus permit staff approve	Yes	Yes
Curfew	Yes	Yes	No
Result of rules violation (non-violent)	Limited ability to leave campus	Meeting with case manager	Meeting with case manager or a tenants’ council
Accommodations	Large rooms of 12 people, arranged in “bays” of four people	Range; can be private bedroom in a large house, semi-private, or not private	Own apartment
<p>*Determined on an individual basis. Someone with less recovery time, or with more sober time who would like to have recovery support, would likely be admitted to the Home’s residential substance use treatment program. Sources: PRI staff research, including: interviews with DVA personnel, GPD providers, providers of case management at a single-site project that includes HUD-VASH veterans, and federal VA staff; review of the federal VA handbook for the GPD program; and review of the federal VA Connecticut brochures for the GPD and HUD-VASH programs.</p>			

There are some additional key differences not shown in the tables. First, transitional housing providers contracted with the federal VA are expected to do outreach to actively find more residents. Second, those providers must deliver quarterly performance reports that include occupancy and, critically, outcome data. The outcome data include residents' employment progress and other goals the providers promised to meet in their federal VA funding applications. The program review committee believes the Veterans' Home could benefit from these activities.

If the Veterans' Home is attempting to provide permanent supportive housing for those residents who choose to remain there long-term, as it appears, the Home falls tremendously short of the federal VA-provided permanent supportive housing standards. The Veterans' Home's services to help residents successfully navigate life are less intensive, while the accommodations and rules offer little to no independence and privacy. Tables II-7 and II-8 notably show:

- The Home's case management staffing level is less than one-third the federal VA's, which is a critical difference because the VA's programs rely on case management as the backbone to assisting veterans in living as productively and independently as possible;
- The Home has rules governing resident behavior and possessions, while permanent supportive housing does not (aside from complying with a lease and laws); and
- The Home does not provide residents with their own apartments, while the VA's permanent supportive housing voucher does.

Roughly half the Home's domiciliary residents have lived there more than five years, abiding by the rules, receiving some comparatively limited case management services, and living without privacy, autonomy, or much self-sufficiency. Again, many people outside the Home with whom committee staff spoke were surprised that dozens of veterans have remained in the Home's living situation for several years. *Home residents who need long-term case management should live in permanent supportive housing, which entails receiving those services more intensively while enjoying much higher levels of privacy, personal freedom, and independence.*

Finally, private rooms for residents are required by federal VA standards for the matching state veterans' home construction grants, when new facilities are being constructed.²² The standards, issued in 2011, apply to both nursing home (or similar) and domiciliary care. *The federal VA has recognized, through these standards, that institutional-like personal space is not appropriate for veterans under government care.*

Other states. Only three of the other nine large state veterans' home domiciles take a "transitional" or "housing readiness" approach, as shown in Appendix G – and one of the three

²² See: U.S. Department of Veterans Affairs, "Design Guide: Community Living Centers," 2011. <http://www.cfm.va.gov/til/dGuide/dgCLC.pdf> (accessed November 20, 2014).

may be changing soon.²³ The others mainly serve either older adults (e.g., those who are 55 or older) and/or those who are disabled.

Of the three large domiciles with a “housing readiness” approach, one offers a much higher level of behavioral health services, and another could potentially change soon. A home in Minnesota that averages 160 residents has four social workers and is pursuing hiring more, for a caseload average of 40 (possibly soon 27). It also has two psychologists, a lower-level mental health professional, and a weekly consulting psychiatrist, as noted earlier. Massachusetts’s Chelsea home is under review by a state-mandated commission. The commission is charged with examining veterans’ long-term health care and housing needs, including those of the state’s veterans’ homes, to ensure the state’s efforts are complementary to others’ services and in line with best practices.²⁴

A “housing readiness” approach effectively is not found in veterans’ homes in the other states bordering Connecticut. New York has no domiciliary care, and Rhode Island’s “housing readiness” domiciliary care is being phased out. Rhode Island’s domicile has an authorized capacity of 79 but only one occupant. The state’s previous, recent domiciliary residents have received HUD-VASH vouchers from the VA, which has been providing case management and other services to assist domiciliary residents in moving to independent living.

Federal VA. The federal VA offers some domiciliary care at various locations throughout the country. The VA’s domiciliary care comes under the Mental Health Residential Rehabilitation Treatment Program. Some of the locations are for particular populations, such as homeless veterans or those with Post-Traumatic Stress Disorder. Federal VA domiciliary care can include treatment services as part of the program or not (with intensive outpatient services provided by the VA). It is intended for veterans with “multiple and severe” medical, behavioral health, and social needs.

While Connecticut’s Veterans’ Home does not currently resemble transitional or permanent supportive housing, neither does it look like federal VA-provided domiciliary care. Quite a few of the federal VA’s requirements for its domiciliary care programs differ from the Veterans’ Home’s. Specifically:

- discharge planning begins on the day of admission;
- time-limited for domiciliary care for homeless vets;²⁵
- “treatment or therapeutic activities” must be planned for each person for four hours daily, including during evenings and on weekends;

²³ Excluding Connecticut, which has the second-highest capacity.

²⁴ Massachusetts Session Law, Acts of 2014, Chapter 62, Section 32. <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter62> (accessed October 23, 2014).

²⁵ Committee staff requested some additional information from the federal VA regarding its Mental Health Residential Rehabilitation Treatment Programs, including the time limit on this particular type of program, but the information was not received in time for inclusion in this report.

- for homeless veterans, there is evidence-based behavioral health treatment, as well as life and vocational skills groups;
- suicide risk assessment is done during admissions screening and upon admission, and an “at risk” determination does not necessarily mean the person will not be admitted;
- there is a much higher on-site supportive staffing level, with at least eight social workers (versus four), four psychologists (versus none, aside from the Home’s residential substance use treatment program), two psychiatrists (versus none), and multiple vocational specialists (compared to one) when the facility is the size of the Connecticut Home’s general domiciliary; and
- each program is accredited by The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.²⁶

The Veterans’ Home does not meet the federal VA’s standards for its own domiciliary care in multiple ways. First, the Home places less emphasis on discharge planning, which is meant to help veterans use their time in care to prepare to live successful, independent lives. Second, there is less attention and fewer resources devoted to treatment and therapeutic activities. Third, the Home has chosen not to accept persons with somewhat recent suicidality, which limits its possible pool of applicants.

²⁶ Department of Veterans Affairs. *VHA Handbook 1162.02: Mental Health Residential Rehabilitation Treatment Program*. 2010. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2354 (accessed November 20, 2014).

Domiciliary Care Recommendations

The program review committee recommends overhauling the Home's general domiciliary care. The recommendations call for recognizing the dual domiciliary populations, short-term and long-term, by creating two separate programs. These programs would more closely mirror the transitional housing and permanent supportive housing that is offered by Connecticut nonprofits, other state agencies, and the federal VA. The recommendations also call for an examination of how the Home can best provide substance use treatment services, including through its residential treatment program.

The recommended transitional housing and permanent supportive housing programs should be located in separate buildings, or at a minimum, on separate floors. It is necessary to clearly separate the Home's populations and programs for two reasons. First, the rules and accommodations should be vastly different, offering more space and independence to permanent supportive housing residents. Second, the staff and resident expectations, as well as the atmosphere, should be different for those who are working toward achieving their short-term goals and leaving the Home, and those who have decided to stay within the Home's (currently) institutionalized setting.

The specific recommendations provided in this chapter are centered on five goals the committee believes the Veterans' Home should continually strive to achieve for every resident, including those in the Health Care Facility:

1. Sensible housing based on current evidence-based and best practices;
2. Appropriate mental and physical care;
3. Personal freedom, dignity, and choice, balanced with individual responsibility;
4. Personal growth and fulfillment, leading to a veteran's highest possible level of independence; and
5. Resident representation in governance and decision-making.

Department of Veterans' Affairs (DVA) personnel may feel they are already living by these goals. The program review committee, however, believes there is substantial room for improvement in each of them, for the vast majority of domiciliary residents.

The committee's recommendations try to balance the concerns of many with moving the Home in a direction that better achieves the five goals. The ultimate purpose is to improve the overall quality of life of the veterans for whom the state is entrusted to care. The recommendations are presented first for domiciliary care overall, and then separately for the transitional and permanent supportive housing programs, as well as the Home's substance use treatment services. The transitional and permanent supportive housing recommendations are quite specific because those proposed programs differ so dramatically from the Home's current practices. The detail is intended to ensure the new programs reflect prevailing standards of care for homeless veterans.

Domiciliary Care Overall

Two distinct programs. The Home has substantial populations of short-, medium-, and long-term residents. While the Home's domiciliary care program has a goal of transitioning new residents out of the Home after a few years, it is not programmatically set up or sufficiently resourced to meet that goal. The Home's services do not match common standards for either short-term (transitional) or longer-term (permanent supportive) housing programs for veterans, as documented in Chapter II. The DVA also is not implementing any of the evidence-based and best practices discussed in Chapter I. Therefore, the program review committee recommends:

- 1. The Department of Veterans' Affairs should replace its current general domiciliary program at the State Veterans' Home with two separate programs that resemble transitional housing and permanent supportive housing.**
- 2. The Department of Veterans' Affairs should determine the number of staff needed to fully implement the recommended programs, including case managers / social workers, employment specialists, and behavioral health staff. The department should consider partnering with staff from other state agencies and nonprofits. The DVA should then pursue the necessary resources.**

The transitional and permanent supportive housing program details recommended later in this chapter are intended to align the Home's programs with the established standards for both types of care. Because the Home's current supportive services staffing is inadequate to meet those standards, DVA will need to assess what resources would be necessary and then request them. The programmatic recommendations should be implemented once sufficient resources are in place.

Resident assessment. It is unclear to what extent current residents have been fully informed about the range of housing options that may be available to them. It is also unknown to what extent the Home's domiciliary care veterans are well-positioned for independent living or alternatives to the Home. The residents who stay as the Home adopts strong transitional and permanent supportive housing programs will need to be in either program to be best-served.

- 3. All current residents of the Veterans' Home's domiciliary care (except for those in the Patriots' Landing program) should be fully assessed and given the option to move out of the Home via a federal Department of Veterans Affairs program. Those who choose to stay at the Home should decide whether they would like to be in its transitional housing or permanent supportive housing program. Once the programs are active, the residents would need to comply with the applicable program rules.**
 - a. Home residents should actively participate in an assessment process, which should be done in-person by a team of contracted case managers who work for the VA and/or nonprofit agencies offering case management services to homeless veterans. Each resident should have an assigned case manager.**
 - b. The assessment should be based on a common information gathering tool. The tool should include:**

- i. education, work history, and particular skills, licenses, certifications, or training;
 - ii. financial resources;
 - iii. overall physical and mental health, including any diagnosed disabilities;
 - iv. ability to complete activities of daily living, including the ability to self-administer medication;
 - v. external supports;
 - vi. current length of stay at the Home; and
 - vii. housing preferences, after first receiving: a) an in-person, one-on-one explanation of federal VA transitional and permanent supportive housing options; b) a description of the Home's new programs; and c) the results of the assigned case manager's recommendations.
- c. The assigned case manager should recommend to the resident the type of VA program for which the person is best-suited and which of the Home's new programs is appropriate for the person (transitional housing or permanent supportive housing). Using this information, each resident should choose his or her living arrangement.

The recommended assessment would ensure each Home resident has a chance to fully understand available housing choices and then make an informed personal decision, based on a case manager's recommendation. It also would provide needed data to help the Home and legislature to understand residents' service needs and preferences. The assessment of current residents should not be done by Home staff because they could be too vested in the outcome.

New applicants and behavioral health. New applicants to the Home should be encouraged to live in the housing most appropriate to their situation. This includes being informed of the federal VA's programs so they may opt for a different setting, closer to their home communities. Allowing veterans to choose their housing arrangement with full information increases personal freedom.

- 4. New applicants to the Veterans' Home should submit a modified version of the assessment for current residents (in addition to an admissions application), including a program preference (for either transitional housing or permanent supportive housing). Based on the assessment, the Home staff should recommend the most appropriate program to the resident. As part of the admissions process, and on the Home's website, the DVA should also give the applicants information on federal VA housing options.**

The Veterans' Home staff acknowledged that although the vast majority of residents have at least one psychiatric diagnosis, many applicants are denied admission due to past or current psychiatric problems. The staff cited the Home's lack of behavioral health services as a reason. During the study, committee staff heard from many people outside the Home that admissions seem unnecessarily restricted, especially since a large share of the neediest veterans do have psychiatric problems. The department should consider what it may require to reach a larger number of homeless veterans.

- 5. The DVA should consider what behavioral health and other staff resources may be necessary in order for the Veterans' Home to accept applicants with more-recent psychiatric problems. The DVA should communicate closely with the federal Department of Veterans Affairs and the Connecticut Department of Mental Health and Addiction Services to develop an analysis. The analysis should be delivered to the Board of Trustees and the legislative committees of cognizance by June 1, 2015.**

The following changes are recommended for all Veterans' Home domiciliary care residents, except those in Patriots' Landing (due to that program's different population, setting, and requirements).

Personal living space. The current living arrangements in the main Residential Facility are unacceptable, based on current evidence-based and best practices for transitional or permanent housing. Residents have no privacy and many complained to program review staff that the habits of their roommates were frequent annoyances that detracted from their quality of life.

- 6. Each Veterans' Home domiciliary resident should have a semi-private or private room, with the room's own door. If semi-private rooms are done, residents should be assessed for compatibility and their personal preference (e.g., if the person would like to have a certain resident as a roommate) and then grouped accordingly.**

The Veterans' Home needs to think creatively about how to better use its living quarters, despite the heating and cooling system constraints. For example, the Home could consider constructing walls out of cubicle materials, in combination with dropped ceilings; donations could be sought. Though not perfect, that method would give residents a greater sense of privacy and dignity than currently exists.

On-campus work. The Veteran Worker and Detail programs were intended to benefit residents but have strayed from that goal and become unsustainable. In some cases, Veteran Workers have held their positions for years, and many have participated in the program for several years, as shown in Chapter II. Therefore, the program has lost its original intent of preparing veterans for employment in the broader community. Neither is it providing temporary income or a boost to residents' job searches. Furthermore, many residents resent working alongside state employees under what they view as worse conditions. The Department of Veterans' Affairs has used the Veteran Worker program to supplement its state employee labor force, which gives credence to residents' resentment.

- 7. The Department of Veterans' Affairs should eliminate the Veteran Worker and Detail programs. Prior to the elimination, the DVA should assess the overall need of each position currently in the programs. The DVA should consider working with the Department of Administrative Services and/or the Office of Policy and Management, or a contracted firm, to conduct the analysis. The analysis should determine which positions will be:**

- a. **Converted to state employee positions through a standard, public recruitment process that gives a hiring preference to current Veteran Workers;**
- b. **Converted to time-limited paid state internship or apprenticeship-type positions, for the Home’s transitional housing participants, with the expectation of attendance and a limited amount of sick time; or**
- c. **Eliminated, possibly through assigning small tasks to all Home residents (e.g., up to one or two hours weekly).**

The reforms in this recommendation would give Veteran Workers a chance at state employment and require the state to more fully recognize what it takes to run the campus. The recommendation would also provide a way for residents to gain temporary income and employment – including training in potentially marketable skills – which could assist with or even encourage job searching off-campus. At the same time, it is possible not all current Veteran Worker or Detail positions should be converted to other types of positions. Committee staff heard during the study that some managers have trouble with Veteran Worker attendance and therefore have more workers than would be necessary, if people reliably showed up to work.

Fee. The current program fee is a source of consternation for a portion of residents. Some complained to committee staff that they pay a fee for a program they perceive as nonexistent. A few are concerned that the fee expenditures are not transparent. Still others said the current flat fee is inherently unfair because all residents pay the same amount, regardless of income (once the fee waiver threshold of \$600 income is reached).

In addition to these resident concerns, the fee has not changed since 2008. If the stagnant rate were to continue, DVA could be facing additional financial pressure.

8. Regarding the Veterans’ Home’s current “program fee” and DVA’s Institutional General Welfare Fund, which houses the program fees, the Department of Veterans’ Affairs should:

- a. **Beginning in the 2015 calendar year, a new resident’s first month at the Home should remain free. The fee should be applied for every month thereafter. Veterans who are admitted to the Home before 2015 will continue to have a free first three months.**
- b. **For transitional housing residents:**
 - i. **Specify that the fee is a “resident care fee” and maintain the current level of \$200 for the 2015 calendar year.**
 - ii. **Effective January 1, 2016, the transitional housing resident fee level should be annually adjusted for inflation. A fee waiver can be requested at any time, based on the Home’s current waiver process, and a waiver should be approved if a resident’s income falls below three times the fee level. Each waiver is valid for six months.**

- c. **For permanent supportive housing residents, replace the program fee with an income-based resident care fee, effective January 1, 2016. The income should be determined after subtracting for taxes and court-ordered payments. The fee should be 30 percent of adjusted income.**
- d. **Provide transparency regarding the Institutional General Welfare Fund by formally sharing with all residents a semiannual, plain-language summary of how the Fund is used in accordance with state law (to “directly benefit veterans or the Veterans’ Home”).**
- e. **Provide the opportunity for residents to make suggestions on projects for which they would like to see the Institutional General Welfare Fund used. Residents’ input should be requested at least semiannually.**

While the program review committee recommendations overall should boost program strength, changing the fee’s terminology may help quell some resentment. In addition, the above recommendations would give residents a voice in determining the fees’ use – and clarity on that use.

Moving from a flat fee to an income-based fee for permanent supportive housing residents would bring the charge in line with general permanent supportive housing practices. This step may also dissuade residents with financial means from choosing to remain at the Home, rather than pursue community-based options, primarily because it is so affordable (\$200 monthly for rent, utilities, food, recreation, and basic healthcare services).

The committee considered recommending an income-based fee for transitional housing residents but did not because nearly all federal VA-contracted transitional housing providers charge a flat fee.

Work and life skills. The Home currently does not hold any life or vocational skills classes. Social workers and the vocational coordinator may do some of these tasks with individual residents.

- 9. **The Veterans’ Home should frequently and routinely (e.g., weekly) offer classes on life and vocational skills, such as establishing a bank account, budgeting, searching for jobs online and through networking, navigating federal VA services, interviewing for jobs, and cooking. The Home should consider opening these classes to veterans in the general public, and assess its equipment to determine whether additional resources are needed. The Home should also seek out volunteers to conduct the classes.**

The Home’s social workers and vocational coordinator can continue to offer assistance with these tasks on an individual basis, but making this assistance clearly available and important could help build more residents’ independence.

Volunteering. The Home could more actively solicit volunteers from the community and arrange more opportunities for its residents to volunteer elsewhere.

10. The Veterans' Home should offer and publicize increased volunteer opportunities for the public on-campus, including at the main Residential Facility, and for veterans in the community.

A greater emphasis on recruiting and welcoming volunteers, paired with encouraging residents to volunteer off-campus, would help reduce the isolation of the Home, especially within domiciliary care. The Home could use volunteers to lead or assist with some life and vocational skills classes, as helpers with basic grounds maintenance, and in many other ways. There are volunteer links on DVA's website, but they are not prominent and the volunteer interest form is from 2009. More active outreach, such as to school districts and churches throughout the region, could help the Home gain volunteer visitors.

Security. The security procedures that have been implemented over the last several years are burdensome for many residents, as well as for the Home's Safety and Security staff. The procedures have conveyed to residents that they are not trusted, independent adults. Furthermore, the re-entry inspections reportedly have uncovered few instances of prohibited items. (The inspections observed by committee staff on several occasions were extremely limited in how they were carried out.) The program review committee understands that DVA may be worried about incidents on-campus. At the same time, some of the security procedures are unnecessary for residents, based on how other veteran housing in the state operates.

11. The Veterans' Home should make the following changes to its security procedures for domiciliary residents:

- a. Domiciliary residents who intend to leave the campus should sign out using a log in their building each time they leave campus, noting whether they intend to return that day or a following day. No permission should be needed to leave the campus.**
- b. The Home should transition to a swipe-card door-locking system for its main Residential Facility and Fellowship House. Upon the transition, a resident should no longer be required to swipe a Home identification card at the campus entrance security building, in order to leave or return to campus, and the identification card should open the vehicle gate.**
- c. The Home should discontinue the mandatory visual package and vehicle inspections done when a resident re-enters campus. An inspection may be done when there is reason to believe a resident is bringing a prohibited item onto campus. Written guidelines should be established by DVA regarding what constitutes "reason to believe" and then distributed to each resident.**
- d. Residents should be allowed to use their personal vehicles from their first day at the Home. Permits should be issued within a resident's first week at the Home and remain valid until the person moves out of the Home.**

Removing some of the security procedures will help the Home better balance several of the five goals presented at the beginning of this chapter.

Penalties. Domiciliary residents who break the Home's rules may be charged with a "violation" and required for a time to request permission, via a pass, in order to leave the campus. The pass restriction may remain in place for between 15 days (for the first violation within a 24-month period) and 60 days (for a fourth violation in the time period). State regulations allow the fourth violation restriction to reach 180 days. Many residents are dissatisfied with the pass restriction system and what they view as unfairness in how violations and penalties are issued.

12. The pass restriction system for handling rule violations should be replaced with the following system as of January 1, 2015:

- a. The first violation should result in an immediate meeting (within one working day) between the resident and his or her case manager / social worker and employment specialist. The meeting should involve discussion of the incident, the underlying reason(s) the incident occurred, consequences for subsequent violations, and the resident's plan to avoid or correct the behavior.**
- b. The second violation should result in a similar meeting as the first, but include the domiciliary care administrator and the staff should emphasize that the third offense results in immediate discharge.**
- c. The third violation should result in discharge, appealable to the DVA commissioner. As is current practice, staff should assist the resident in locating a place to live.**

Removing the punitive nature of the pass system is intended to support the Home's rehabilitative goal and give the residents more independence – but also more responsibility. The new system would treat violations as a call for intervention. This system is similar to how transitional housing providers handle violations.

Transitional Housing Program

The program review committee recommends:

13. The Veterans' Home's new transitional housing program should have the following components to ensure a focus on successfully discharging residents to independent living and encouraging personal responsibility:

- a. New residents should have a stay limit of nine months in the transitional program.**
 - i. If a resident reaches the seven-month point, there should be a meeting with the person's case manager / social worker, the employment specialist, and B Clinic personnel to determine what steps need to be taken should the person reach the nine-month stay limit. All options, including entirely independent housing, federal VA programs, and the Home's programs, should be fully discussed and considered. The**

resident should select two preferences and, working with the case manager, aggressively pursue them.

- ii. If, at the nine month point, alternative housing has not been found, a three-month stay extension is possible upon resident request to the program director. The program director should solicit staff opinions from each supportive services area when making the decision.

- b. Current residents in the transitional housing program should have a two-year stay limit.

- i. If, by the twentieth month in the program, a resident is employed and/or enrolled in education or training for at least 30 hours per week, the resident should have the ability to stay in the transitional program for an additional year.

- ii. If a current resident reaches the 21-month point, there should be a meeting with the person's case manager / social worker, the employment specialist, and B Clinic personnel to determine what steps need to be taken should the person reach the 24-month stay limit. All options, including entirely independent housing, federal VA programs, and the Home's programs, should be fully discussed and considered. The resident should select two preferences and, working with the case manager, aggressively pursue them.

- c. A veteran may participate in the transitional housing program twice, either consecutively or at two separate times. If a veteran is approaching the time limit of a second round in the transitional housing program, and prefers to stay at the Home, the resident should move to the permanent supportive housing program.

- d. Discharge planning should begin on the day of admission, including meetings with the person's case manager / social worker and employment specialist.

- e. There should be clear, unified messages from all staff that the resident will leave the program at the specified time limit and needs to spend the time in the program finding employment, pursuing education and/or training, acquiring benefits (including housing benefits), and locating housing options, as appropriate. Staff should project a positive attitude regarding living independently in the community and not use the time limits in any negative manner against residents.

- f. Each resident should meet at least weekly with the person's social worker / case manager. There should be a maximum ratio of one social worker / case manager for every 25 residents. Each resident should also meet at least weekly with an employment specialist if not enrolled in education or training. Those who are enrolled should meet at least monthly with the employment specialist.

- g. There should be a monthly meeting for each resident that includes the person's social worker / case manager, employment specialist, and B Clinic nurse; the resident must attend. The first such meeting should occur within the person's first week.**
- h. When veterans move to independent living, the social worker / case manager should remain in contact and open to assisting the former resident for up to one year. At minimum, the social worker should collect information every three months (including at 12 months after discharge from the Home) on employment and education status, treatment services, and housing type.**
- i. Upon discharge for a violation, or upon voluntarily leaving the Home to avoid a third offense, a resident should be allowed to re-enter the program after three months have passed, if the person has not previously participated in the transitional housing program.**

These recommendations collectively would transform the Home's supportive services from low intensity to high, from allowing service disengagement to (for this program) requiring participation. With these changes, the Home will have a true transitional program that nearly mirrors transitional programs offered by other homeless services providers.

The rationale behind limiting the time in the program and re-admissions is to give residents and staff a sense of urgency around the importance of making the best possible use of veterans' time at the Home. Currently that sense is absent. Furthermore, if a program has not worked for a resident twice, it is highly unlikely that a third time will result in success; the resident should pursue other options (which could include permanent supportive housing at the Home).

Permanent Supportive Housing Program

The program review committee recommends:

- 14. The Veterans' Home's new permanent supportive housing program should have the following components to recognize the long-term nature of some residents' stays and encourage independence:**
 - a. Each resident's social worker / case manager should reach out to the veteran at least weekly; participation in supportive services is the resident's personal choice. The social worker / case manager should monitor the person's well-being and assist in improvement. The social worker / case manager should encourage the resident to attend life skills classes and apply for independent housing programs, such as HUD-VASH and other options. There should be a maximum ratio of one social worker / case manager for every 35 residents.**
 - b. The Home should work to place these residents in a separate building(s) from transitional housing residents (e.g., one side of the main Residential Facility); at minimum, in the short-term, they should be on separate floors. In the long-**

term, the Home should place its permanent supportive housing residents in studio or one-bedroom apartments.

- c. Once the permanent supportive housing residents are in a separate building(s), all rules not involving building and personal safety should be eliminated. There should be a set of rules specifically for residents of the program, mirroring a typical apartment or house lease agreement. A process should be established for eviction if rules are seriously or repeatedly broken. The DVA should develop guidelines for what offenses or accumulation of offenses may result in eviction. Evictions should be appealable to the Board of Trustees. Readmission should be allowed once, no earlier than six months later, for those required to leave.**
- d. There should be a tenants' association, which should meet monthly, to: review program rules and offerings; make suggestions on rules, program offerings, accommodations, and other aspects of the permanent supportive housing program; and receive complaints from residents. The tenants' association should provide a detailed annual report of its activities to the Board of Trustees.**
- e. Residents should be encouraged to attend group recreational activities designed to meet their interests, and may choose to use the Home's on-site medical services (B Clinic) as well as its Dining Hall. Once a permanent supportive housing resident has access to a kitchen with a working stove, the person can choose to use the Dining Hall as a guest, which should include payment.**
- f. The Home should consider starting a compensated work therapy program, modeled after the best practices of such programs, for its permanent supportive housing residents.**

These recommendations acknowledge that many veterans have chosen to live at the Home more or less permanently, and treat them accordingly, based on federally-endorsed evidence-based and best practices. It is the program review committee's strong opinion that persons living in a place for several years should be given the rights and responsibilities of tenants. They should be encouraged to maintain a level of independence in their personal choices, as in any permanent housing arrangement. They also should have their own apartment, including kitchen facilities (though some may choose to eat at the Home's dining hall). The residents should have more frequent contact with a social worker / case manager than is currently done at the Home, in line with current best practices for permanent supportive housing, but should not be required to engage in services. They also should be encouraged to consider moving to permanent supportive housing in the community via other government agency programs.

Substance Use Treatment Services

The Home's residential substance use treatment program is unique, offering a six- to twelve-month program with the possibility of two additional years in the treatment building. It is

unclear if any of the program's stages match evidence-based and best practices. There has been no meaningful communication between the program's staff and the relevant state and federal departments regarding program design.

The Home does not offer substance use treatment or recovery services to the other domiciliary residents, other than the 12-step meetings held by the treatment program. There could be a need to provide services, however, because about half of those veterans have a substance use disorder diagnosis.

Therefore, the program review committee recommends:

15. The Department of Veterans' Affairs should develop and implement a plan by January 1, 2016, to improve its substance use treatment services, as currently provided at the Veterans' Home's Fellowship House.

- a. As part of the plan's formulation, DVA should work intensively with the Department of Mental Health and Addiction Services, the Department of Public Health, the federal Department of Veterans Affairs, veteran organizations, and substance use recovery organizations.**
- b. The plan should be based on evidence-based and best practices for substance use treatment.**
- c. The plan should consider:**
 - i. all aspects of the Home's residential substance use treatment program;**
 - ii. how the Home can best serve its many residents who are in recovery but do not live in Fellowship House; and**
 - iii. whether DVA should offer any substance use treatment to Connecticut veterans in the community who may wish to participate in veteran-specific substance use treatment, and the resources that would be required to take that step.**
- d. The plan should also include:**
 - i. Clear missions for all substance use treatment programs envisioned;**
 - ii. Performance measures, including but not limited to participant satisfaction and outcomes, for all programs; and**
 - iii. How the program staff will collect data on the performance measures.**

The Veterans' Home's residential substance use treatment participants are satisfied with the program, but there is potential for improvement. The DVA should learn how other government agencies who deliver or oversee substance use treatment believe the Home's

program could be improved, and adjust the Home's residential program accordingly. In addition, the Home should consider what type of recovery support services could be helpful to its general domiciliary residents. There may also be a role for the Home to play in giving substance use treatment to a wider range of veterans, such as those who are not homeless but could benefit from residential or other treatment.

Health Care Facility: Assessment and Recommendations

Overall, the Home is providing quality 24-hour nursing care at its Sgt. John L. Levitow Veterans Healthcare Center. The center, more commonly known as the Health Care Facility (HCF), performed well against the standards in its most recent state and federal inspections, including having proper direct care staffing levels and satisfactory facility conditions.¹ The inspections, however, identified two deficiencies regarding resident safety: a serious patient fall due to inadequate precautions in a section of the facility, and the water temperature being too hot in residents' rooms. The facility has either made or is in the process of making specific corrections to rectify its deficient performance.

A key area needing attention by the facility, and the Department of Veterans' Affairs, is the level of nursing staff available for residents' care. Recent cost saving measures require fewer nursing staff on each shift, thus lowering the amount of time direct care staff are available for residents. This follows a 22 percent reduction in nursing positions dedicated directly to residents' care (since FY 09). Although the new staffing standard is well within applicable state licensing requirements, the overall effect on residents' care needs to be closely monitored.

As best the committee could determine, residents are satisfied with living at the Health Care Facility and the overall level of care they receive from the facility. Areas residents indicated as needing improvement include more timely response by nurse aides to residents' immediate needs, a higher level of dignity and respect for residents by some staff, and the overall quality of food served. The facility also does not formally solicit residents' feedback.

The HCF, like the rest of DVA, is beset by certain management information system issues, including data collection and maintenance in some areas. For example, committee staff asked the facility for various admissions-related data for the last five fiscal years. Although the facility provided information in many of the areas requested, it could not provide key admissions data prior to 2013 – including the number of applications received and reviewed by the facility, and the number of veterans admitted to the facility. The committee believes this example, along with other data management problems of the Home identified throughout the report, points to a broader issue within the department, as addressed in Chapter V.

Overview of the Health Care Facility

The Home's 125-bed HCF provides mainly long-term nursing care. The facility has physical and occupational therapy staff, a pharmacy, and a small clinic. It also provides nursing staff to run the domiciliary care medical clinic. The facility accounts for half of the Department

¹ The Department of Consumer Protection inspects the facility's pharmacy every seven years for registration purposes, and the Department of Public Health inspects the Home's laboratory every two years for state licensure and federal certification that allows CMS reimbursement. (The committee did not examine those inspection results, but focused its review on the three primary state and federal inspections of the Health Care Facility operations).

of Veterans' Affairs' budget, and serves roughly a third of the Home's residents, making it an important part of the Home.

The Health Care Facility is heavily regulated by the state and two federal agencies, unlike the Home's domiciliary care, which only undergoes VA inspections.² As a recipient of the VA's per diem payments for nursing care, the facility undergoes annual inspections by the VA. The inspections cover over 150 standards against which the facility's performance is measured, for a more comprehensive inspection than conducted of the Home's domiciliary care. The state Department of Public Health (DPH) also inspects the HCF as part of the facility's state Chronic Disease Hospital licensure, with inspections every two years.³ Further, as a recipient of Medicare and Medicaid payments, the HCF is inspected every four years against the federal Centers for Medicare and Medicaid (CMS) standards.⁴

Assessment and Recommendations

How effective is it? *The Health Care Facility largely meets its primary goal of offering residents a high level of care to ensure their health, safety, comfort, and overall satisfaction.* The committee examined several measures to determine the Health Care Facility's overall effectiveness. Direct care staffing resources, resident safety, occupancy, and residents' satisfaction were reviewed.⁵

- **Program goal – Provide high-quality care:** *The Health Care Facility provides an overall level of care that meets or exceeds most regulatory and resident standards.* The facility offers care to veterans with a range of physical and mental issues. As part of its Chronic Disease Hospital license, the HCF is required to have a certain level of medical staff present at the facility, including medical doctors and a licensed pharmacist. This requirement adds a level of on-site professional care staff not required of long-term care facilities licensed under other categories.⁶ At the same time, the HCF's current staffing levels are not sufficient to avoid overtime costs or the use of outside nursing services when there is not enough regular staff to cover shifts, under the facility's current staffing level goal.

² The state Department of Public Health, as part of its inspection of the Health Care Facility, inspects the food services operation located in the main dining hall, including the kitchen facility, since it is responsible for providing meals to residents in the Health Care Facility as well as most domiciliary care residents.

³ Additional state regulatory requirements applicable to all long-term care facilities apply to the HCF. For example, there are internal oversight requirements (i.e., certain committees to oversee service quality) for events such as falls and medication errors, and infection control, along with requirements to submit specific reports to DPH, including "adverse events" (e.g., untimely deaths).

⁴ CMS inspections are conducted by the state Department of Public Health in conjunction with its biennial licensing inspections of the Health Care Facility.

⁵ Due to this study's time constraints, a comparison of the Health Care Facility's performance with other facilities licensed as Chronic Disease Hospitals could not be conducted.

⁶ When medical doctors are not at the facility, an on-call service at the University of Connecticut Health Center is used.

Direct care staffing. *The direct nursing care staffing level exceeds state licensure requirements, but has recently been reduced as a cost saving measure. Although a few issues with the Health Care Facility became apparent during the study, none was as prevalent as the level of direct care staffing. Direct care staff are registered nurses, licensed practical nurses, and certified nurse aides who provide care for residents.*

Direct care staff have the most daily interaction with residents of all staff at the facility, and provide a range of professional and personal care services to ensure the residents' needs are met. As with any long-term care facility, direct care staff are vital to daily operations. The DPH requirements for nurse staffing at facilities licensed as Chronic Disease Hospitals are provided in Table IV-I.

Table IV-1. Required Nurse Staffing Levels of Chronic Disease Hospitals in Connecticut		
<i>Shift</i>	<i>Maximum Ratio of Patients to Registered Nurses on Duty</i>	<i>Maximum Ratio of All Nursing Staff (RN, LPN, CNA) on Duty</i>
First (7:00 a.m. to 3:00 p.m.)	30:1	10:1
Second (3:00 p.m. to 11:00 p.m.)	35:1	12:1
Third (11:00 p.m. to 7:00 a.m.)	45:1	15:1
Source: Conn. State Regs. Sec. 19-13-D(e).		

The VA's requirements for veterans' home nursing staff as a skilled nursing facility primarily include:⁷ 1) providing an organized nursing service with a sufficient number of qualified nursing personnel, including RNs, to meet total nursing care needs of residents 24 hours a day, 7 days a week; and 2) sufficient nursing services to ensure there is a minimum direct care nurse staffing per patient per 24 hours, 7 days a week of no less than 2.5 hours (also known as hours per patient day, or HPPD).

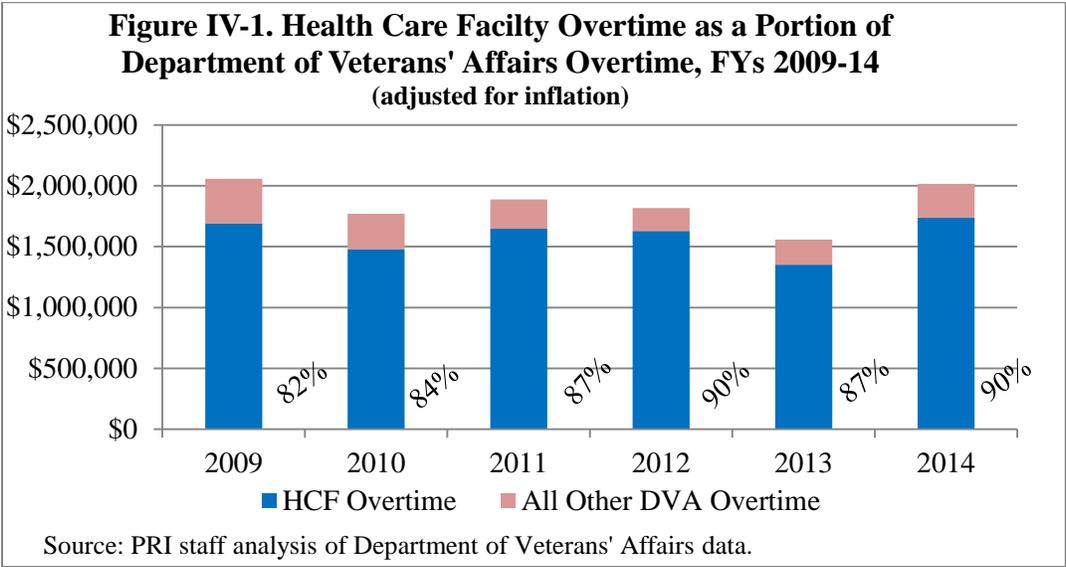
*A review of the facility's most recent DPH inspection report showed no regulatory violations for direct care staffing levels, thus the minimum staffing ratios were met. In addition, the most recent federal VA inspection showed the facility's rating for nursing services met the necessary requirements.*⁸ The federal inspection also showed the HCF met the requirements for nurse aide training; the training is approved by the State.

⁷ The VA recognizes the Health Care Facility as a skilled nursing facility for its regulatory purposes.

⁸ Both the federal VA and state DPH inspections occurred in fall 2014 (October and September, respectively).

The facility has used overtime and private nursing services contractors (i.e., pool staff) to help fill the void between the number of nursing staff at the HCF and the number of staff necessary to meet the facility’s hours per patient day standard. The Health Care Facility has generally used an HPPD level of 3.7 to 4.0, which the current administrator considers low in comparison with private nursing homes in the state.⁹

Figure IV-1 shows fluctuation in overtime costs (adjusted for inflation) for the Health Care Facility as a portion of the department’s total overtime expenditures since FY 09.¹⁰ HCF overtime remained relatively level for FYs 11 and 12, at just over \$1.6 million. Overtime costs dropped 17 percent in FY 13 to \$1.35 million, before increasing again in FY 14 to \$1.74 million, the highest total for the six-year period.



The department’s fiscal office told committee staff the primary reason for the significant decrease in FY 13 was a concerted effort to increase the number of hours part-time nurse aides were permitted to work per week, which reduced the amount of overtime for that year. The office said despite the change continuing in FY 14, the HCF used additional overtime that year to maintain its staffing standard.

In any given year, HCF overtime expenditures averaged \$1.6 million (86 percent) of the department’s total for the last six fiscal years, and ranged from 82 to 90 percent of the department’s total overtime costs. It should be noted, the number of

⁹ The history behind why the Home uses its particular HPPD standard is based on a report produced by the DVA’s planning director in 2012 examining staffing at the Health Care Facility, which stated the average HPPD for long-term care facilities in Connecticut was 3.7 at that time.

¹⁰ Overtime for the Health Care Facility is for all staff, not just direct care staff. However, committee staff was told that direct care staff account for most of the facility’s overtime expenditures.

full- and part-time direct nursing staff (including head nurses) assigned to the various resident floors of the facility decreased 22 percent between FYs 09-14, from 119 to 93. The total staffing for the facility dropped 15 percent, from 189 to 161, for the same period.

The facility has been instructed by DVA leadership to lower its total expenditure, namely by limiting overtime. To do that, the department has required the facility to start using an HPPD standard of 3.5 for direct care staff, instead of 3.7, as of mid-November 2014. The department initially wanted to lower the HPPD level to 3.0, which would still allow the facility to meet state licensing standards. At the request of the facility administrator, who is strongly opposed to any reduction in direct care staffing due to potential safety issues, the new standard was established at 3.5 for now. As discussed more below, the department must give this issue specific attention.

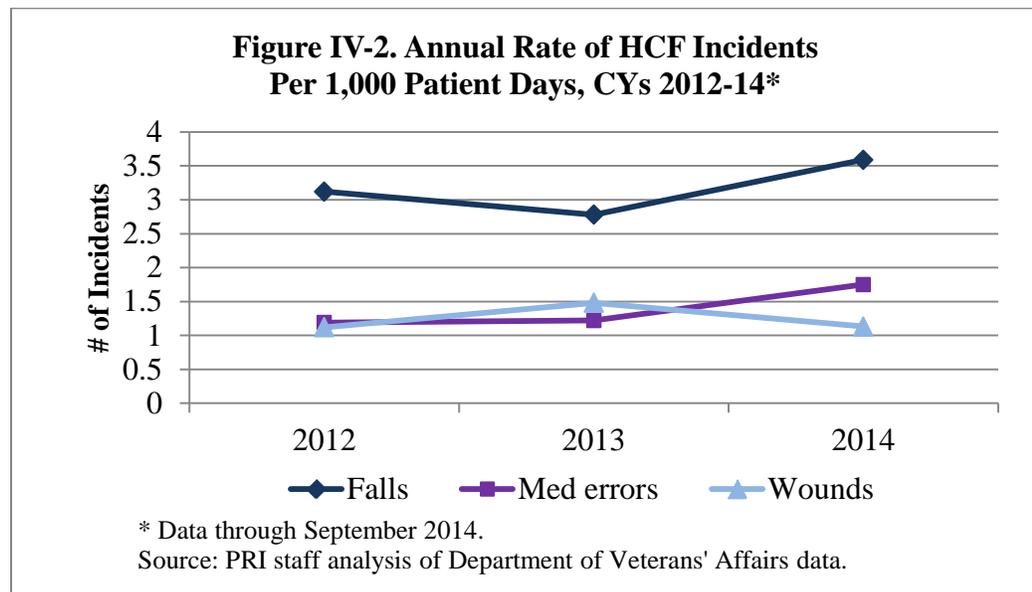
Safety. *The Health Care Facility performs well on several levels regarding residents' safety, although medication errors and falls rose in 2014 (as of September, prior to the lower HPPD standard) from the previous year.* As discussed below, results of federal and state inspections showed positive outcomes for most of the resident safety standards they examined. The committee's analysis of annual incident rates, as a proxy for overall safety performance, shows recent increases in falls and medication errors (but not wounds), and the Health Care Facility has taken steps to address those issues.

Inspection results. On the whole, the most recent federal VA and DPH inspections of the Health Care Facility revealed relatively few deficiencies where residents' safety was directly affected. In addition, none of the inspection reports cited the facility for any continued violations found previously.

The facility received one negative rating on its federal 158-point inspection: water temperature too hot in residents' rooms, which was addressed the same day it was found by inspectors. A new testing procedure was also put into place as part of the facility's required plan of correction.

The DPH inspection revealed two safety-related issues: an unlocked door leading to the loading dock, which allowed a veteran to leave the facility and wander out to the dock and fall off resulting in injury and hospitalization, and a tripping hazard in one of the facility's common areas. (The latter issue was also documented in the federal CMS inspection, which is conducted by DPH inspectors.) The issues were promptly taken care of by the HCF. The facility's plan of correction, submitted to DPH, stated proper procedures would be re-emphasized to facility staff and a new key pad on the door leading out to the loading dock of the facility would be installed.

Incidents. The committee examined three key measures related to resident safety: the numbers of falls, medication errors, and severe wounds.¹¹ Figure IV-2 shows the annual rates (per 1,000 patient days) for each of these incidents at the Health Care Facility for 2012-14. *After a decline in 2013, the rate of falls increased 29 percent in 2014. After remaining relatively steady from 2012 to 2013, the medication error rate jumped 43 percent in 2014. The rate of wounds decreased 24 percent in 2014, to the same level it was in 2012.* The increases in falls and medication errors in 2014 correspond with an increase in overtime, which may or may not be associated.



The Health Care Facility staff is aware its fall and medication error rates have steeply risen. To address the issues, the the facility created a special task force in August to examine reasons for the increased incidents and has begun implementing solutions to help lower incident rates, including more staff education on policies and procedures. The task force meets monthly.

Although the Home fared well on its most recent federal and state inspections in most areas, including resident safety, the uptick in falls and medication errors in FY 14 to their highest levels in three years, could signal potential issues. Combined with the new direct nurse staffing standard discussed above, the program review committee believes *close attention needs to be paid to resident quality care in the Health Care Facility given the recent cutbacks in direct care staffing*, and recommends:

¹¹ Other indicators of the facility's performance include the use restraints, adverse events (e.g., assaults), and whether the facility is meeting the physical, mental, and emotional needs of residents identified in each resident's care plan. Due to time constraints, the committee focused on the three performance indicators provided above in the text.

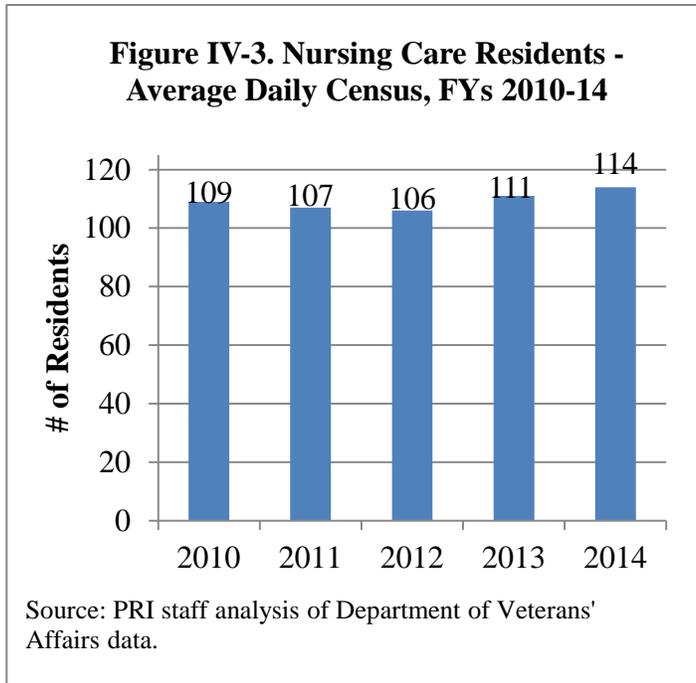
16. The Health Care Facility should continue to track its overall performance and work toward continuous improvement regarding resident care and safety. The DVA commissioner and Board of Trustees (and regulators) should carefully monitor direct care staffing levels at the facility to ensure its performance is not compromised in any way as a result of cost reduction measures.

- **Occupancy:** *The Health Care Facility is experiencing backlog in admissions; a short waitlist exists for the first time since the facility opened in 2008. The Health Care Facility has a maximum occupancy of 125 residents.¹² A formal waitlist for prospective residents was not necessary prior to this year. The HCF currently has a waitlist of four veterans who have been approved for admission but are awaiting beds. The facility does not estimate how long any applicant will be on the waitlist.*

Figure IV-3 shows after three years of decline in the average daily number of residents in the Health Care Facility (during FYs 10-12), to a low of 106 residents, there has been an increase since, to a five-year high in FY 14 of 114 residents.

Under current practices, it is not possible for the Health Care Facility to reach 100 percent occupancy. This is because HCF staff try to keep about 10 beds open for domiciliary care residents needing short-term rehabilitation at any given time. They also reserve beds (generally for ten days) for current residents who need to go to an acute care hospital for treatment.

The Health Care Facility has been operating very close to maximum capacity, which creates multiple issues. First, additional staffing is needed to ensure the facility’s HPPD standard is met. Since there is a finite number of facility staff, an increase in residents typically results in more overtime or additional use of outside nursing services. Second, a strain may be put on the Veterans’ Home for domiciliary care residents who are aging in place and need long-term care, but may not be able to move to the HCF due to capacity issues. Third, operating near or at maximum capacity means the facility cannot offer veterans in the broader



¹² One room is used for a sensory area for dementia residents.

community and their primary caregivers respite care services, an issue identified during this study. The number of respite days provided by the Health Care Facility fell from 245 days in FY 10 to zero days in FY 14, due to a lack of bed capacity. The committee recommends:

17. The Department of Veterans' Affairs should conduct a full needs assessment of its long-term care program to determine if action is necessary to help alleviate capacity concerns and increase the availability of respite care at the Health Care Facility. At minimum, the assessment should examine whether the use of off-site short-term rehabilitation services for domiciliary care residents offers a pragmatic solution. The department should present its findings to the Board of Trustees by July 1, 2015.

- **Resident satisfaction:** *Residents are generally satisfied with the care they receive, although the Health Care Facility has no formal mechanism to collect feedback from residents (or family members).*

Committee staff spent a day at the Health Care Facility personally surveying residents about their experience and satisfaction levels.¹³ A set list of questions was asked of each resident, but many of the discussions expanded beyond the interview protocol. The residents who committee staff spoke with had lived at the facility for an average of just under three years. Key results of the survey were:

- 85% were satisfied with living at the facility;
- 100% felt safe there;
- 69% felt like they have been treated with respect and dignity by facility staff, with most complaints centered around a lack of respect/concern by nurse aides;
- 23% said they have been verbally mistreated by facility staff; one resident said he was physically mistreated, but that the situation had been rectified;
- 92% were satisfied with the care at the facility;
 - 92% with *medical* care
 - 92% with *therapy* care
 - 77% with *nursing* care, with dissatisfaction coming from residents who said the aides used from private nursing services either had been unfamiliar with residents or slow to respond to residents' needs;
- 69% were dissatisfied with the facility's food, with most concerns about meals not being hot or lacking taste;
- 77% were satisfied with the facility's recreation activities, although several residents said they have not participated at their own choosing, not because they have not liked the activities;

¹³ The Health Care Facility provided the committee staff with a list of all residents who did not have conservators, as a method to determine which residents to survey, in person, at the facility. On the day of the survey, the original list contained 35 residents, but one resident had returned to domiciliary care and one resident was in the hospital, for a final total of 33 residents. PRI staff sorted the list in random order prior to going to the facility to conduct the survey. While there, committee staff attempted to contact 30 residents, and had discussions with 13 residents; residents were not available for various reasons (e.g., at medical appointments, not in room, sleeping, or eating).

- 85% were comfortable with bringing any complaint to the facility's staff; and
- every resident knew there was a residents' council at the facility to listen to residents and help address their concerns.

The survey results presented above show mostly positive results about the Health Care Facility's performance and that residents are satisfied with living at the facility. Although a limited number of residents was surveyed, the committee believes the HCF should use the results to make changes where necessary, including a sharp focus on ensuring staff treats residents with dignity and respect at all times. The committee also believes the facility could benefit from a formal mechanism to collect residents' feedback about the facility's performance. While the HCF residents' council partly serves this purpose, an additional method is needed. (Chapter V addresses this area for the Health Care Facility and domiciliary care.)

How does it compare? The Health Care Facility is highly regulated, meets established standards for long-term care, and serves only veterans. Comparisons with other nursing facilities, although interesting, would not be wholly applicable here. In addition, the VA does not publish data from its inspections in a way that would enable a quality comparison across facilities.

Overarching Issues

The preceding chapters focus on domiciliary and nursing care provided at the Veterans' Home. In addition to the specific findings and recommendations presented earlier, several broad-based issues pertaining to the Home's overall operations became apparent during the study. These issues, when combined, point to systemic deficiencies at the Home that should be addressed to improve operational efficiency and effectiveness. The information and recommendations provided below are intended to strengthen the Home's leadership, oversight, performance monitoring, and external perception.

Leadership

As discussed earlier, the Department of Veterans' Affairs has not adjusted its general domiciliary program to either prevailing standards of homelessness programs or for major shifts in housing/homelessness policy. Implementation of the changes recommended in this report will need strong, effective leadership by the department as well as a coordinated and collaborative effort with stakeholders throughout the state. Without these, the committee believes the Home cannot fully serve veterans who seek the state's assistance.

Over the last decade or more, DVA leadership intermittently has been in contact with various housing- and veteran-related organizations but has not implemented most of the advice provided on how to transform its programs and/or buildings. The department generally has not coordinated with or been a part of the housing/homelessness nonprofit sector. Neither has it developed a strong relationship with the federal Department of Veterans Affairs (VA). The DVA is seen as "isolated" – the word numerous people used to describe the Home during conversations with program review committee staff – operating without consideration of evidence-based approaches or current best practices for housing veterans.

There have, however, been a few recent events that indicate the department's partial willingness to make progress in certain areas:

1. converting the West Street Houses to Patriots' Landing, which is a transitional housing arrangement mainly for veteran families, with case management services provided by a private nonprofit;
2. allowing nonprofit agencies to come to the Home to assess interested veterans for possible participation in the federal Supportive Services for Veteran Families (SSVF) program, which could help them obtain off-campus housing;
3. offering tours of the Home to legislators and stakeholders; and
4. agreeing to participate in the state's Homeless Management Information System (HMIS), which is electronic tracking of a person's use of homeless services statewide.

Although these events are short of fully transforming the Home's residential service program as recommended by the committee, they point to DVA becoming more responsive and possibly open to making more fundamental changes in the future. Despite these efforts, *it is clear that additional coordination and collaboration is needed between the Home and external stakeholders if changes are to occur.*¹ *Strong leadership from the Home's administrators and program managers is vital to this objective.* The committee recommends:

18. DVA should fully coordinate and collaborate with key stakeholders who focus on veteran issues, particularly affordable housing for veterans, to identify ways to continually improve the Veterans' Home's services using evidence-based approaches and best practices. As part of this effort, the department should develop a stronger working relationship with the federal VA in Connecticut to better understand the VA's housing programs for veterans, while providing the VA an opportunity to more fully understand the Home's programs.

The committee recently became aware of two important internal issues at the Home that point to either a leadership void or potential leadership conflict. The first deals with direct care staffing levels at the Home's long-term care facility, and the second with a newly-formed Residential Plus Program (assisted living-type program) for the Home's domiciliary residents.

Health Care Facility administration and staffing. The acting commissioner recently created an Executive Assistant position within the commissioner's office. The unclassified position is analogous to a chief of staff or deputy commissioner. The person serving in the new position previously held the classified position of planning director, and was responsible for the planning, lab, and information technology functions of the department.

The new Executive Assistant retains responsibility of his previous functions, but now oversees the Health Care Facility (HCF).² The HCF administrator reports to the Executive Assistant instead of directly to the commissioner, as in years past. This change in and of itself is not necessarily unique, except the HCF budget is almost half of the department's total budget, amounting to more than any other function of the Home.³ Given the relatively small size of the DVA's budget compared to other state agencies, it would seem to make sense organizationally that the administrator of the department's largest expenditure function would be a direct-report to the commissioner, as was previously the case. In contrast, the domiciliary administrator continues to report to the commissioner.

Through the Executive Assistant, staffing changes have occurred at the Health Care Facility, primarily to lower overtime costs. As discussed in the previous chapter, the facility has been instructed to decrease its direct care standard from the current 3.7 hours per resident per day to 3.5, thus reducing the direct care nursing staff required per shift. Although this change will

¹ The committee has learned from VA-Connecticut that it recently offered the DVA commissioner an opportunity to temporarily suspend VA referrals to the Home, giving it an opportunity to make improvements to its facilities that both the VA and department consider necessary. The commissioner agreed, and such referrals are on hold (at least as of December 2, 2014).

² According to DVA, the Executive Assistant holds a Ph.D., in Health Administration and is Board Certified in Healthcare Management.

³ FY 14 total expenditures for the department were \$28.8 million. Health Care Facility expenditures totaled \$14 million, or just under 50 percent of the department's total expenditures.

result in fewer hours the nursing staff spends with residents over the course of a day, the department has said the new staffing levels are still well above the minimum required under state licensing requirements.⁴ The current HCF administrator does not agree the standard should be lower because resident care could be compromised. On the other hand, the department has said it needs to find increased efficiencies and has identified a lower direct care staffing standard at the HCF as a key area for cost savings. The committee understands both viewpoints, and believes the commissioner and Board of Trustees should continue to monitor the situation, as recommended in Chapter IV.

Residential Plus Program. This new program is designed as a way to fill the Home's void in care for residents in the Residential Facility whose needs are too complex for that setting, but do not rise to the level of care provided by the Health Care Facility. The Residential Plus Program (RPP) allows residents to live in the Residential Facility near its medical clinic, with increased nursing care to assist residents with activities of daily living. Nurse's aides from the Health Care Facility provide the additional care, on first and second shifts. There are about 13 residents in the program.

Admissions to the Residential Plus Program were stopped in June 2014 by the previous commissioner to address issues. The DVA has admitted *the program was poorly designed, does not follow the necessary state Department of Public Health licensure guidelines that could be applicable, and has required more nursing and janitorial staff than originally anticipated.* Apparently, some work with DPH has progressed, but the program remains in administrative limbo.

The committee believes the difficulties experienced by RPP, including the suspension of new admissions to the program, point to a larger issue DVA must address: how the department plans to accommodate residents who are aging in place. The average age of domiciliary residents is 61, and almost a quarter of respondents to the committee staff's survey indicated they have no intention of ever moving out of the Home. These factors collectively mean *the Home needs to sufficiently address its aging domiciliary care population who need additional services the Home is not currently prepared to offer.*

19. The Department of Veterans' Affairs should work with its Board of Trustees on devising a strategy and program to address the issue of residents who are aging in place. A well-designed plan should be developed by October 1, 2015. A summary of the plan should be forwarded to the department's legislative committees of cognizance, and included in the board's 2015 annual report. If needed, additional resources should be requested of the legislature.

Performance Oversight and Monitoring

The department has not engaged in any strong internal efforts to evaluate the quality and outcomes of its services. Program accountability has become a routine business practice for most state-contracted nonprofits, but the Department of Veterans' Affairs has demanded little from the Home, which accounts for the vast majority of the department's focus and resources. It is

⁴ DVA notes the current state Chronic Disease Hospital licensing requirements for nurse staffing equate to 2.75 hours per patient per day.

unsurprising, then, that the department has not regularly produced for its Board of Trustees or for the legislature any quality or outcome data that could have indicated problems, particularly within domiciliary care.

At the same time, *minimal external accountability of the Home has been required*. For example, the board has not been fully active (until recently) or independent of DVA, and the legislature has not included DVA in its Results-Based Accountability (RBA) efforts. The legislature also splits responsibility for the department between two committees, Veterans' Affairs and Public Safety and Security, which might have created confusion over who is responsible for overseeing the Home's programs and performance.

Board of Trustees. State law requires the establishment of a 17-member Board of Trustees for the DVA, comprised of the commissioner and 16 members appointed by the governor and legislative leaders.⁵ Board members are volunteers, and their service is coterminous with their appointing authority. The board is required to:

- meet quarterly and “upon the call of the commissioner;”
- advise and assist the commissioner in: the Veterans' Home's operation; administration, expansion, or modification of the department's existing programs and services; and development of new programs and services;
- review and approve any regulations concerning admission, discharge, or transfer procedures, as well as a per diem fee schedule for programs, services, and benefits; and
- develop an annual report on its activities and recommendations for improving service delivery and new programs, and submit the report to the governor and DVA's legislative committees of cognizance.

The Board of Trustees failed to meet between December 2010 and September 2012. It tried to meet in early 2012, but did not achieve a quorum so the meeting was cancelled. Since then, the board has met quarterly. In its most recent audit of the department (covering fiscal years 2011-13), the state auditors also found the board did not meet its statutory requirements for meeting or providing sufficient notice of its meetings.

Table V-1 shows, *attendance at recent board meetings has been sporadic*, with a quorum not reached in three of the last eight meetings. *A review of the board's minutes also indicates certain members missing numerous meetings.* For example, one member missed all eight meetings, another was absent six times, and three members did not attend five meetings. In addition, at no time since at least September 2012 has there been a full complement of members appointed to the board, although the number of vacancies has been decreasing; only one vacancy needed to be filled as of June 2014.

⁵ C.G.S. Sec. 27-102n.

Table V-1. Department of Veterans Affairs Board of Trustees: Activity					
<i>Calendar Year</i>	<i>Number Attending Meeting</i>	<i>Number Absent from Meeting</i>	<i>Quorum Met*</i>	<i>Number Appointed**</i>	<i>Number of Vacant Appointments</i>
2012					
September	10	2	✓	11	5
2013					
January	6	7	No	12	4
March	9	4	✓	12	4
June	6	7	No	12	4
September	10	4	✓	13	3
2014					
January	7	7	No	13	3
June	9	7	✓	15	1
October	12	4	✓	15	1
*According to statute, a quorum of the board is a majority of its members.					
**Does not include the DVA commissioner, who is a standing member of the Board, and not appointed to the Board by the governor or legislature.					
Source: PRI staff analysis of Board of Trustees minutes.					

The board has failed to fulfill one of its duties and appears not to have been highly engaged with the overall performance of the Veterans' Home. The board has not met its statutory requirement of producing an annual report since 2007. In addition, based on a review of the board's minutes since late 2012, until recently it has had very limited discussion on the Home's overall performance in meeting its missions. The committee believes the board needs to take a more proactive approach to fulfilling its role, but also needs more information from the department for that to occur. State law does not require the board to have a chairperson, unlike other state governmental boards in Connecticut, which may have contributed to the board's low engagement.

The acting commissioner appears to want a more active, transparent board, based on a recent board meeting attended by committee staff. For example, the commissioner requested the board members work on different ad-hoc committees to examine various operations of the Home, with reports made back to the full board. There also were commitments for more input from residents, to properly advertise board meetings, and to complete the required annual reports on time.

These initiatives are signs the board is progressing in a positive direction. The committee believes, however, additional work by the board is necessary to strengthen its oversight and monitoring role of the Veterans' Home. The following recommendations are made to that end:

20. The Board of Trustees should be strengthened in the following ways:

- a. All current and new board members should fully understand and work toward their role to advise and assist the commissioner on the Home's programs, services, and administration. Members should request the necessary information from the department to appropriately monitor the Home's overall progress towards meeting its missions and the department should provide the information in a timely manner.
- b. The board should develop (and submit to the legislature and governor) an annual report by February 15 of its previous calendar year's activities. At minimum, the report should include the Home's progress in fulfilling its mission based on programmatic outcomes.
- c. A full complement of members should be appointed to the board by March 1, 2015. The appointing authorities should continue to ensure members are appointed in a timely way when vacancies occur.
- d. The governor should appoint a chairperson, other than the DVA commissioner, from among the members of the board. The chairperson should have the authority to call meetings of the board, as should a majority of the board membership.
- e. Beginning January 1, 2015, any board member who fails to attend three consecutive meetings or who fails to attend 50 percent of all meetings held during any calendar year should be deemed to have resigned from the board.
- f. Board membership should include one veteran from each of the Home's permanent and transitional housing programs, and long-term care facility. The members should be elected yearly, or upon a member's resignation, by fellow residents, and serve in a non-voting capacity on the board.
- g. All meeting notices, minutes, and reports of the board should be prominently posted on the department's website (and provided in accordance with all current statutory requirements). The information should be kept current, with meeting minutes posted to the website within seven days after each board meeting (with an indication that they are considered "draft" until approved by the board). Any historical information pertaining to the board – dating back to at least January 1, 2012 – also should be posted.

Program monitoring. A proper data management system with the ability to produce accurate and timely information regarding quality is vital to the Home's overall performance. The data management deficiencies previously discussed impede the Home's collection and analysis of critical data. Without adequate and timely information, proper oversight and monitoring is not possible.

The Home is making some improvements to its data systems. It is currently transferring to an electronic health records system. The move, part of a federal requirement, is scheduled to begin implementation in 2015. The intended result is a modernized record-keeping system that should prove very helpful in tracking and managing resident data. In addition, the Home continues work on implementing its strategic plan of upgrading the agency's computer network infrastructure with support from the Department of Administrative Services.

Progress in these areas, while important, only addresses part of the Home's current data issues. The Home still needs to develop relevant performance measures, and then collect and analyze the data to fully evaluate program quality – including outcomes – to ensure the Home is meeting its mission. The Home must develop the internal capacity to determine whether its programs are operating well and improving the lives of its residents. The program review committee recommends:

- 21. The Department of Veterans' Affairs should establish an internal workgroup to examine the overall capacity of the department's management information system. The workgroup should include agency leadership, program managers, and the Department of Administrative Services. The group should review the program data currently collected by program managers and the system(s) used to collect the data. The group should develop appropriate measures to gauge programmatic implementation and outcomes and ensure the data necessary to support such examination is collected and maintained. Once the workgroup's review is completed, it should report its findings to the department's Board of Trustees.**
- 22. Beginning January 1, 2016, and annually thereafter, the department should develop an annual Results-Based Accountability-style report card to fully capture its performance based on RBA principles. The report card should be promptly distributed to the Board of Trustees and the legislature's committees of cognizance, and posted on the department's website.**

Another way the Home can help monitor its performance is to formally solicit and use feedback from residents about their overall satisfaction with the Home and its services, which is not done for either domiciliary or nursing care. The committee found its surveys of residents (and local veteran liaisons) very informative. The response rate to the domiciliary care survey, in particular, was positive and showed many residents wanted to have their opinions and thoughts considered in how the Home operates and can be improved. Residents at the Health Care Facility were also appreciative that their feedback was requested.

- 23. The Veterans' Home should collect residents' feedback through an anonymous annual survey regarding, at minimum, specific services and program components. The results should be formally shared with all residents and the Board of Trustees. The board should include the results in its annual reports.**

The Home needs to monitor its own performance and continually work to improve resident satisfaction. Surveys of residents can be one mechanism to provide the Home, Board of

Trustees, and external stakeholders with honest feedback from residents about their experiences at, and perceptions of, the Home.

Public Relations

The Home has been hindered by deficient outreach and public relations. In discussions with key stakeholders throughout the state who work on veterans issues, including a survey of local veterans liaisons, many were either unfamiliar with the Veterans' Home and its services or had limited knowledge. The Home's Stand Down event seemed to be the most widely known aspect of the Home.

The department's practice has been to not actively solicit donations, either individual- or corporate-based, aside from its Stand Down event. It is unclear to the committee why this choice was made. The DVA does accept donations, and there is information on its website about how donations to the Home may be made. Given the Home's many needs, it only makes sense to proactively seek donations that could serve to enhance the Home's physical structure and services to its veterans.

The Home has been portrayed negatively in the press recently. In addition, a core group of residents and some from outside the facility have levied accusations against the Home for several years that continue to plague the agency, and various lawsuits have been brought against DVA. The committee believes it would serve the department well to do all it can to proactively enhance its public perception, including the possibility of a "rebranding" effort, particularly for the Veterans' Home.⁶ To that end, the department is seeking a "manager of community advocacy" position along with a legislative liaison, which should go a long way in helping the department with its external affairs.

Long-Range Planning

The intent of this report's recommendations involving domiciliary care is to move the Home toward a system that more clearly delineates transitional housing from permanent supportive housing, with the goal of providing better quality of life for the Home's residents. The time frame to implement the recommendations is considered short-term. Additional long-term work is needed to fully determine what the Home should reflect or represent from a philosophical and practical perspective.

Appropriateness of the Home's institutional setting. Most of the Home's buildings, although structurally well-built, are approaching 80 years old. Given the era when the buildings were constructed, the main Residential Facility was built around a "barracks" design, and the entire facility has a distinct institutional feel, both visually and programmatically.

⁶ The committee believes part of this effort should be to remove the fence surrounding the campus as quickly as possible. The fence only adds to the perception that the Home is an institution-style complex. Although there may have been good reason for the fence in the past, it is no longer needed. The state also should consider renaming the Home as a "rebranding" effort and to better differentiate its different housing programs, as recommended by the committee.

There is debate around whether a portion of veterans prefers to live in the Home's domiciliary care (presuming financial and logistical ability to live elsewhere) and if the Home, in its current capacity and physical structure, should continue to be an option for veterans from the state's perspective. This debate is about whether it is appropriate for people to live, long-term, in an institutionalized setting. Generally housing policy in Connecticut has shifted to community-based living. Many institutions that provided essentially permanent housing for people with mental disorders or developmental disabilities have been closed, while others are being phased out. There is also greater emphasis on providing medical and life care services in the community for persons who need nursing care, instead of admitting people to nursing homes.

Veterans in domiciliary care, however, actively can choose to continue to live in an institutional setting, which changes the question somewhat.⁷ Some staff at the Home believe certain veterans are happiest and healthiest there, due to the structure and veteran camaraderie the staff perceives. That sentiment was also conveyed by several residents at the committee's two public hearings on this study. Others are concerned that there must continue to be a place where a veteran can always live, provided the person meets admission requirements.

Housing First versus transitional housing. As discussed in Chapter I, Housing First – the practice of permanently housing homeless persons without preconditions and followed by any necessary supportive services – is an evidence-based approach and implemented by multiple federal housing programs for veterans. It is possible the DVA, however, has not adopted any Housing First-oriented programs, or more aggressively encouraged the Home's residents to move off campus to permanent housing, because there is still some debate around the effectiveness of transitional housing (loosely, the Home's current model) and permanent supportive housing using the Housing First approach.

Many of those providing or most familiar with transitional housing programs assert that transitional housing is a necessary or preferred step for homeless veterans, who might particularly thrive in a more structured environment. Transitional housing for persons leaving incarceration or chronic homelessness, or who are in substance use recovery, might also be appropriate, in the view of some. The huge philosophical shift needed to embrace Housing First's embodiments of permanent supportive housing and rapid rehousing, which prioritize housing in the community, can be a difficult change. Concern also exists that there simply are not enough affordable housing units to fully move from a transitional housing to a Housing First approach. These concerns are understandable, even though little research exists on supporting the efficacy of transitional housing.

Setting the debates aside, it cannot be ignored that the Veterans' Home houses well over 200 domiciliary care veterans. Some are short-term residents, and others are not. The Home, however, is not meeting accepted supportive services standards for either population, which must change in the short- and long-term.

⁷ For example, 24 percent of respondents to committee staff's survey of domiciliary residents indicated they do not plan on ever leaving the Home. Several residents who testified at the committee's public hearings also said the Home has been a positive influence in their lives and, in some cases, saved their lives.

Vision. The Department of Veterans' Affairs, like many state agencies, has felt pressed by the fiscal climate over the last several years. Nevertheless, it is a responsibility of leadership to propose a vision of how to best serve clients, even in tough budgetary times.⁸ While such a vision might have been privately held, nothing has been produced – either on paper, or in terms of a philosophical shift at the Home. It is possible that a clear statement of how effectively homeless veterans are being served in its domiciliary care, how that compares to evidence-based practices, and what it would take to bridge any gap, would have been sufficiently compelling to produce any needed resources. The agency transformed its long-term health care program in 2008 through building a new facility, but has not taken any focused steps to do the same for its domiciliary care, which serves more people with different needs.

The committee believes Connecticut is at a critical crossroads with its Veterans' Home. An important opportunity exists to create a long-term vision for how the state provides residential services and care for veterans, not only at the Veterans' Home, but statewide through nonprofit service agencies. In addition to this study, a working group of key stakeholders under the direction of the Lieutenant Governor has been created to examine the Home and decide if its services and campus are in need of change, including a full review of the Home's facilities.⁹ Combined, and working in coordination, these initiatives can establish the necessary improvements for how the State Veterans' Home can best serve Connecticut's veterans, now and in the future.¹⁰

⁸ C.G.S. Sec. 27-102l(c)(6) gives the DVA commissioner the power and duty to develop a long-range plan. To date, no such plan has been developed to the committee's knowledge.

⁹ The Veterans' Home has numerous facilities-related issues. For example, there are over 200,000 square feet of vacant space that must be minimally maintained to retain the structural integrity of the buildings (at the department's expense), doors that do not meet current federal standards for persons with disabilities, and no sprinkler system in the Residential Facility's main dining hall. DVA is in the process of securing funding to address some of the safety-related facilities problems. The legislature recently approved \$500,000 to conduct a facilities review at the Home.

¹⁰ The program review committee encourages the Lieutenant Governor's working group, as part of its efforts to examine the Home, to assess the need and capacity for transitional and permanent supportive housing (as well as residential substance use treatment) among Connecticut veterans statewide.

Appendices

Housing First

Achieving permanent (supportive) housing through a Housing First approach has become a key strategy for federal homelessness programs. Developed as a concept in the early 1990s, Housing First is a service delivery framework designed to fight homelessness, and not a specific program. Housing First programs are intended for homeless individuals who are then housed permanently.¹ The federal Substance Abuse and Mental Health Services Administration has identified Housing First as an evidence-based best practice for serving people experiencing chronic homelessness.²

What is it? The Housing First framework has two core components: 1) quickly move people from dire or precarious living conditions, such as living on the street or in emergency shelters, straight to permanent housing; and 2) eliminate preconditions to permanent housing.³ Securing permanent housing for someone experiencing homelessness fulfills the basic human need of housing, and is seen as the first step toward dealing with the issue of homelessness – particularly chronic homelessness.⁴ Complete fidelity to the model means sobriety, completion of a treatment program, psychiatric stability, or employment are not preconditions to permanent housing.

Housing First can also extend to helping people on the verge of losing housing, remain there. This involves offering financial or other resources to stabilize the immediate threat of homelessness, then services to help the problem from recurring.

Housing First support services vary but usually include case management and community-based clinical teams to provide continuous access to: crisis intervention; mental health, primary care, and addictions treatment; financial management; landlord and family mediation; and employment.⁵ Although Housing First emphasizes a combination of housing and supports, clients are not required to engage in services to obtain or maintain housing.⁶ While

¹ Pearson, Carol L., Locke, Gretchen, Montgomery, Ann Elizabeth, and Buron, Larry, 2007, *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness*, U.S. Department of Housing and Urban Development, Office of Policy Development and Research. <http://www.huduser.org/portal/publications/hsgfirst.pdf> (accessed November 4, 2014).

² Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based and Effective Programs and Practices, Pathways' Housing First Program. <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=365> (accessed November 5, 2014).

³ Tsemberis, Sam. *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Manual*, (2010), as cited in *European Journal of Homelessness*, Vol. 5, No. 2, December 2011. <http://www.feantsaresearch.org/IMG/pdf/review-2-3.pdf> (accessed November 2, 2014).

⁴ *Ibid*

⁵ *Ibid*

⁶ U.S. Interagency Council on Homelessness, *Housing First*, Washington, D.C. Undated. http://usich.gov/usich_resources/solutions/explore/housing_first/ (accessed November 22, 2014).

participants can refuse support services, some Housing First programs may require meetings with a team member at least four to six times monthly to ensure their safety and well-being.⁷

Housing First is a markedly different approach from “housing readiness” to ending homelessness. Within the housing readiness model, people experiencing homelessness may cycle through various phases of housing (e.g., emergency shelters and transitional housing) and be required to meet certain conditions, such as participation in treatment programs, before “gaining” permanent housing.⁸ The Housing First approach focuses on the housing component first, and commits to working with clients as long as they need assistance.

How effective is it? In addition to recognition by SAMHSA as an evidence-based best practice, additional national research points to the overall efficacy of Housing First as a viable approach to ending homelessness, including among veterans. The National Center for Homelessness Among Veterans determined studies have demonstrated that Housing First is a clinically effective and fiscally efficient model of permanent supportive housing that can be implemented successfully in VA Homeless Programs. Housing First works because veterans are more likely to achieve stability and improved quality of life when the risks, uncertainty, and trauma associated with homelessness are removed.⁹

According to the U.S. Interagency Council on Homelessness, Housing First programs have been shown to have higher housing retention rates, lower returns to homelessness, and significant reductions in the use of crisis services and institutions.¹⁰ Specific research around residential stability shows, for a two-year time frame, Housing First participants were stably housed for 19 months compared to 7 months for participants in traditional programs that made treatment and sobriety prerequisites for housing.¹¹

Two key VA programs have initiated a Housing First approach, and the VA’s longstanding transitional housing program seems to be moving toward incorporating several concepts associated with Housing First, as discussed in Chapter I.

⁷ Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based and Effective Programs and Practices, Pathways’ Housing First Program. First Program.

<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=365> (accessed November 5, 2014).

⁸ Tsemberis, Sam. *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Manual*, (2010), as cited in European Journal of Homelessness, Vol. 5, No. 2, December 2011.

<http://www.feantsaresearch.org/IMG/pdf/review-2-3.pdf> (accessed November 2, 2014).

⁹ VA National Center on Homelessness Among Veterans <http://www.endveteranhomelessness.org/housing-first-veteran-centered-care> (accessed November 17, 2014).

¹⁰ U.S. Interagency Council on Homelessness, *The Housing First Checklist: A Practical Tool for Assessing Housing First in Practice*. Undated. http://usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf (accessed November 20, 2014).

¹¹ Substance Abuse and Mental Health Services Administration. <http://www.nrepp.samhsa.gov> (accessed November 19, 2014).

Appendix B

Table B-1. HUD-VASH in Connecticut, FFYs 2008-2014									
<i>VA-Medical Center</i>	<i>Location of High Need</i>	<i>FY 2008</i>	<i>FY 2009</i>	<i>FY 2010</i>	<i>FY 2011</i>	<i>FY 2012</i>	<i>FY 2013</i>	<i>FY2014 Rd. 1</i>	<i>Total</i>
Danbury Community-Based Outpatient Clinic	Danbury	0	0	15	0	0	0	0	15
Newington	Hartford	0	35	15	50	50	0	0	135
Newington	Hartford and Statewide	0	0	25	0	0	10	42	77
John J. McGuirk Outpatient Clinic (New London)	New London	0	0	25	0	0	0	0	25
Waterbury Community-Based Outpatient Clinic	Waterbury	0	35	25	25	40	0	0	125
West Haven	Bridgeport	0	0	0	0	0	15	0	30
West Haven	Bridgeport and Statewide	0	0	25	0	10	15	0	50
West Haven	New Haven	0	35	0	0	50	0	0	85
West Haven	West Haven	70	0	25	0	15	15	12	137
Total		70	105	155	75	165	55	54	679
Source of data: U.S. Department of Housing and Urban Development.									

Appendix C

Table C-1. Supportive Services for Veteran Families Grant Awards in Connecticut, FFY 2014		
<i>Grantee</i>	<i>Award Amount</i>	<i>Number of Participants Served</i>
Community Renewal Team, Inc. (CRT)	\$519,000	~175 participant households in the Central Connecticut Counties of Hartford, Middlesex, New London, and New Haven
The Workplace, Inc.	\$1,256,494	~240 participant households in Southwest and South-central Connecticut
Columbus House, Inc.	\$1,487,245	~300 participant households in New Haven, New London and Middlesex Counties
Source: Department of Veterans Affairs: 2014 SSVF Awards. http://www.va.gov/HOMELESS/ssvf/docs/FY2014_Grantees_SSVF_Abstract_Website_Version_August2014.pdf		

Domiciliary Resident Survey

The program review committee staff surveyed the Veterans' Home's domiciliary residents living in the main Residential Facility (i.e., the Domicile), Fellowship House, and STAR apartments. The survey and its accompanying logistics were one of the major ways in which the committee staff gathered information on the residents' experiences, perceptions, and satisfaction regarding the Home. This appendix describes survey distribution efforts, collection, participation, and data entry and analysis. It also provides the survey results, which were entered into a copy of the survey.

Pre-Distribution

In late September, the program review committee staff sent a letter to all Veterans' Home residents (except those in Patriots' Landing). The letter notified them of the committee's study and requested their participation in multiple, upcoming ways: the domiciliary resident survey; the committee's October and November public hearings; interviews with some Health Care Facility residents; and attending a Veterans' Council meeting.

In late October, the committee staff issued another letter, this time to only domiciliary residents. The letter informed the residents that the survey would be delivered shortly and asked them to participate in a community meeting, scheduled for Monday, November 3, so committee staff could introduce the survey to them and answer any questions. No Home staff attended the meeting, at the program review committee staff's request.

The community meeting was held. An estimated 60 to 70 residents were present for all or part of the meeting. Committee staff answered questions about the study, the survey, and the impacts of both. They also heard numerous complaints. The meeting lasted nearly an hour.

Distribution and Collection

Program review committee staff delivered the survey to residents via the Home's mail system on the afternoon of Monday, November 3. The survey was anonymous; no names were collected and neither the surveys nor the envelopes were numbered to track which residents had responded. To limit the possibility of a resident filling out multiple, copied surveys, residents were instructed to return their surveys in enclosed envelopes.

Survey collection was done both in-person and through the mail. The study team members took turns sitting at a table in the dining hall during the entirety of all three meals for the two days following survey delivery (Tuesday and Wednesday). The team collected the surveys in an open box. Many residents chose to use the opportunity to speak with the committee staff about the study and/or the Home. A few residents returned the survey via mail. The deadline for receipt was Friday, November 7. Some surveys were received well after the deadline; these were reviewed by committee staff but not included in the analysis, which was nearly complete by the following Friday.

Participation

Ninety-six surveys were returned on-time, of the 223 distributed, for a response rate of 43 percent. Survey respondents seem to have been very slightly younger than the whole domiciliary population, with median ages of 61 and 62, respectively. Some caution in this respect is necessary because the share who chose not to provide an age was fairly large (9 percent). All three of the domiciliary populations surveyed – main Residential Facility, Fellowship House, and STAR – were represented in the responses, with slight under-representation from Fellowship House residents (14 percent of responses, versus 16 percent of the population) and correspondingly higher over-representation from main Residential Facility residents.

There seems to have been substantial over-representation from Veteran Workers, who were about 58 percent of respondents but only 38 percent of the domiciliary population. The effects of this over-representation are unclear.

Data Entry and Analysis

Survey data were entered into Excel by a legislative nonpartisan administrative assistant. The study staff analyzed the data using SPSS and converted text responses to the most frequently responded categories, to facilitate data analysis.

The results follow, entered into a copy of the survey. The survey's spacing has been adjusted to accommodate the results and this document's margins. The original survey was two double-sided pages.

**Legislative Program Review Committee
State Veterans' Home: Residents Survey**

General Information

[Note: M= indicates the percent of returned surveys missing a response to the particular question. The percentages in the response options were calculated excluding the missing responses.]

1. In your current stay, how long have you lived at the Veterans' Home? **(circle one)** *Missing=1%*
 - a. 3 months or less: 5%
 - b. 3 - 6 months: 6%
 - c. 6 months - one year: 8%
 - d. 1 - 3 years: 20%
 - e. 3 - 5 years: 7%
 - f. 5 - 10 years: 36%
 - g. 10 - 20 years: 15%
 - h. more than 20 years: 2%

2. How old are you? _____ years *Median = 61 years. 25th percentile: 56 and 75th: 66*

3. What part of the Residential Facility do you currently live in? **(circle one)** *M=2%*
 - a. Main Domicile: 85%
 - b. Fellowship House: 14%
 - c. STAR: 1%

4. Which Veteran Improvement Program (VIP) are you currently in? **(circle one)** *M=4%*
 - a. Accelerated: 2%
 - b. Standard: 15%
 - c. Extended: 21%
 - d. None (by my choice): 15%
 - e. I don't know: 47%

5. How many different times have you lived at the Home, including your current stay? **(circle one)** *M=1%*
 - a. This is my first time: 76%
 - b. 2 times: 21%
 - c. 3 times: 1%
 - d. 4 or more times: 2%

6. If you've lived at the Home before, were you ever involuntarily discharged? **(circle one)** Yes No
Of those who indicated they had lived there before and responded to this question, 43% said yes.

7. Are you currently: **(circle Yes or No to each question)**
 - a. A Veteran Worker? *M=10%* Yes: 58% No: 42%
 - b. Employed off campus? *M=20%* Yes: 4% No: 96%
 - c. Looking for a job off campus? *M=18%* Yes: 29% No: 71%
 - d. Applying for Veteran benefits or a program that could help you move off campus? *M=15%* Yes: 38% No: 62%
 - e. Enrolled in education or a job training program? *M=20%* Yes: 12% No: 88%

Overall

8. What is the main reason you live at the Veterans' Home? **(circle only one answer)** *M=1%*
Percentages below include all responses, including the 22% who marked more than one answer
 - a. My current off-campus job does not pay me enough or give me the fringe benefits I need to move out: 3%
 - b. I like being around other veterans: 0%
 - c. It is an affordable place to live: 16%
 - d. The Home's services (medical, substance use treatment, social work, and/or education and job) help

me: 27%

- e. I think of it as my retirement home: 14%
- f. I have no other place to live: 52%
- g. Other reason: 21%

9. Overall, how satisfied are you with living at the Veterans' Home? **(circle one)** $M=3\%$

- a. Very satisfied: 15%
- b. Satisfied: 34%
- c. Neutral: 33%
- d. Dissatisfied: 11%
- e. Very dissatisfied: 7%

10. If you are "Dissatisfied" or "Very dissatisfied" with living at the Home, briefly explain why: *[Free response, not analyzed statistically but were read]*

11. When do you want to live outside the Veterans' Home? **(circle one)** $M=4\%$

- a. Right now: 16%
- b. In less than a year: 10%
- c. In a year or two: 35%
- d. More than two years from now: 15%
- e. Never, I want to stay: 24%

12. On average, how often do you leave the Veterans' Home campus (not including for medical appointments)? **(circle one)** $M=3\%$

- a. Daily: 35%
- b. Weekly: 40%
- c. Every few weeks: 13%
- d. Monthly: 4%
- e. Every few months: 5%
- f. Yearly: 1%
- g. Never: 1%

13. Are you satisfied with how often you get off campus? **(circle one)** $M=4\%$ Yes: 76% No: 24%

14. If you answered "No" to Question 13, why aren't you satisfied? **(circle all that apply)**

- a. The transportation provided by the Home or CT Transit does not meet my needs: 39%
- b. I mostly have to rely on family or friends to provide transportation: 36%
- c. I usually can't leave without staff approval, due to pass restriction: 18%
- d. I don't want to go through a Security check when I re-enter campus, so I don't leave: 11%
- e. I'm concerned I will relapse into bad habits, so I don't leave: 0%
- f. Other reason(s): 39%

Quality of Services

15. How satisfied are you with the condition of the Home's facilities? **(mark for each area, using an "x")**

<u>Facility Condition</u>	<i>Very Satisfied</i>	<i>Satisfied</i>	<i>Neutral</i>	<i>Dissatisfied</i>	<i>Very Dissatisfied</i>	<i>Have not used</i>
a. Your main living area $M=3\%$	18%	42%	23%	10%	5%	2%
b. Bathrooms $M=2\%$	16%	48%	18%	13%	5%	0%

c. Dining hall <i>M=3%</i>	12%	41%	24%	16%	8%	0%
d. Winners' Circle <i>M=1%</i>	13%	35%	33%	8%	4%	7%
e. Inside common areas <i>M=1%</i>	15%	32%	40%	10%	2%	2%
f. Outside grounds/common areas <i>M=2%</i>	21%	45%	27%	3%	2%	2%

16. How satisfied are you with how well the Veterans' Home staff helps you? (mark for each service, using an "x")

<u>Service</u>	<i>Very Satisfied</i>	<i>Satisfied</i>	<i>Neutral</i>	<i>Dissatisfied</i>	<i>Very Dissatisfied</i>	<i>I don't need or want help with this</i>
a. Achieve your goals to move off-campus <i>M=10%</i>	6%	15%	38%	9%	17%	14%
b. Find off-campus employment: <i>M=12%</i>	4%	6%	42%	9%	14%	25%
c. Find off-campus housing: <i>M=10%</i>	4%	7%	44%	11%	16%	19%
d. Deal with substance use issues: <i>M=10%</i>	20%	21%	20%	2%	4%	34%
e. Deal with mental health issues: <i>M=8%</i>	14%	16%	30%	6%	8%	27%
f. Connect with family or friends: <i>M=9%</i>	12%	21%	26%	9%	6%	26%
g. Receive on-site medical care: <i>M=10%</i>	23%	26%	23%	15%	6%	7%
h. Find recreation activities: <i>M=8%</i>	14%	22%	33%	18%	8%	6%
i. Find transportation: <i>M=10%</i>	13%	26%	34%	15%	4%	9%
j. Eat appropriate food: <i>M=10%</i>	13%	27%	26%	15%	17%	2%

17. How would you feel if the Veterans' Home offered private living quarters (with common bathrooms) to all residents in the main domicile? (circle one) *M=9%*

- a. I would like this: 81% b. I would not care: 16% c. I would not like this: 3%

18. How often do you think you're treated fairly by the Home's staff? (circle one) *M=5%*

- a. All of the time: 26% b. Most of the time: 34% c. About half of the time: 11% d. Sometimes: 22% e. Never: 7%

19. How often do you feel safe at the Veterans' Home? (circle one) *M=4%*

- a. All of the time: 50% b. Most of the time: 38% c. About half of the time: 8% d. Sometimes: 3% e. Never: 1%

Complaints

20. How comfortable are you with bringing any complaint you have to the Home's staff? **(circle one)** $M=4\%$
- | | | | | |
|----------------------|-----------------|-------------|-------------------|------------------------|
| a. Very comfortable: | b. Comfortable: | c. Neutral: | d. Uncomfortable: | e. Very uncomfortable: |
| 12% | 23% | 23% | 21% | 22% |
21. Within the last two years, have you complained to Veterans' Home staff about anything or about any other staff person at the Home? **(circle one)** $M=4\%$ Yes: 39% No: 61%
22. If you have complained to staff in the last two years: **(circle one for each question below)**
- a. Do you feel staff paid attention to you about your complaint(s)? $M=39\%$ Yes: 42% No: 58%
- b. Was your complaint(s) resolved to your satisfaction? $M=39\%$ Yes: 29% No: 71%
- c. If your complaint(s) was not resolved to your satisfaction, did staff explain their decision to you?
 $M=48\%$ Yes: 38% No: 62%
- d. How were you treated by staff after you complained? $M=43\%$ a. Better: 9% b. The same: 64% c. Worse: 27%
23. If you have not complained about anything to staff, why not? [Free response; $M=39\%$]
No need to complain/problem is not a big deal: 41% *Don't think anything would change: 27%*
Fear of staff retaliation: 24% *Other: 8%*
24. Within the last two years, have you brought any complaints to the Veterans' Council? **(circle one)** $M=9\%$
Yes: 31% No: 69%
25. If you have complained to the Veterans' Council within the last two years: **(circle one answer for each question)**
- a. Do you feel the Council paid attention to you about your complaint(s)? $M=54\%$ Yes: 41% No: 59%
- b. Was your complaint(s) resolved to your satisfaction? $M=54\%$ Yes: 27% No: 73%
- c. If your complaint(s) was not resolved to your satisfaction, did the Council explain the decision to you?
 $M=54\%$ Yes: 31% No: 69%
26. If you have not complained to the Veterans' Council, why not? [Free response; $M=35\%$]
Nothing would change: 35% *Too close to staff/administration: 32%*
No need to complain / problem is not a big deal: 24% *Fear of staff retaliation: 5%*
Other: 5% *Fear of resident retaliation: 3%*
27. Overall, how satisfied are you with the Veterans' Council's ability to get results for residents? **(circle one)**
 $M=9\%$
- | | | | | |
|--------------------|---------------|-------------|------------------|-----------------------|
| a. Very satisfied: | b. Satisfied: | c. Neutral: | d. Dissatisfied: | e. Very dissatisfied: |
| 7% | 10% | 41% | 20% | 22% |

Campus Rules

28. How do you rate the rules at the Veterans' Home? **(circle one)** $M=4\%$
- a. Too strict: 47% b. About right: 49% c. Not strict enough: 4%
29. Based on the Home's existing rules, do you think conduct charges/violations are issued: **(circle one)**
 $M=5\%$
- a. Too often: 42% b. About the right amount of time: 50% c. Not enough times: 9%
30. How do you rate the penalties for breaking the Home's current rules? **(circle one)** $M=7\%$
- a. Too tough: 43% b. About right: 47% c. Not tough enough: 10%
31. How often do you think you're treated fairly by staff at the Home when you're involved in a conduct/charge violation? **(circle one)** $M=13\%$
- a. All of the time: 13% b. Most of the time: 39% c. About half of the time: 13% d. Sometimes: 12% e. Never: 21%
32. If you think some rules at the Home should be changed or eliminated, which rules do you suggest? **(list up to three)** [*Free response; M=41%*]
1. *Eliminate Breathalyzers: 26%*
 2. *Eliminate pass restrictions: 20%*
 3. *Eliminate trunk / gate inspections: 16%*
 4. *Eliminate need to get a pass or swipe a card: 14%*
 5. *Eliminate program fee: 14%*
 6. *Eliminate curfew: 7%*
 7. *Change / be more flexible on lights out: 4%*
 8. *Relax meal dress requirements: 4%*
 9. *Relax indoor phone use policies: 4%*
- Other changes written in, not gathering more than 1 response each: 41%*

Thank you for completing the survey. Please include a separate sheet with any additional thoughts, concerns, or suggestions.

Appendix E

Table E-1. Domiciliary Resident Rules	
	<i>Can Result in Immediate Discharge</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
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	

Table E-1. Domiciliary Resident Rules	
	<i>Can Result in Immediate Discharge</i>
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	
<p>*Although smoking anywhere than in designated areas is considered a major violation by state regulation, Veterans' Home managers indicated 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 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: PRI staff review of the Veterans' Home Residential Facility Rules and Regulations Handbook and of applicable state regulation (R.C.S.A. 27-102I(d)-200 through -201).</p>	

Town Veteran Liaison Survey

The program review committee staff surveyed towns' veteran contact persons. The contacts act as a conduit to towns for information from Department of Veterans' Affairs (DVA) and others. They also assist veterans who are seeking assistance or information. This survey contributed to the committee staff's understanding of how the Home is perceived, how actively DVA seeks referrals to the Home, and from whom the Home receives referrals. This appendix discusses survey methods and participation. It also contains the survey results.

Methods

In October, DVA's Office of Advocacy and Assistance provided program review committee staff with a list of towns' designated veteran contact persons. There were 117 people on the list, with some towns having multiple representatives. Of them, 12 had no e-mail address and 10 of the given e-mail addresses were invalid. Therefore, the survey was distributed to 95 town veteran contacts, representing 87 towns.

The survey was developed, fielded, and analyzed using Survey Monkey, an online tool. A link to the survey was sent to the town veteran contacts via an e-mail message from program review committee staff on Tuesday, November 4. Recipients were requested to complete the survey by Friday, November 7, and to coordinate with other designated contacts from their town to ensure only one person (speaking for all the contacts) participated.

Participation

Of the 95 town veteran contacts sent a survey, 34 responded. If instructions were followed and only one person from each of the 87 towns filled out a survey, the response rate was 39 percent. Basing the response rate on the number of recipients (not towns) included, the rate drops slightly, to 36 percent.

It is important to note that the town veteran contact list did not include anyone from some of Connecticut's cities. Only two of the state's larger cities (distinct from inner-ring suburbs) were represented. Therefore, the survey should not be considered to give a strong sense of how the contacts for the most populous towns think of and refer to the Home. There were no other obvious geographic shortcomings of the survey participant list.

Results

The results are presented below:

- 1. How many people live in your town?**
 - a. Under 5,000: 18%
 - b. 5,000 to 25,000: 56%
 - c. 25,001 to 50,000: 9%

- d. 50,000 to 100,000: 9%
 - e. More than 100,000: 9%
 - f. No response: 0% of respondents
- 2. In the last two years, have you referred anyone to the Connecticut State Veterans' Home for admission to the Home's Health Care Facility (similar to a nursing home)?**
- a. Yes: 18%
 - b. No: 82%
 - c. No response: 0% of respondents
- 3. About how many people have you referred to the Home's Health Care Facility?**
- a. A few (3 or under): 100%
 - b. Some (4 or more): 0%
 - c. Many (10 or more): 0%
 - d. No response: 0% of those who said they had referred someone
- 4. In the last two years, have you referred anyone to the Veterans' Home for admission to the Home's domiciliary (residential services for homeless veterans)?**
- a. Yes: 15%
 - b. No: 85%
 - c. No response: 3% of respondents
- 5. About how many people have you referred to the Home's domiciliary?**
- a. A few (3 or under): 100%
 - b. Some (4 or more): 0%
 - c. Many (10 or more): 0%
 - d. No response: 0% of those who said they had referred someone
- 6. Overall, what is your opinion of the Veterans' Home's Health Care Facility (similar to a nursing home)?**
- a. Favorable: 18%
 - b. Unfavorable: 6%
 - c. Neutral: 18%
 - d. I don't know enough about it to have an opinion: 59%
 - e. No response: 0% of respondents
- 7. Please explain your opinion, if you'd like to. *[free response; answers have been categorized below and some people's responses included in multiple categories, when multiple aspects mentioned]***
- a. Facilities mentioned
 - i. Favorably: 2 people
-

- ii. Unfavorably: 1 person [*Note: The comment was that the facility was old, so the respondent may have been confusing it with domiciliary care*]
 - b. Staff mentioned
 - i. Favorably: 3 people
 - ii. Unfavorably: 1 person [*Note: This comment was by the person who responded that the facility was old, so the respondent may have been confusing it with domiciliary care*]
 - c. Distance to location mentioned
 - i. Unfavorably: 1 person
 - d. Rules mentioned
 - i. Favorably: 1 person
 - e. Other (1 person each):
 - i. Favorable: “Important” for veterans with “special needs”
 - ii. Neutral: Had visited once, for Stand Down
 - iii. Unfavorable: Multiple veterans “refuse[d] to talk to me after I mentioned it as an option” [*Note: This comment was by the person who responded that the facility was old, so the respondent may have been confusing it with domiciliary care*]
 - f. No response: 80% of respondents
 - 8. Overall, what is your opinion of the Veterans’ Home’s domiciliary (residential services for homeless veterans)?**
 - a. Favorable: 27%
 - b. Unfavorable: 9%
 - c. Neutral: 12%
 - d. I don’t know enough about it to have an opinion: 53%
 - e. No response: 0% of respondents
 - 9. Please explain your opinion, if you’d like to.** [*free response; answers have been categorized below and some people’s responses included in multiple categories, when multiple aspects mentioned*]
 - a. Facilities mentioned: 0
 - b. Staff mentioned: 0
 - c. Distance to location mentioned
 - i. Unfavorably: 1 person
 - d. Rules mentioned
 - i. Favorably: 1 person
 - ii. Unfavorably: 1 person
 - e. Other (1 person each):
 - i. Favorable:
 - 1. “Important” for veterans with “special needs”
-

2. One veteran was referred and was appreciative.
3. Veterans look happy there.
- ii. Neutral: Had visited once, for Stand Down
- iii. Unfavorable:
 1. Last resort option: “absolutely no other options”
 2. “They don’t want to be segregated from mainstream society.”
- f. No response: 85% of respondents

10. In the last two years, has the Veterans’ Home or the State Department of Veterans’ Affairs (DVA) contacted you to give you basic information about the Home? (Exclude notifications about the annual Stand Down event or other DVA services)

- a. Yes: 12%
- b. No: 85%
- c. I don’t remember: 3%
- d. No response: 0% of respondents

11. In the last two years, has the Veterans’ Home or the State DVA encouraged you to refer people for admission to the Home?

- a. Yes: 6%
- b. No: 91%
- c. I don’t know: 3%
- d. No response: 3% of respondents

Appendix G

Table G-1. Other State Veterans' Homes Domiciliary Care				
	<i>Transitional / "housing readiness"</i>	<i>Capacity (Dom. Only)</i>	<i>Recent Ave. Occupancy Rate (%)*</i>	<i>24-hour nursing care at same home?</i>
10 Largest Domiciles				
California: Yountville	No	817	72%	Yes
<i>Connecticut</i>	<i>Yes</i>	488	51	<i>Yes</i>
Massachusetts: Chelsea	Yes	305	81	Yes
Ohio: Sandusky	No	300	54	Yes
California: Barstow	No	220	30	Yes
California: Chula Vista	No	220	60	Yes
Minnesota: Hastings	Yes	200	76	No
W. Virginia: Barboursville	Yes	195	44	No
Maryland	No	168	80	Yes
Pennsylvania: Hollidaysburg	No**	167	83	Yes
Surrounding States				
Massachusetts: Chelsea	<i>See above</i>			
New York	N/A	0	N/A	N/A
Rhode Island	Yes	79***	11	Yes
<p>*Average from September 2012 to May 2013. **Serves homeless veterans. Lacks the employment and case management services, as well as program design, necessary to be considered transitional, according to that home's staff. ***Current actual capacity is 1, according to a home administrator. Sources: "Transitional/'housing readiness approach'" determination made by PRI staff upon review of each home's website and, for Rhode Island, Massachusetts, and Pennsylvania, telephone conversations with high-level home managers. Current "Capacity (Dom. [Domiciliary] Only)" was provided by personnel from the United States Department of Veterans Affairs in October 2014. "Recent Ave. Occupancy Rate (%)" was accessed on July 3, 2014 via: http://www.nonvacare.va.gov/state-homes.asp.</p>				

Appendix H: October 2014 Study Update

Staff Update

Veterans' Home at Rocky Hill:
Residential Services

October 1, 2014

Legislative Program Review
and Investigations Committee

Connecticut General Assembly

2013-2014 Committee Members

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

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. (U.S. Department of Veterans Affairs, "State Veterans Home (SVH) Per Diem Payment Program," *Veterans Health Administration Handbook 1601SH.01*, August 2011. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2442 (accessed September 10, 2014).)

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; and 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 Jordan, Eric, “New Member Orientation,” presentation at the 2014 NASVH summer conference (July 27-August 1) in Charleston, South Carolina. <http://www.nasvh.org/Conferences/conferenceLinks.cfm> (accessed August 26, 2014).

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.

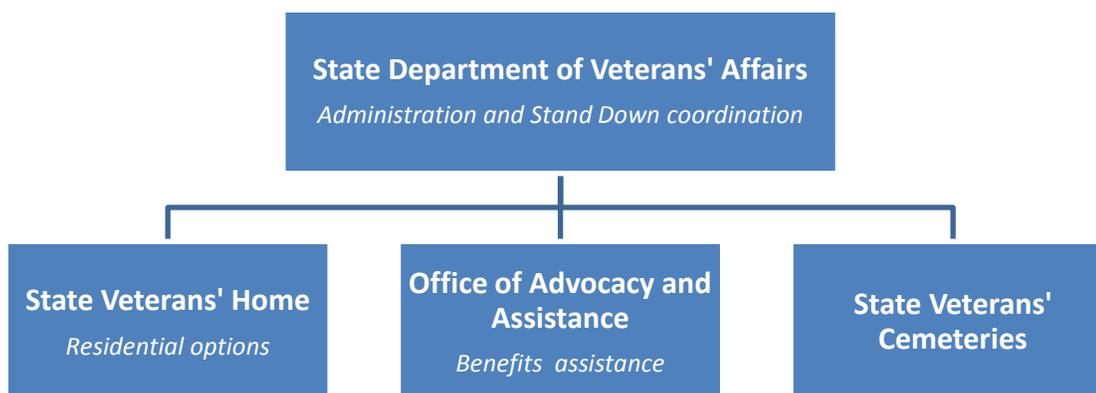
Office of Advocacy and Assistance. This office is staffed by an administrator as well as five Veteran Service Officers, each with supplementary personnel. The service officers and their staff are distributed across Connecticut’s five congressional districts. They help Connecticut veterans obtain and 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 State of Connecticut Auditors of Public Accounts, *Auditors’ Report; Department of Veterans’ Affairs for the Fiscal Years Ended June 30, 2011, 2012 and 2013.*

http://cga.ct.gov/apa/reports/Veterans%20Affairs,%20Department%20of%2020140915_FY2011,2012,2013.pdf (accessed September 15, 2014).

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, Ascellon 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. ([www.HealthIT.gov](http://www.healthit.gov), “Are there penalties for providers who don't switch to electronic health records (EHR)?” <http://www.healthit.gov/providers->

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.

[professionals/faqs/are-there-penalties-providers-who-don%E2%80%99t-switch-electronic-health-record](#) (accessed September 10, 2014).

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

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, or 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 saving 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.

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

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, as noted earlier.

- 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)

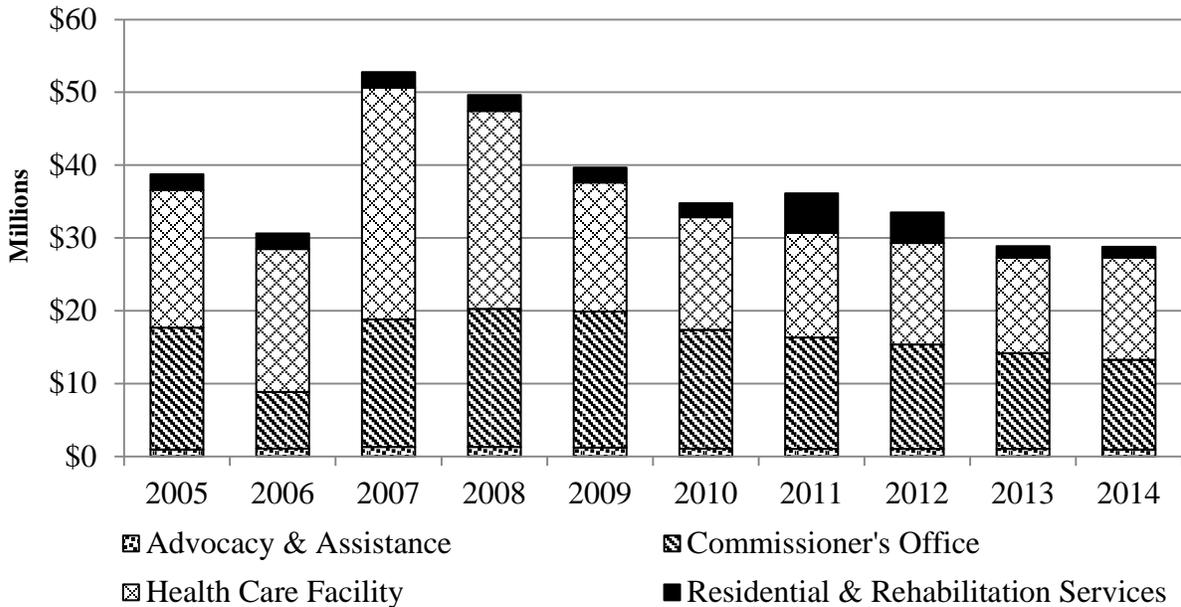
- "Other Expenses" (e.g., maintenance supplies and services, utilities, motor fuel, heating oil, medical supplies, drugs/pharmaceuticals, laundry services)
 - DVA: \$5.5 million
 - Veterans' Home: nearly all (OAA only accounted for \$30,000)
 - Commissioner's Office: \$3.4 million (62 percent)
 - Health 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.

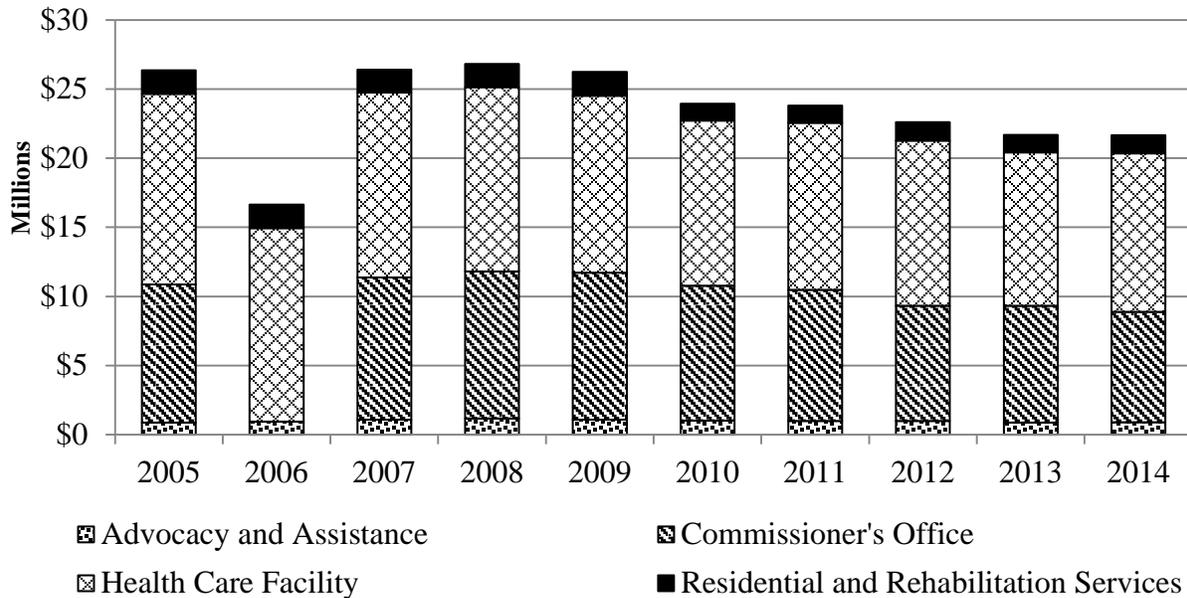
Source: PRI staff analysis of Department of Veterans' Affairs data.

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 million 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".

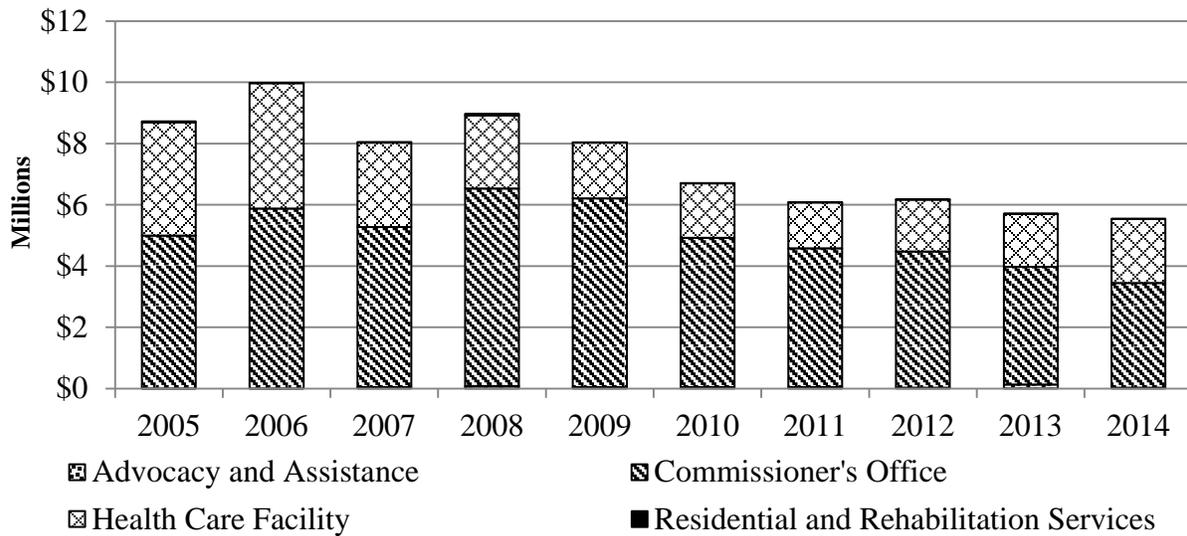
Source: PRI staff analysis of Department of Veterans' Affairs data.

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 operation.

**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: PRI staff analysis of Department of Veterans' Affairs data.

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.⁴ 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 were \$23 million (including 50 percent reimbursement rate for Medicaid claims and full reimbursement for DSH claims).
- The main sources of DVA-generated revenue/reimbursements were:
 - 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.

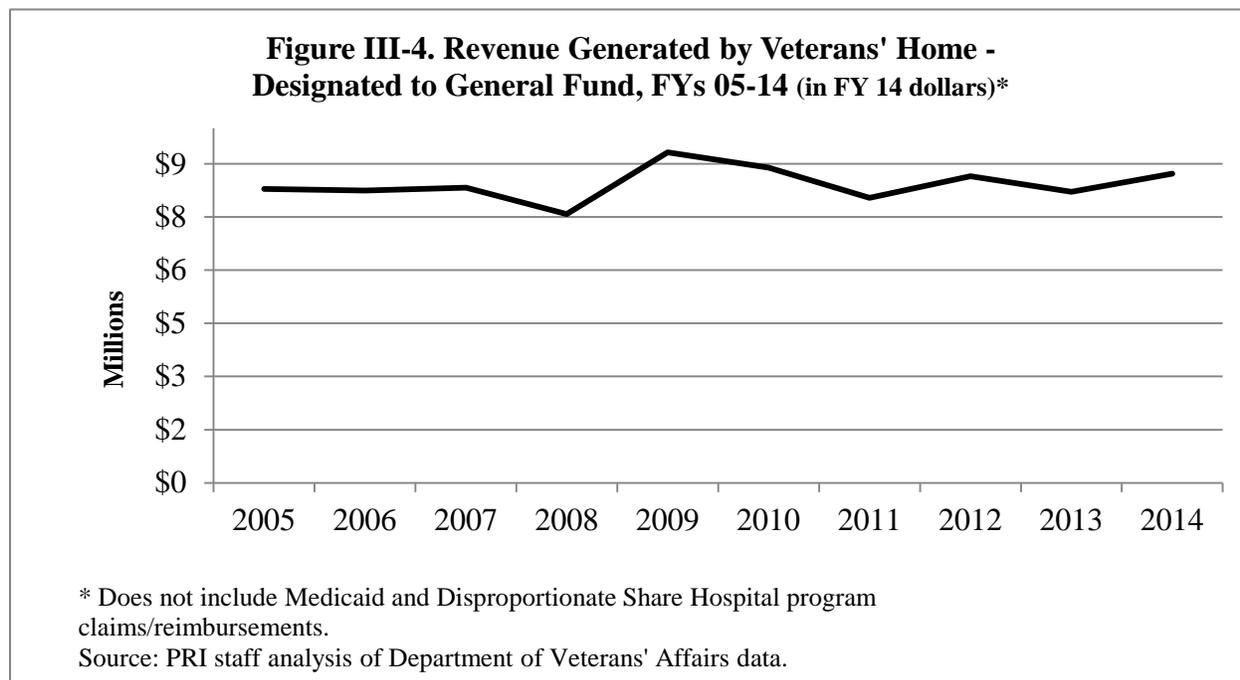
DVA Revenue Designated for the State General Fund

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. 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.

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

⁴ Medicaid is a shared state/federal health insurance program; state claims are reimbursed 50 percent by the Centers for Medicare and Medicaid 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.

the 10-year period, the annual revenue amounts fluctuated between \$7.5 million (FY 08), to \$9.3 million (FY 09).

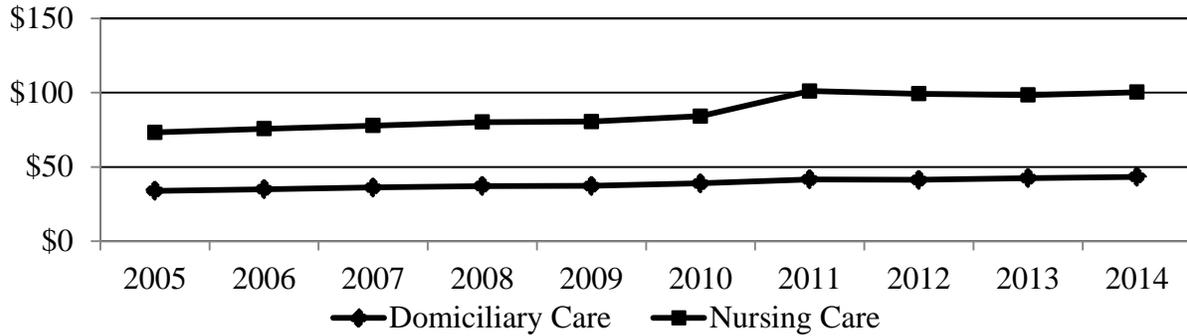


Federal per diem grants. The VA administers a grant program to support state veterans homes. To qualify for the program, a home must meet specific criteria, provide care to eligible veterans, and be recognized by the VA as a state veterans home. The per diem, per resident payment program is based on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

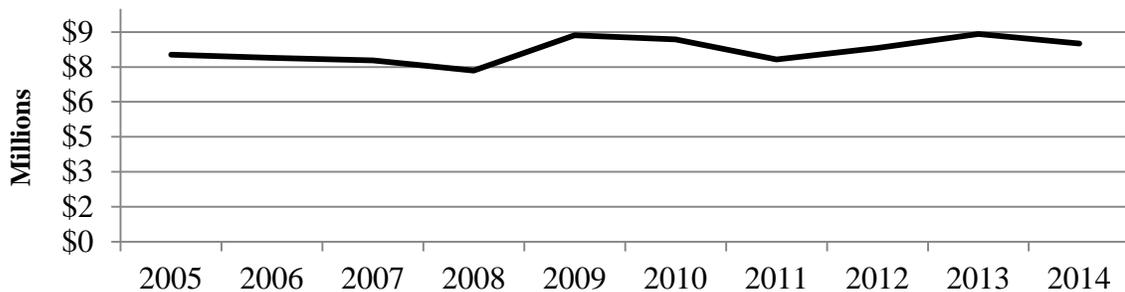
Figure III-5. Federal VA Per Diem Rates, FYs 05-14
(in FY 14 Dollars)



Source: PRI staff analysis of Department of Veterans' Affairs data.

The Connecticut Department of Veterans' Affairs bills the federal VA directly for its per diem grant. The department follows a specific process to capture the pertinent information required by the VA before payments will be released, including tracking 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 slightly declined until FY 08, and since then, has had 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)



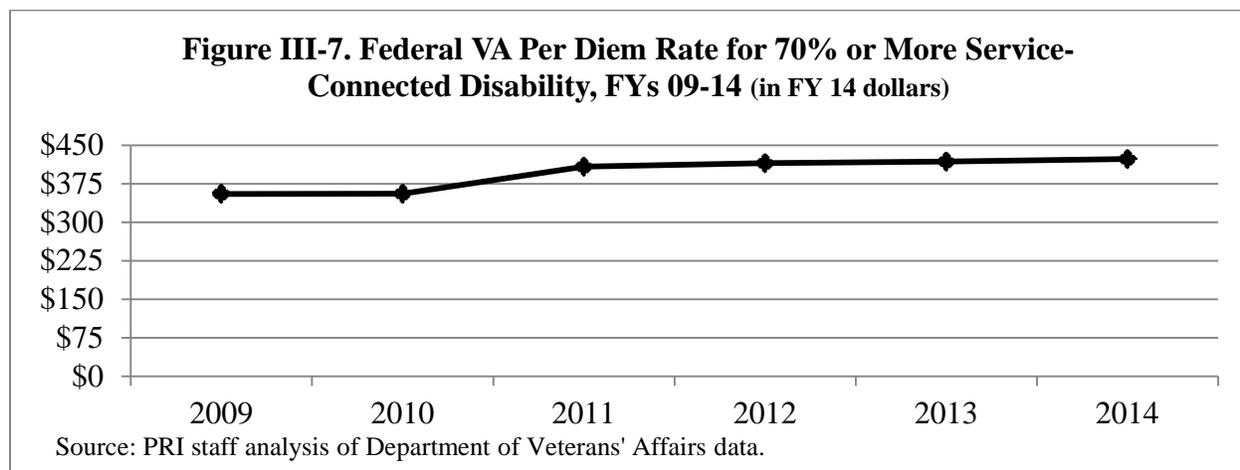
Source: PRI staff analysis of Department of Veterans' Affairs data.

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).⁵

⁵ The VA per diem payment data provided to committee staff was the annual payment totals. There was no distinction in the data between per diem revenue generated for residents receiving domiciliary versus nursing care.

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.⁶ 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 and self-pay. 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 to those of any licensed nursing home in 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. 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 chronic disease hospital, not a skilled nursing facility. 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

⁶ There are five licensed chronic disease hospitals in Connecticut.

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.

legally liable relative) are billed monthly. The costs for residents covered by Medicaid are paid 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.⁸ 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 someone 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.

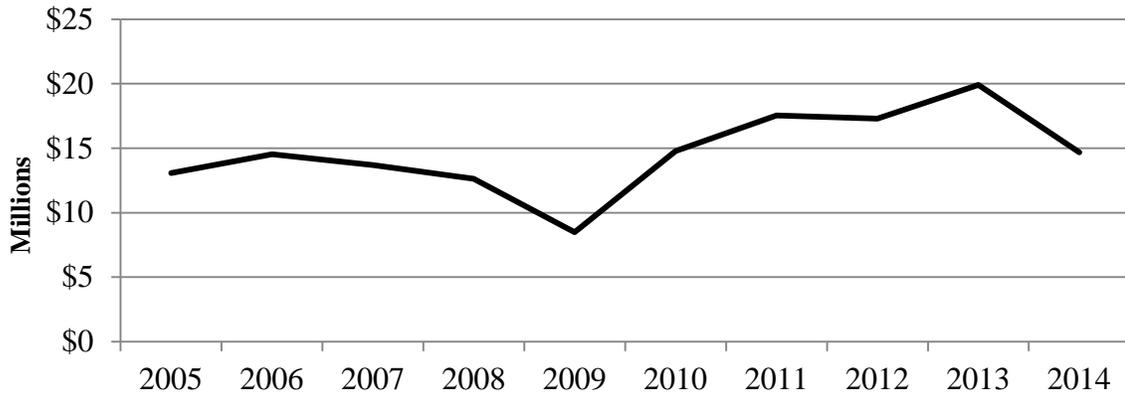
If a veteran's income is insufficient to cover the monthly Medicaid rate (i.e., the Home's self-pay rate), the amount the person can contribute to the cost of care is determined by the Home. The veteran's "applied income" is calculated by taking total monthly income from all sources and subtracting the \$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 charged to Medicaid through the state's billing process. The amount reimbursed by Medicaid is accepted by the HCF as full payment for the resident.⁹

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 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.

⁸ 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. 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 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.

⁹ The HCF, as a chronic disease hospital and not an acute care facility, can only charge *Medicare* for the very few times residents' care is considered acute status (Medicare will also pay for up to 90 days following an acute care hospital stay if the HCF resident is in need of rehabilitation at a non-HCF facility. 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.

Figure III-8. Veterans' Home Medicaid Billable Claims, FYs 05-14
(in FY 14 dollars)



Source: PRI staff analysis of Department of Veterans' Affairs data.

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.¹⁰ Federal law further establishes an annual DSH allotment for each state. Connecticut's FY 14 allotment was roughly \$213 million for hospitals throughout the state, including the Veterans' Home HCF.¹¹ The Home began participating in the DSH program 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.¹² 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 expanded health insurance coverage requirements.¹³ As noted above, the Health Care Facility, as a CDH, 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 \$4.4

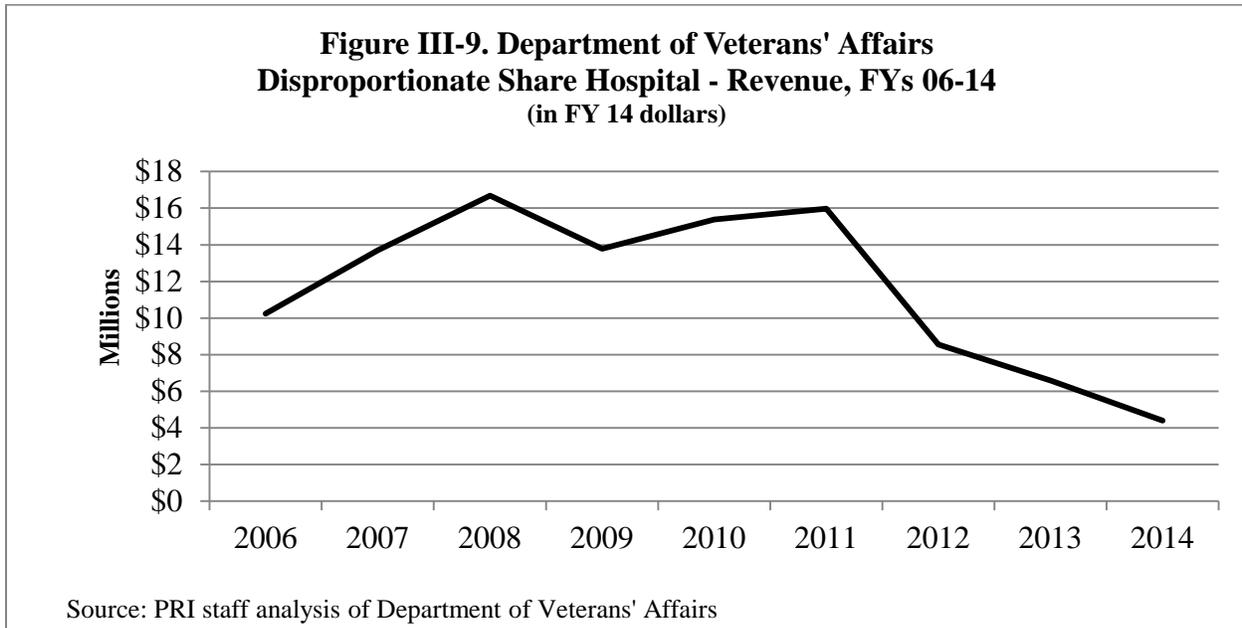
¹⁰ See: <http://www.medicaid.gov/About-Us/About-Us.html>, accessed August 29, 2014.

¹¹ 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.

¹² C.G.S. Sec. 17b-239(c)

¹³ Office of Legislative Research Report 2013-R-0266.

million in FY 14, to a high of \$16.7 million in FY 08.¹⁴ 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 unable to do so.¹⁵ The department's initial determination of a person's financial capacity must be made within 30 days after admission to the Home.¹⁶ 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 a resident's financial means to pay for care must be made from time to time, at the commissioner's discretion. The Home's fiscal manager may examine any change in a resident's financial circumstances based on information received that the resident's income or assets may have changed. Veterans must immediately notify the department's Business Office of any changes or if they want to request a fee waiver.

The fee amount for domiciliary care has been approved by the DVA Board of Trustees, and the fee for nursing care is the daily rate allowed by Medicaid. The resident fees housed in the DVA's Institutional General Welfare Fund. The IGWF is a separate fund maintained by DVA, 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.

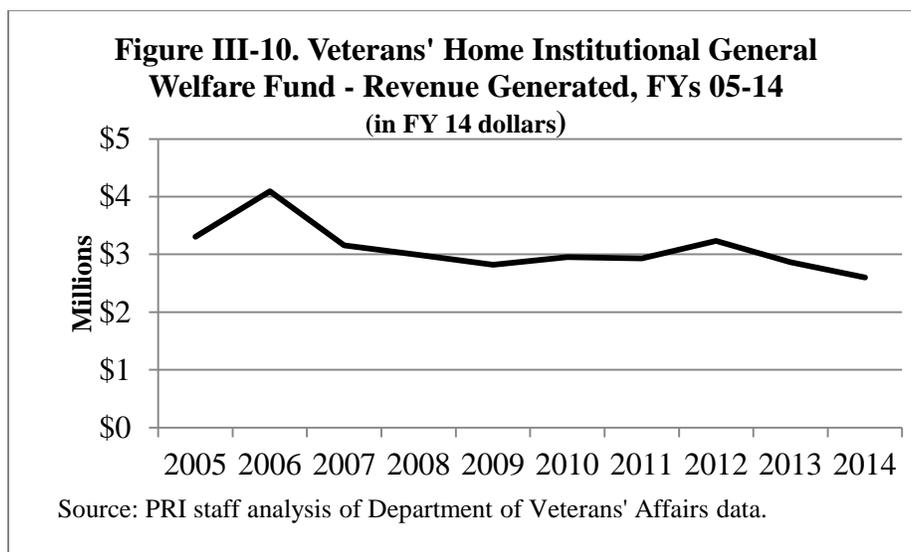
¹⁴ Disproportionate Share Hospital reimbursements to the state are made at 100 percent.

¹⁵ Regs. Conn. State Agencies (R.C.S.A.) 27-102l(d)-254(a)

¹⁶ R.C.S.A. 27-102l(d)-256(a)

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.¹⁷ 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.¹⁸

Figure III-10 shows the yearly fund balances of the Veterans’ Home Institutional General Welfare Fund for FYs 05-14. The annual fund 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 balance 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.



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.¹⁹ 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

¹⁷ 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.

¹⁸ C.G.S. Sec. 27-106(b)

¹⁹ C.G.S. Sec. 27-106(b)

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 set the rate generally at \$200, instead of the graduated fees endorsed by the board.

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.

DVA estimates a resident would need income of \$600-800 a month to afford the \$200 resident fee.²⁰ 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 Business Office.

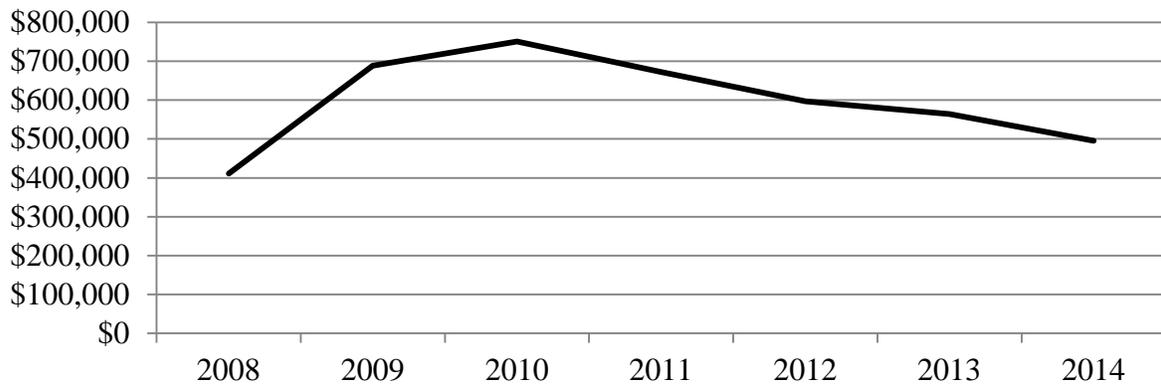
Table III-1. Veterans’ Home Domiciliary Care Monthly Fee Structure, August 2014	
<i>Length of Stay</i>	<i>Monthly Billing Rate</i>
0-3 Months	\$0*
>3 Months	\$200
*Veterans admitted after the 15 th of the month or discharged prior to the 15 th of the month are not billed for that month. Source: DVA Residential Facility Rules and Regulations Handbook, 2014.	

The Home makes the monthly 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 may attempt to collect the outstanding balance. All collections are deposited in the IGWF.

Figure III-11 shows the annual revenue generated for the IGWF through domiciliary care resident fees for FYs 08-14. 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.

²⁰ Possible sources of income include employment at the Home, outside employment, and government benefits.

**Figure III-11. Veterans' Home Domiciliary Care: Resident Program
Fees Collected, FYs 08-14 (in FY 14 dollars)**



Source: PRI staff analysis of Department of Veterans' Affairs data.

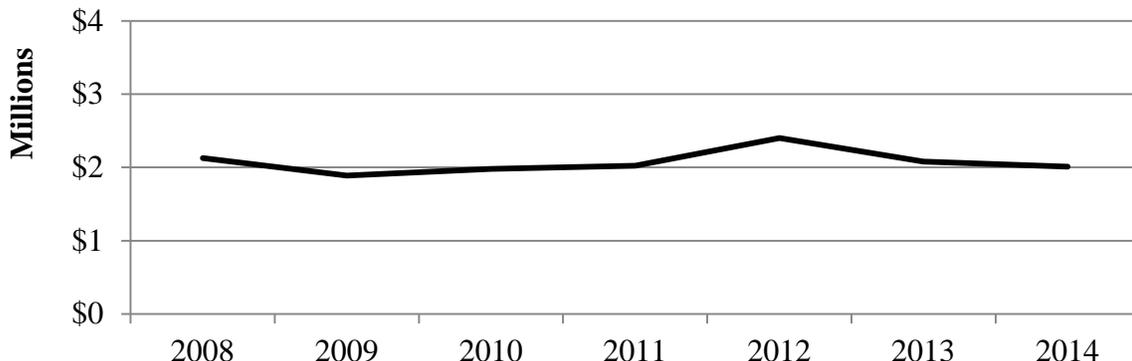
Resident billing: Nursing care. Residents of the Health Care Facility also are required to contribute to their cost of care. As discussed above, HCF residents' contribution to their care is based on three factors: 1) whether the veteran is paying for care through personal funds; 2) if Medicaid pays for most of the care costs; or 3) if the VA pays the service-connected disability rate. The amount paid by the resident remains in the IGWF, while Medicaid and federal VA reimbursements go to the General Fund.²¹

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.

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.

²¹ Someone coming to the HCF from the Residential Facility may be admitted to the facility under the \$200 domiciliary 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 department's business 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.

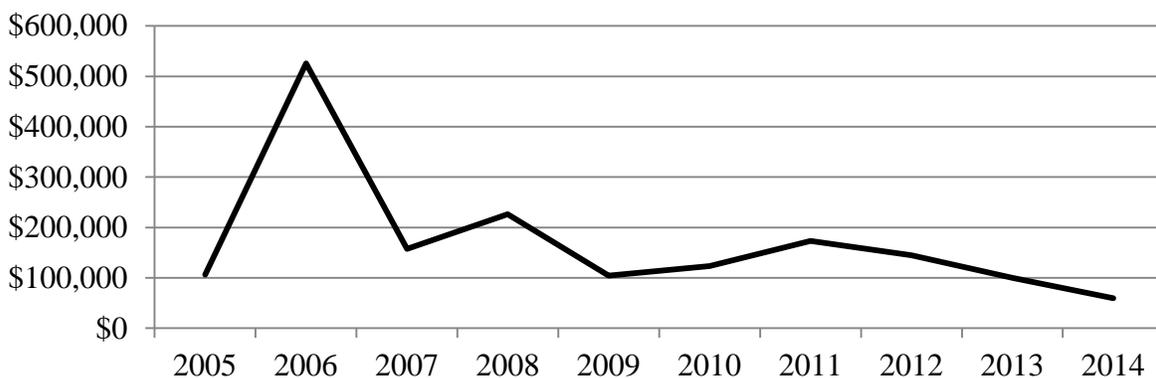
Figure III-12. Veterans' Home Nursing Care Residents' Applied Income Collected, FYs 08-14 (in FY 14 dollars)



Source: PRI staff analysis of Department of Veterans' Affairs data.

For accounting purposes, donations are maintained in an interest-bearing account separate from the resident fees. DVA believes this encourages donations 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: PRI staff analysis of Department of Veterans' Affairs data.

Estimated Cost of Care

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

Source: 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.

DVA provided staffing resource data for FYs 08-14. The information was submitted 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. Overall employee levels have decreased since FY 08. The department’s total number of filled/paid positions within the department dropped 17 percent over the seven-year period, from 379 to 313. This includes full- and part-time positions. There also was a 20 percent decline 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). 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: PRI staff analysis of Department of Veterans’ Affairs data.							

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. The Home's 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. The domiciles are collectively called the "Dom" or "Domicile," and have eight wings labeled A-H. Each living space there accommodates 12 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. Committee staff examined domiciliary care information using four specific dates as data points over each calendar year for 2009-2014.³ For most of the information provided below, staff averaged the year's data points as an approximation of the annual average.

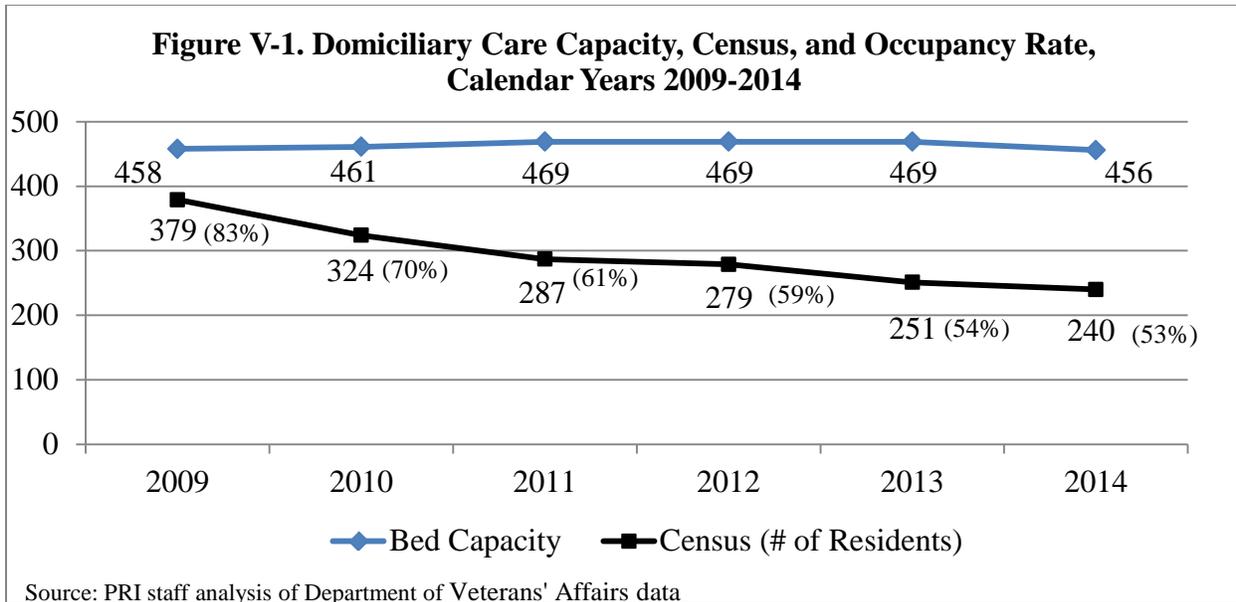
Overall. The number of beds available to veterans for domiciliary care fluctuated slightly between 2009 and 2014, as shown in Figure V-1. It rose from 458 to 469 in 2011 (up 2 percent), remained flat through 2013, and then declined to 456 in 2014 – just under 2009 capacity. The

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

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.

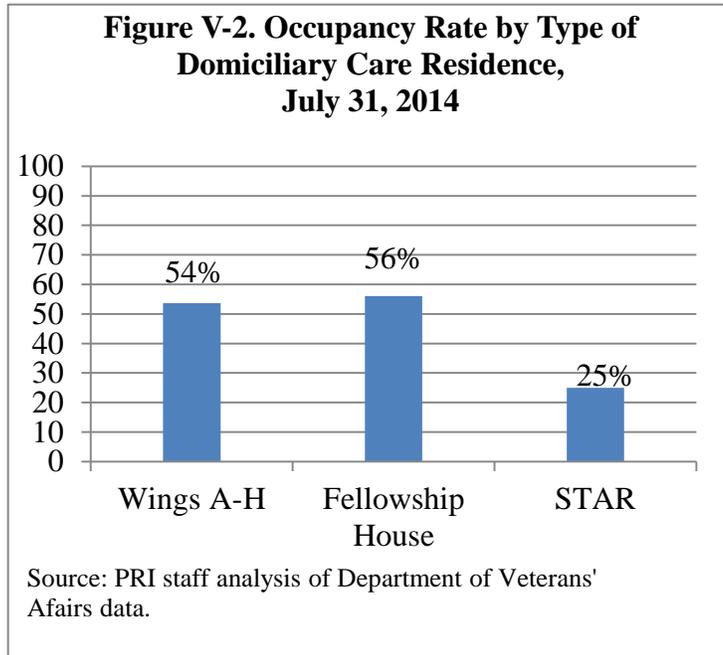


By residence type. Table V-2 provides the number of beds in operation at the various residences offering domiciliary care, as of July 31, 2014. The main Residential Facility accounts for almost eight of every ten beds. Sixteen percent of domiciliary care beds are for substance use recovery in the Fellowship House, while the STAR and Patriots' Landing programs account for 3 and 2 percent, respectively.

Table V-2. Domiciliary Care Bed Capacity by Type of Residence, 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: PRI staff analysis of Department of Veterans' Affairs data.

Figure V-2 shows the occupancy rate for each type of residence on July 31, 2014. Wings A-H 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

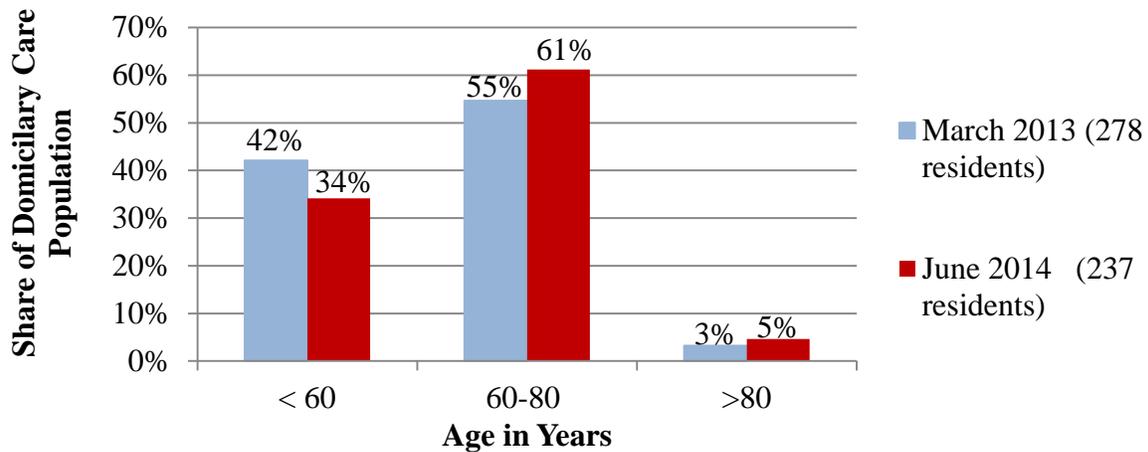
Most domiciliary care residents are older and dealing with a variety of medical conditions, according to limited data provided by Home staff.⁴ Just under half have lived at the Home for more than five years. The resident population appears to be aging and experiencing increased health problems, based 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).

⁴ 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: PRI staff analysis of Department of Veterans' Affairs data.

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

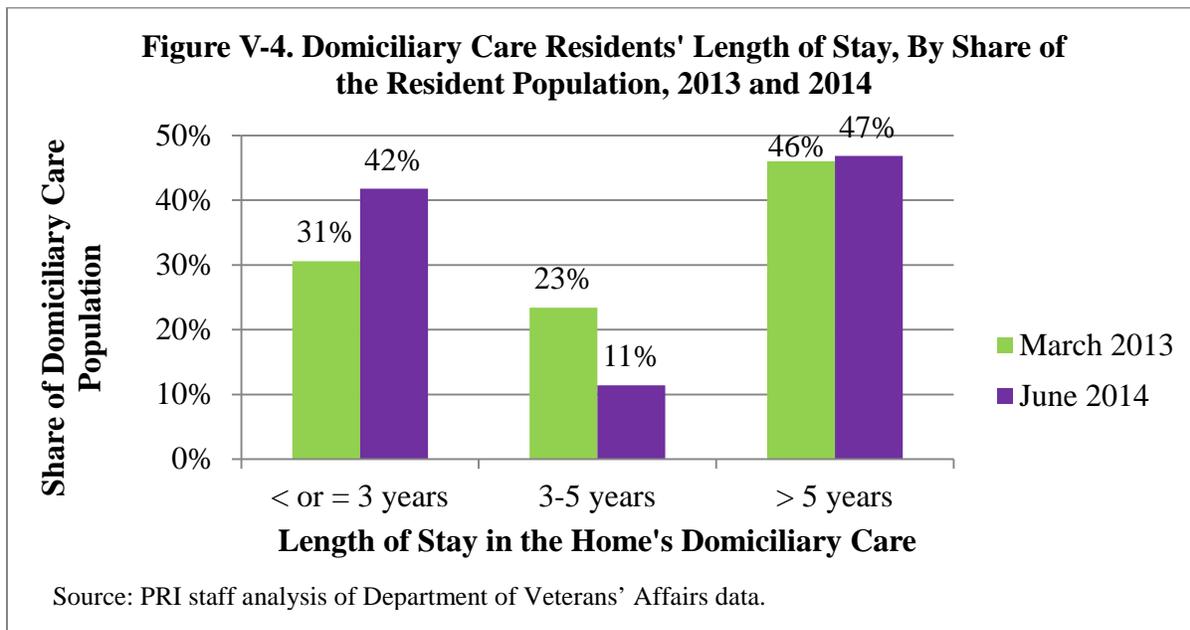
	<i>Share of Resident Population</i>		<i>Percent Change</i>
	<i>March 2013 (n=278)</i>	<i>June 2014 (n=237)</i>	
Medical Conditions			
Psychiatric diagnosis	79%	87%	10%
Substance use	72%	83%	16%
Diabetes	51%	46%	-9%
Hypertension / Elevated cholesterol / Heart disease	73%	87%	18%
Cognitive impairment	30%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

Source: PRI staff analysis of Department of Veterans' Affairs data.

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). Some of the highest jumps include the 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. State regulation 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 it deems necessary. 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, 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 requirements, the coordinator provides information either to the veteran or a case manager so the appropriate housing and/or services may be found.⁵

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.⁶ 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 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)⁷, and domiciliary care application coordinators.⁸ DVA medical personnel are 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.⁹ Each application is then discussed, and the team decides whether to admit, suspend, or deny the application.

⁵ 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.

⁶ Regs. Conn. State Agencies (R.C.S.A.) Sec. 27-102I-103(g).

⁷ 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.

⁸ The admission team's meeting observed by committee staff was attended by all but the nursing supervisor and the admission coordinator.

⁹ 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 and/or participate in a prescreen with Home staff.
- 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 generally a delay of at least a few days because there may be a short lag 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. It explains 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 the veteran with 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.¹⁰

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. The admissions rate ranged from 36 to 43 percent.

Table V-4. Domiciliary Care Admission Statistics, CYs 2012-2014			
	<i>2012</i>	<i>2013</i>	<i>2014 (as of June 1)</i>
Applications received	149	125	69
Applications denied	57	34	29
Applications withdrawn	20	13	9
Admissions	55	54	25
Note: Some applications 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: PRI staff analysis of Department of Veterans’ Affairs data.			

Services

Several services are available to nearly all domiciliary care residents while they live at the Veterans’ Home:¹¹

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

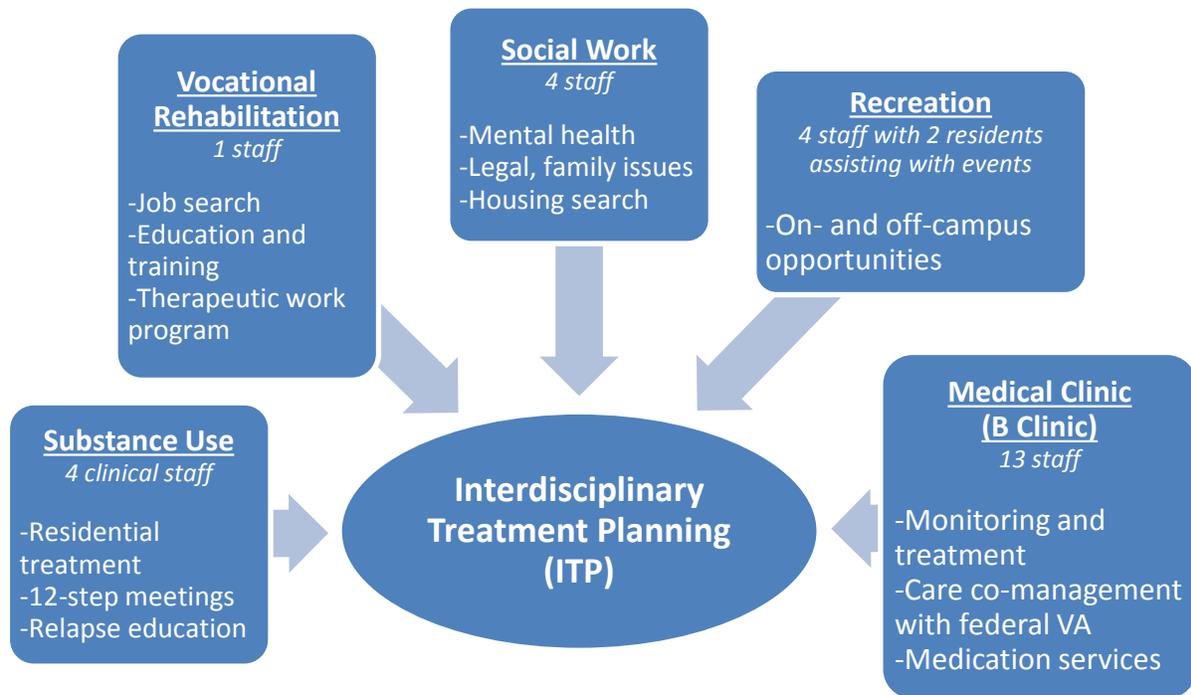
¹⁰ Chrysalis Center, Inc. provides case management services to Patriots’ Landing residents.

¹¹ 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).

Outlined below is 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. Figure V-5 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. 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 person’s first ITP meeting is held. 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 by the social worker to attend the first ITP meeting.¹² 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. Any 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.

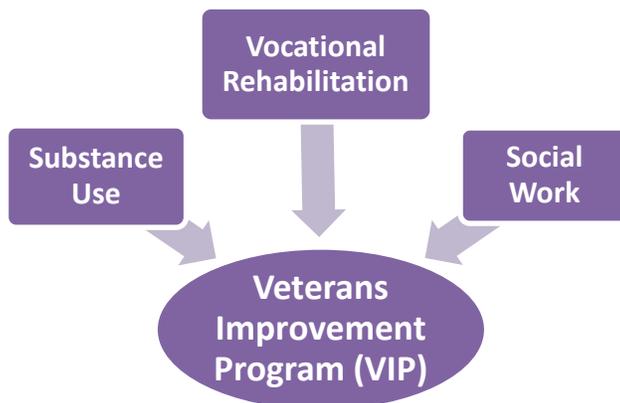
When a resident's situation has changed so a different Veterans' Home setting might be more appropriate, that may be discussed in a regular ITP meeting and in a special ITP meeting. A few additional Home staff may attend a special ITP meeting: a doctor or APRN from the Health Care Facility, a nursing 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

¹² 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 (2-1-1 Connecticut, “Conservator of Estate / Conservator of Person.” <http://www.211ct.org/InformationLibrary/Documents/Conservator-Court%20Visitor%20Program%20rj.asp> (accessed September 22, 2014).

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 who had pulled out from VIP later wants to restart efforts to depart from the Home, he or she is 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 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 worker 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.

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 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.¹³

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,¹⁴ 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

¹³ Thirty-eight percent of residents participated in the Veteran Worker program and 45 percent had a work Detail.

¹⁴ 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.¹⁵

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 Counselors¹⁶); 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.

¹⁵ The Home does not encourage carpooling to education or training programs in resident vehicles.

¹⁶ 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;¹⁷ 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 a gathering place with several televisions similar to a non-alcoholic sports bar that offers free coffee, soda, and bottled water, as well as ice cream and other types of coffee;¹⁸

¹⁷ 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.¹⁹



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

¹⁸ Small servings are 50 cents and large are one dollar, for both drip coffee and ice cream. Residents use pre-purchased tickets to pay for their items. (Coffee prepared in a single-serving brewing system is free, courtesy of a donation.)

¹⁹ There are also two tennis courts, with basketball hoops, that are not in useable condition.

winter, there is a weekly bowling league. Recreational opportunities generally are open to both domiciliary care and Health Care Facility residents.

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 Winners 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.

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.²⁰

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

²⁰ 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.²¹

Medication storage and administration. Just over one-third (36 percent) of residents use the B Clinic's Medication Administration Program (MAP).²² 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;

²¹ Monthly average gathered over three months: March, April, and May 2014.

²² 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 contracted 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 into the Medication Administration Program (if not already participating);
- 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, 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”²³ 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

²³ 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.²⁴ 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 department's 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.

²⁴ 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,²⁵ 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 the resident work program participants 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.

²⁵ 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).²⁶

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,

²⁶ 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.

addressing 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-7 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 his 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 not have had any rule violations in the previous six 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 up to three 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 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.²⁷ Until Public Act 14-187 (effective July 1, 2014), many of the domiciliary care rules were in state regulation.²⁸ 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'

²⁷ C.G.S. Sec. 27-106

²⁸ 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.²⁹

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

²⁹ 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 designated areas is considered a major violation by state regulation, Veterans' Home managers indicated 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 Domicile porches;	

Table V-6. Resident Rules

	<i>Major Violation</i>
<p>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 know 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.³⁰

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.

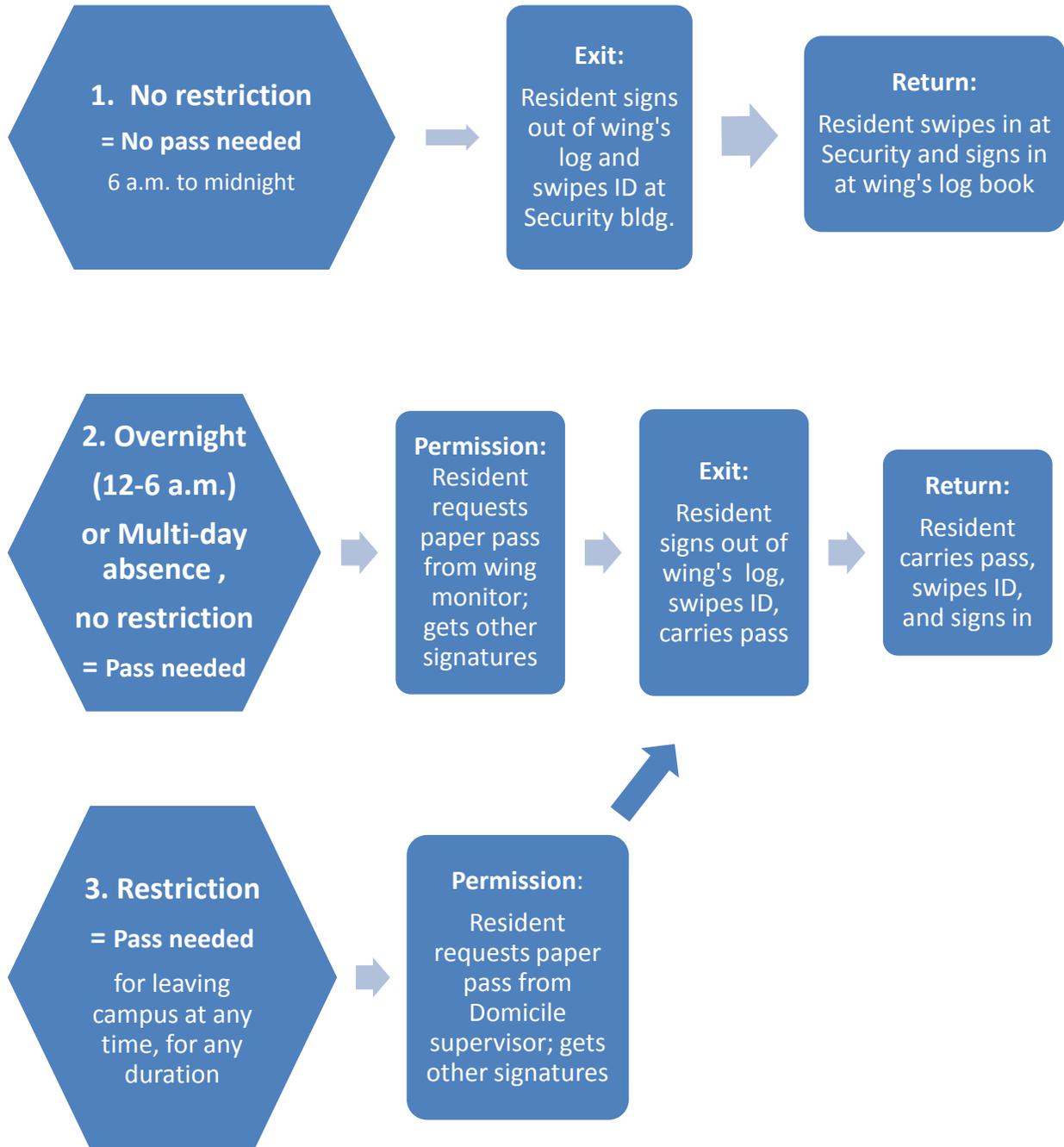
As illustrated, generally a resident who wants to leave the campus for any amount of time from 6 a.m. to midnight can do so without permission if they do not have any restriction on their passage on and off campus. Each resident also is expected to contribute to the upkeep and functioning of the Home 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.³¹ 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:

³⁰ 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.

³¹ 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 an absence of 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 shown in 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 examined 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, during both 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.³² 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 total 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

³² 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 domiciliary care 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, 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.³³

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)		
# of Violations in a 24-Month Period	Penalties	
	Length of Pass Restriction (days)	Length of Work Suspension (days): <i>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. 27-102l(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 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

³³ R.C.S.A. Sec. 27-102l(d)-213

to suspend the discharge for a maximum of six months, except for any offense related to illegal substances and paraphernalia.³⁴

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 the resident 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.

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

³⁴ R.C.S.A. Sec. 27-1021(d)-213(b)2

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.) The appeal process is rarely used, according to Home staff.

West Street houses' rules and consequences. Residents of the West Street houses 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 shared with 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.³⁵ 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.³⁶

³⁵ R.C.S.A. Sec. 27-1021(d)-90(c)4(A)iv

³⁶ 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. 27-1021(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 (i.e., "Health Care Facility".) The current building is a standalone structure completed in September 2008. The new facility replaced an older building on the Home's campus that was used for long-term care, as well as a hospital for veterans in earlier years.

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, and spiritual care. It can also provide 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. As such, the VA treats the facility as a nursing home. Inspections of the facility are conducted by federal VA and DPH staff.²

Facility Capacity and Special Settings

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

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

¹ C.G.S. Sec. 19a-535b(a).

² 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 the residents' 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 duties, 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. The office reviews a veteran's ability to pay for care and what payment method(s) will be used.

Once the admission packet is received by HCF staff, a copy is sent to the Business Office for pre-admission review. The office reviews the packet to ensure all the necessary documents are included with the application, including discharge papers, income/asset questionnaire, and power of attorney (POA) or probate court conservatorship.

Following the initial review, the Business Office contacts the financially responsible party to review the cost of care. If there is POA or a conservator in place, the office will contact that person to review cost of care and the resident's financial obligations. Any questions regarding billing are answered so the financially responsible party is aware of all costs and is making an informed decision.

The HCF staff also does a mental assessment to determine if the prospective admit has dementia or there is a question as to the person's competency and ability to make health care and/or financial decisions. If this is the case, and there is no prior power of attorney or conservatorship in place, the next of kin is advised that he or she must petition the probate court to ensure a conservator can be appointed. In this situation, the veteran would not be admitted until this appointment was made.³

Once the admissions packet is complete, it is reviewed by an HCF admission team, similar to domiciliary care applications. For the HCF, the team 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. 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:

³ Newington Probate Court covers Rocky Hill.

- 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; has a 100 percent 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. Veterans may move from the Residential Facility to the Health Care Facility if additional care is necessary. Usually, the B Clinic staff 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 a 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, for example, when 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 may be 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 an acute care 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 is 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.

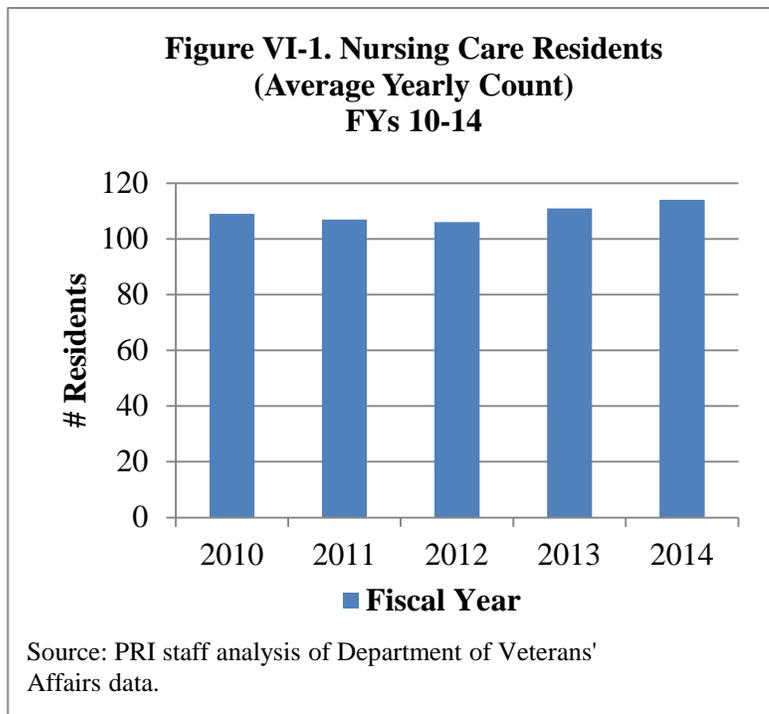
HCF personnel also said they try to keep up to nine beds available for domiciliary care veterans who need short-term, sub-acute care because they are recuperating from a physically-debilitating event that prevents them from living at the Residential Facility or they are preparing for an upcoming procedure (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. A 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 nine were received in FY 14 – a quarter fewer than the prior year. All applications to the HCF for both years were approved for admission.⁴

Occupancy. Resident occupancy for the Health Care Facility for FYs 10-14 is shown in Figure VI-1. The average yearly number of HCF residents for FYs 10-12 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 the highest among 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 veterans were conserved in FY 14.

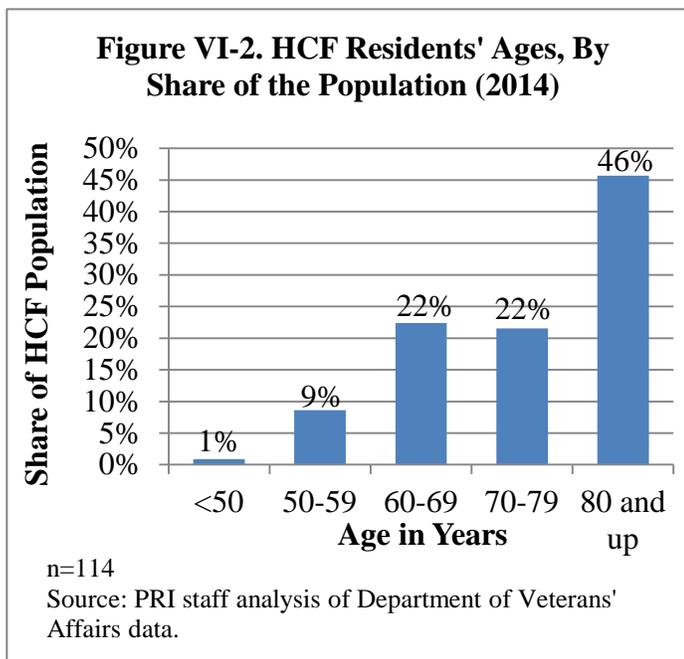


⁴ As of August 2014, there was a waitlist of five veterans. An additional two veterans were pending financial approval and one veteran was awaiting an on-site visit to determine if the person’s needs could be met by the facility.

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

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.⁵ For a veteran with a 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.⁶



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.⁷ 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

⁵ 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.)

⁶ Health Care Facility ITP core members are the facility's medical doctor, head nurse, social worker, dietician, and pharmacist.

⁷ "Current" means on medication or presently/recently in treatment.

- 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 a doctor, who is responsible for directing the veteran's care. When there is no doctor at the HCF, the University of Connecticut Health Center provides on-call medical service.⁸

In addition to the medical doctors, there is one director of nursing, three nurse practitioners (APRNs), five nurse supervisors, one infection control nurse, two bed utilization nurses, and one part-time clinical educator. Other nursing staff cover 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 (LPNs), and 20 full-time and 39 part-time nurse aides (who mostly work four days weekly).

HCF Clinic. There is a small clinic within the HCF that mainly provides certain specialized health care services for 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, physiatry, 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 a limited number of 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;
- physiatry: 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.

⁸ The contract requires on-call telephone 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.

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 oversees HCF admissions applications through that process, and works with hospitals on re-admissions. The scheduler and an LPN set up multiple types of appointments at the 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 is notified. 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 through 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 annually, and the Residential Facility an average of 18 times.

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 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 medical doctor or APRN

employed at either the Home or federal VA, 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 an incoming resident 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 to help improve strength and balance, in part to reduce falls. These classes include Tai Chi, walking, and circuit training, and as well as movement groups.

All classes except circuit training are led by a rehabilitation aide and occur twice weekly. Circuit training is offered for a few hours each week, 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; 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 two 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.⁹

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. Others are special events, like performances by a magician, a barbershop quartet, one of Connecticut's State Troubadours, and a choir.

Recreation staff also attempt 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.¹⁰

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

⁹ There are fewer activities on Sunday, when the chapel worship services often are the only recreation events.

¹⁰ Regs. Conn. State Agencies Sec. 27-102/(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 long-term care facility/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).

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. Approved applications are kept on file until either 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 declines in the numbers of applications received, veterans admitted, and total number of Respite Care days all beginning in FY 12, were due to a lack of available beds and a reduction in direct care 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: PRI staff analysis of Department of Veterans’ Affairs data.				

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 approaching or beyond 60 years old, and 5 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 8 percent of domiciliary care residents are under 50 years old. (Data are 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 certain program 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.

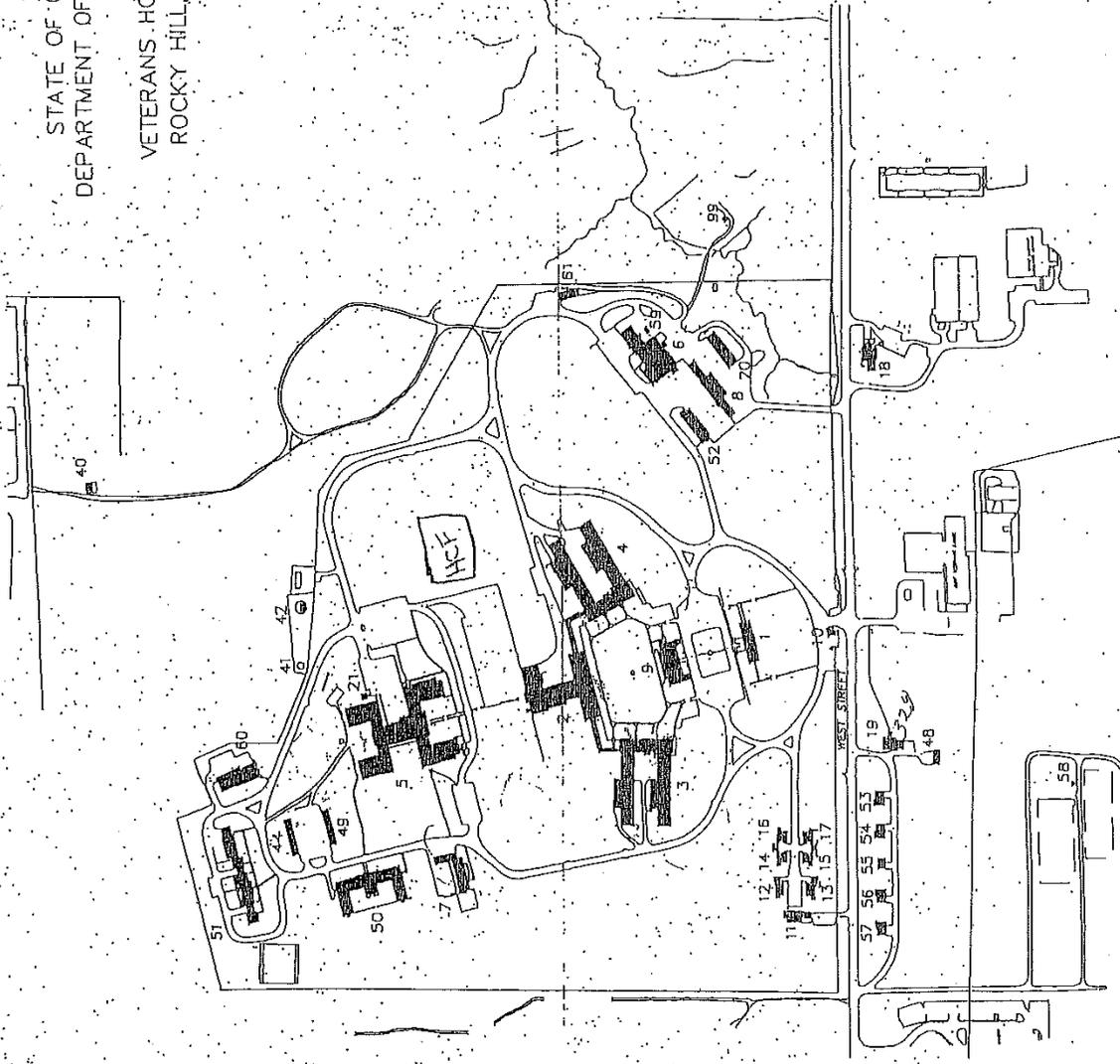
- *Should the Connecticut State Veterans’ Home adopt any other state homes’ policies, rules, or programs that seem to work well (from among those others that will be examined)?*

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	---

<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	---

<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 demolishment	---
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	---		

*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.

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 the DVA Business Office 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 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.

Agency Response



STATE OF CONNECTICUT

DEPARTMENT OF VETERANS' AFFAIRS

287 West Street
Rocky Hill, Connecticut 06067

2/18/2015

Legislative Program Review and Investigations Committee (PRI)

The Legislative Program Review and Investigations Committee initiated a review of the operations of the Veterans' Home under the Connecticut Department of Veterans' Affairs to ensure its residential services are delivered fairly and adequately. The process for admitting, discharging, and transferring residents, as well as resolving residents' complaints and implementing conduct rules, were highlighted.

Once notified by the Committee of the review, their initiative was fully embraced. The entire staff here at the Home has spent many hours gathering documentation in support of the committee's inquiries including fully supporting two public hearings as well as a campus wide veteran's survey for PRI review.

The staff and I look at this review as a positive process by the State Legislature. As an agency we have reviewed the proposed recommendations and look forward to discussing the report with the Veterans Working Group during the Governor's Review Initiative.

A handwritten signature in blue ink, appearing to read "Joseph T. Perkins".

Joseph T. Perkins
Acting Commissioner
Department of Veterans' Affairs