



Minnesota Governor's Veterans Long -Term Care Advisory Commission Report

*Let us strive on to finish the work we are in; to bind up the nation's wounds;
and care for him who shall have borne the battle...*

Abraham Lincoln

March 4, 1865



November 2007

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Governor's Veterans Long-Term Care Advisory Commission

The Honorable Governor Tim Pawlenty
Governor, State of Minnesota
130 State Capitol
75 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155

November 19, 2007

Dear Governor Pawlenty:

As chair of the Veterans Long-Term Care Advisory Commission, I am pleased to present to you the Commission's report. Your charge to the Commission was to "be bold" in addressing the care problems at the Minneapolis Home and to provide advice on how the state can better serve veterans in the future. The report addresses the Minneapolis facility and recommends a new way to provide long-term care and support to Minnesota veterans, consistent with Minnesota's innovative approach to long-term care for non-veterans.

Care at the Minneapolis Home

The many rule violations and poor care outcomes at the Minneapolis facility that led to the formation of the Commission must *stay* fixed. The good news is that, currently, there are no outstanding correction orders at the Minneapolis Home. The Veterans Home Board, its consultants, facility leadership and staff have made many improvements and should be commended for the progress to date. The Commission's primary concern here is sustainability. Without strong leadership, reliable systems of care, and a positive work environment, care problems will likely resurface. The report focuses on ways to sustain the high level of care our veterans deserve.

Governance and leadership

In making its recommendations, the Commission stresses the importance of strong leadership and clear lines of responsibility and accountability. As such, the Commission recommends transferring the Veterans Home program to the Minnesota Department of Veterans Affairs. This transition should include continued monitoring of the Minneapolis facility as required by the Minnesota Department of Health in the current stipulation settlement and other support. The recent appointment of the new executive director is a positive step toward achieving the Commission's recommendations and, for realizing the promise of an exciting new vision for the Veterans Home program.

A new approach to veterans long-term care

Minnesota must seize the opportunity to redefine how the Veterans Home program serves veterans. There is broad support for a new approach, where veterans and their families could look to all five campuses for:

- **Professional Care Planning and Coordination.** Anyone who has helped a loved one access long-term care knows that it can be a trying process. The campuses would be a preferred place for veterans and families to go for professional assistance in the development of a plan of care that could in many cases allow veterans to access community based services allowing them to live independently in their own homes. Facilitating access to a variety of care and support options is especially important as over 550 individuals are on the waiting list at the veterans homes.
- **Alternatives to Institutional Care.** The campuses would become regional points of entry to a state-of-the-art continuum of quality care. Services could include geriatric evaluation and other assessments, community services, adult day care, home services, local assisted living, respite services, and others—including skilled nursing care at the veterans homes.
- **New Housing with Services Options.** The five campuses would provide new housing options with supportive services. The transformed campuses should embody principles of privacy, small scale normal living environments, quality of life emphasis, state-of-the-art architectural design and use of technology. Redesign should rebalance resources to achieve a much greater emphasis on supportive housing and assistive living rather than nursing homes. These new housing and support options would be designed to serve a new generation of younger veterans as well.
- **Excellence in Chronic Disease Management, Nursing and Rehabilitative Care.** The campuses would be highly integrated with the VA Medical Centers (Minneapolis, St. Cloud, Fargo, and Sioux Falls) and provide veterans seamless access to the Veteran Integrated Service Network, community-based outpatient clinics, and rehabilitative services. This is especially important as returning veterans present new acute, post-acute and rehabilitative care challenges.

Minnesota has long been recognized as a national leader in developing creative alternatives to providing care for its elders. Today, there is strong support for a similar transition in caring for our veterans. This transition, however, must also result in a care system that meets the needs of future veterans including those, for example, now returning from Iraq and Afghanistan.

This is, indeed, the time to be bold. Veterans and their families, the current Veterans Home Board and their staff, Veterans organizations, legislative leaders and others have all expressed their support of the Commission's recommendations.

The Commission and its members are committed to help advance these recommendations and the important work of serving our veterans in any way that may be of help. Please do not hesitate to call on us.

Sincerely,



Dale Thompson, Chair
Governor's Veterans Long-Term Care Advisory Commission

Acknowledgements

Many people contributed to this report and – by working together – have come to believe that Minnesota can serve veterans long-term care needs in a new and enhanced way.

The commission would like to especially thank the family members who were faithful in attending all of the commission's meetings. They helped keep the focus squarely where it needed to be – on veterans.

Thank you to the current Veterans Homes Board and its chair, Jeff Johnson. The commission has come to respect the individual and collective commitment of personal time and effort the board members have made to caring for veterans. It is our belief that they are committed to whatever is the best way forward to achieving better results.

The Veterans Homes Board staff and their consultant were always responsive and made it possible to prepare a report complete with relevant background and facts.

Also thank you to the legislators who participated as ex-officio members to the commission and consistently offered their support, perspective, and encouragement consistent with the growing commitment the Minnesota Legislature has shown to veterans.

The commission held nine meetings from May 16, 2007, to November 19, 2007, during which time it also benefited from the contributions of:

- Governor Tim Pawlenty;
- Residents and staff at the Minneapolis Veterans Home;
- Jeff Johnson, Veterans Homes Board Chairman;
- Charles (Chip) Cox, Interim-Executive Director of Veterans Homes Board;
- Union officials;
- Staff from the Minnesota Department of Finance, Employee Relations, Health, Human Services, Veterans Affairs;
- U.S. Department of Veteran Affairs Medical Center in Minneapolis;
- Veterans service organizations;
- Previous Blue-Ribbon Commission members with extensive historical knowledge of the Veterans Homes;
- Long-term care experts and leaders from Stratis Health, Presbyterian Homes, Benedictine Health System, UCare, Ecumen, Tealwood Care Centers, Eldercare of Minnesota, and others.

The work was punctuated by a strong consensus among commission members and others that it is time to dramatically enhance the supportive services offered to Minnesota veterans.

EXECUTIVE SUMMARY

Introduction

Between July 2005 and April 2007, the Minnesota Department of Health conducted two full licensure inspections of the Minneapolis Veterans Home. Sixteen onsite Office of Health Facility Complaints (OHFC) investigations were completed and seven were substantiated. A total of 66 correction orders were issued and 11 penalty assessments were issued which resulted in fines to the Home in the amount of \$42,300. Governor Pawlenty created the Veterans Long-Term Care Advisory Commission in response to these events.

Although the Minneapolis facility is the only one of five homes experiencing serious regulatory problems, the commission believes that these recommendations will benefit all five homes including those in Silver Bay, Fergus Falls, Hastings and Luverne. The commission's report addresses the Minneapolis facility and recommends a new way to provide long-term care and support to Minnesota veterans, consistent with Minnesota's innovative approach to long-term care for non-veterans.

It is important to note that the commission believes that resources are not the source of the troubles at the Minneapolis Home or the Veterans Home program, overall. Agency resources appear to be sufficient for the current VHP program. However, resources must be allocated properly. For example, agency level (central office) resources need to be restructured and possibly increased to strengthen key functions, especially during the next 3-5 year transition period. For this reason agency leadership must have the latitude to focus resources where they can have the greatest impact.

Recommendations to Strengthen Governance and Executive Leadership

The governance and leadership of the Minnesota Veterans Homes will play a vital role in an extraordinary multi-year effort to fully implement these recommendations. The Board's recent recruitment and hiring of an executive director is a positive step in strengthening the executive leadership of the Veterans Home program. An effective governance structure is also needed to rebuild the credibility of the Minneapolis facility and to enable all five facilities to serve veterans in an enhanced way.

Governance:

- **Transfer the Veterans Home program (VHP) to the DVA.** The VHP can succeed under a number of governing models. However, it is imperative that responsibility and accountability for the VHP be clarified and strengthened. It is also logical that state services to veterans be delivered through the only state agency with the mission to serve veterans.

- **Restructure the DVA to create a deputy commissioner of veteran health care, which is the equivalent of the existing executive director position.** The deputy commissioner of veteran health care would be responsible for supervising the Veterans Home program and would report directly to the commissioner of the DVA.
- **Clarify and communicate the chain of command.** The commissioner of DVA must hire and hold the deputy commissioner of veteran health care accountable for the success of the VHP. The deputy commissioner of veteran health care must hire and supervise a central staff responsible for the essential support functions and facility administrators, who in turn are directly responsible for the operations of the facilities.
- **Revise the DVA's mission and duties in statute to explicitly include post-acute health care and long-term care.**
- **Establish in statute a new Veteran Health Care Board which would advise the commissioner of the DVA. The nine member Veteran Health Care Board membership must be composed primarily of health care and long-term care experts and fairly represent the geographic areas of the state.**
- **Establish formal interagency agreements between the DVA and partner agencies, including departments of human services and health, the housing finance agency, and the board on aging.** The purpose of the agreements would be to ensure that the DVA and the Health Care Board benefit from the specialized expertise of these agencies.
- **Establish in statute that the governance structure of the VHP, including the Veteran Health Care Board, will be evaluated within five years to assure continued accountability and active involvement of health care experts and stakeholders in the governance structure.**

Leadership:

- **Establish appropriate executive leadership compensation.** In order to attract and retain highly skilled and talented executive leadership in the future, the compensation for these positions must be commensurate with similar positions in the market. The commission recommends that compensation for the deputy commissioner and the administrator of the Minneapolis facility be given special consideration when determining compensation level.
- **Establish a strong leadership team in Minneapolis.** The senior leadership positions with the Minneapolis Home should be filled immediately with competent leaders who are committed to working with the other agency leaders *over the long haul*. The leadership team in Minneapolis must have a clear charge,

be visible and engaged with employees and veterans, and they must get people excited about the mission.

- **Establish practical ways for the administrators, home staff, and the deputy commissioner to communicate frequently and develop as a team of leaders. They must work together to achieve improvements in both internal and external benchmarks for employee, resident, and family satisfaction across all five facilities.**
- **The administrators of the five facilities can also help lead by:**
 - Actively engaging family and resident councils, employees and leadership in promoting and building a resident-centered approach at the facilities.
 - Creating a positive, healthy work environment at the facilities.
 - Informing the Veteran Health Care Board and deputy commissioner about the needs of their facilities.
- **All employees of the Veterans Home program can help lead the way by:**
 - Drawing on their own personal commitment to veterans.
 - Taking responsibility for learning about the new direction of the VHP and looking for ways to personally contribute to the cause.
 - Sharing and celebrating successes.
- **The commissioner of the DVA, the deputy commissioner of veteran health care, and the proposed Veteran Health Care Board must help lead this effort by mobilizing a diverse range of expertise (health care, veterans benefits, long-term care, housing, organizational performance, and other areas) to help the VHP achieve its potential.**
- **The Governor and the Legislature, together, must act urgently to implement these recommendations.** For example, the Governor must immediately restructure the Veterans Home program within state government, clarify and strengthen the chain of command, and hold people accountable. The Legislature must maintain the high commitment it has already shown through increased appropriations to veterans programs and implement the recommendations which require legislative action.

Recommendations to Achieve and Sustain “State-of-the-Art” Clinical Operations

The many rule violations and poor care outcomes at the Minneapolis facility that led to the formation of the Commission must be corrected and *stay* fixed.

The good news is that, currently, there are no outstanding correction orders at the Minneapolis Home. The Veterans Home Board, its consultants, facility leadership and staff have made many improvements and should be commended for the progress to date.

The Commission's primary concern here is sustainability. Without strong leadership, reliable systems of care, and a positive work environment, care problems will likely resurface.

- **Create a customized transition plan for the Minneapolis facility.** This transition plan should include continued monitoring as required by the Minnesota Department of Health in the current stipulation settlement.
- **Strengthen delivery of primary health care for veterans.** The U.S. Department of Veterans Administration program in the region, working in partnership with the state of Minnesota, is responsible for the delivery of primary health care, chronic disease management, and primary mental health services to veterans served by the Veterans Home program. The Veterans Administration has substantial expertise in these areas, including Alzheimer's care, brain injury programs, and others. To date, residents of the Minneapolis Veterans Home have not received the full benefit of this capability. The commission recommends that the state work with the leadership at the VISNs to ensure that delivery of primary care to residents of state veterans homes be seen as an integral part of the VISN programs.
- **Hire a medical director at the agency level and designate clinical directors at each facility.** The medical director must be a licensed physician and provide direction and oversight to each facility's clinical operations. The facility's clinical director may be licensed physician, a certified-nurse practitioner (CNP) or a certified physician assistant (PA-C). The clinical director at the Minneapolis facility should be a full-time licensed physician, since the issues are particularly complex and require clear authority and responsibility.
- **Develop a clinical leadership team at each Home, composed of the clinical director, primary care physicians, nurse practitioners, director of nursing and social work, pharmacist, and other key stakeholders as appropriate.**
- **Select and embrace a quality improvement approach and implement it consistently across all five facilities through a quality improvement plan.**
- **Update the Veterans Homes' electronic capabilities, both hardware and software, and integrate the systems with the VA Medical Center systems to allow for better access to medical records for both parties when treating the resident (of Veterans Homes) and patient (of VA Medical Center).**
- **Provide ongoing training and develop staff and clinical teams based on the improvement plan's goals and targets.**

Recommendations to Improve Core Organizational Systems and Performance

The most successful multi-facility post-acute care organizations tend to centrally manage key administrative functions and achieve economies of scale in areas such as fiscal management, human resources, and information technology. They also have a core of central staff responsible for system-wide performance goals (such as clinical quality improvement) that work side-by-side with the facility administrators and staff to help achieve performance targets.

When the commission reviewed how the VHP manages key administrative functions, it found that the Veterans Home program is out of synch with the best performers. The commission estimates that 3 – 5 percent of total revenue is typically needed to manage an organization’s resources across multiple facilities. Expenditures for the Veterans Homes Board (Board office) in FY2007 were \$1,469,000. This is slightly over 2 percent of total expenditures.¹

- **Restructure staff and budget, and consider the need for increased appropriations, so that central office staff have the capacity to provide value-added support at the facility level that result in measurable improvements in targeted areas.**
- **Develop a “balanced scorecard” for each of the five facilities to provide useful information on key areas of performance.**
- **Use the performance measurement system to set and monitor performance targets, catch early warning signs of trouble, and problem solve where performance deficits are identified.**

Recommendations to Achieve Focus and Strategic Direction

Minnesota must seize the opportunity to redefine how the Veterans Home program serves veterans. There is broad support for a new approach, where veterans and their families could look to all five campuses for:

- **Professional Care Planning and Coordination.** Anyone who has helped a loved one access long-term care knows that it can be a trying process. The campuses would be a preferred place for veterans and families to go for professional assistance in the development of a plan of care that could in many cases allow veterans to access community based services allowing them to live independently in their own homes. Facilitating access to a variety of care and support options is especially important as over 550 individuals are on the waiting list at the veterans homes.

¹Minnesota Department of Finance, Expenditures in FY 07 for Minnesota Veterans Homes Board, October, 2007.

- **Alternatives to Institutional Care.** The campuses would become regional points of entry to a state-of-the-art continuum of quality care. Services could include geriatric evaluation and other assessments, community services, adult day care, home services, local assisted living, respite services, and others—including skilled nursing care at the veterans homes.
- **New Housing with Services Options.** The five campuses would provide new housing options with supportive services. The transformed campuses should embody principles of privacy, small scale normal living environments, quality of life emphasis, state-of-the-art architectural design and use of technology. Redesign should rebalance resources to achieve a much greater emphasis on supportive housing and assistive living rather than nursing homes. These new housing and support options would be designed to serve a new generation of younger veterans as well.
- **Excellence in Chronic Disease Management, Nursing and Rehabilitative Care.** The campuses would be highly integrated with the VA Medical Centers (Minneapolis, St. Cloud, Fargo and Sioux Falls) and provide veterans seamless access to the Veteran Integrated Service Network, community-based outpatient clinics, and rehabilitative services. The campuses should also work closely with the University of Minnesota’s academic and research programs. This is especially important as returning veterans present new acute, post-acute and rehabilitative care challenges.

The Veterans Homes program has a unique window of opportunity to build on its mission – and on renewed public support for veterans – to create a new vision for the Veterans Homes.

INTRODUCTION

Governor Pawlenty created the Veterans Long-Term Care Advisory Commission in response to ongoing problems at the Minneapolis Veterans Home. The commission was asked to “provide recommendations to the Governor on long-term care operations, administration, management and governance models which incorporate the best examples of innovative approaches to maximizing quality care and quality of life for veterans.”² The executive order can be found in Appendix A.

The commission consists of fifteen members – seven voting members and eight ex-officio members, including four legislators. A listing of commission members with a short biography of each is listed in Appendix B. Staff from the Department of Administration’s Management Analysis & Development provided meeting facilitation, research, report writing, and staff support to the commission.

MINNESOTA’S STATE VETERANS HOMES PROGRAM

State Veterans Homes Program

The five veterans homes located in Minnesota are operated under the State Veterans Homes Program (VHP). The five homes are located in Fergus Falls, Hastings, Luverne, Minneapolis, and Silver Bay. The veterans homes provide skilled nursing care, special dementia care units, domiciliary (boarding care)³, and residential programs for veterans who are homeless.

The State Veterans Homes Program is one of three national programs provided by the U.S. Veterans Health Administration of the U.S. Department of Veterans Affairs (U.S. DVA) whereby veterans can access nursing home services. The program is a cooperative venture between the state of Minnesota and the U.S. DVA. Minnesota petitions the U.S. DVA for matching construction grants and the state, the veteran, and U.S. DVA pay a portion of the per diem, which is set in legislation. State veterans homes are to accept all veterans needing short-term or long-term nursing home care. Services vary among the five veterans homes in Minnesota depending on resources and capability of the home in providing them.⁴

In addition to nursing home care, there is a variety of other long-term care services offered by the U.S. DVA either directly or through contracts with community-based agencies. Some of these services include inpatient or outpatient respite care, inpatient or

² Executive Order 07-02, signed by Governor Pawlenty on February 28, 2007, <http://www.governor.state.mn.us/priorities/governorsorders/executiveorders/PROD007996.html>.

³ Domiciliary care provides rehabilitative and long-term, health-maintenance care for veterans who require minimal medical care but do not need the skilled nursing services provided in nursing homes. A Domiciliary also provides rehabilitative care for veterans who are homeless (Department of Veterans Affairs, *Federal Benefits for Veterans and Dependents*, 2007 Edition).

⁴ Department of Veterans Affairs, *Federal Benefits for Veterans and Dependents*, 2007 edition.

outpatient geriatric evaluation and management, hospice and palliative care, adult day health care, and home-based primary care. Veterans generally pay a co-pay to receive these services. Currently, there is no tracking system in place to determine how many veterans in Minnesota are accessing these services in their community.

The Minnesota Veterans Homes operate from three sources of funding: U.S. DVA per diem, state appropriation and resident co-payments. If eligible, veterans can also receive compensation, pension, or Aid and Attendance benefits that can be used to purchase other nursing home care or personal care services. See Appendix C for veterans homes' population, benefits received by veterans in veterans' homes, and a description of benefits available to veterans.

Governance and Executive Management

Since 1988, the Minnesota Veterans Homes have been governed by the Minnesota Veterans Homes Board. Prior to 1988, the homes were under the responsibility of the Minnesota Department of Veterans Affairs.

Currently, Board members are appointed by the Governor for four-year terms. There are currently nine voting members and three ex-officio members. Membership is guided by a newly revised state statute, which requires a chair who must be a veteran; eight public members experienced in policy formulation with professional experience in health care delivery; and, at least five members who must be members of congressionally chartered veterans' organizations or their auxiliaries that have a statewide organizational structure and state level officers in Minnesota.⁵ The changes that occurred with this legislation are: 1) the chair of the board must be a veteran; 2) the board can select an executive director from a pool of non-veteran applicants if they are unable to find a qualified veteran for the position; and, 3) the chairs of the committees dealing with veterans affairs (ex-officio members) from each House can send a designee who does not have to be a veteran. See Appendix D for a comparison of the previous statutory language to the new statutory language, and a table that lists the current board members and their qualifications.

Veterans Homes Board Mission

The mission of the Veterans Homes Board (the Board) "is to oversee and guarantee high-quality health care for veterans and dependents in its care."⁶

Board Responsibilities

The Board of Directors is responsible for the strategic direction of the agency⁷ (Board office and five homes) and for seeing that each of its facilities are being responsive to the health care needs of veterans and their spouses. It is to lead the organization to its desired performance by crafting governing policies and ensuring the proper governance and management of the facilities.⁸ The Board hires and supervises the executive director,

⁵ Source: Laws of Minnesota 2007, Chap. 45, Article 2, Sections 4 and 5, (the Omnibus Agriculture and Veterans Affairs Bill of 2007 - HF2227), <http://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=H2227.4.html&session=ls85>.

⁶ Minnesota Veterans Homes Board, *Veterans Homes Board Policies*, 2004.

⁷ Minnesota Veterans Homes PowerPoint presentation given to the commission by Board Vice-Chairman, Dan Williams, May 31, 2007.

⁸ Minnesota Veterans Homes Board, *Veterans Homes Board Policies*, 2004.

hires the administrators and approves the budget for the five homes.⁹ Appendix E provides an organizational chart of the Minnesota Veterans Homes.

Staffing Summary

The five homes and Board of Directors are supported by a centralized management team located at the Veterans Homes Board office in St. Paul. The Board office houses the executive director, who is hired directly by the Board and reports to the Board, and 14 additional FTEs (listed below) that support the executive director and the Board. Three separate committees of the Board include a special review committee, finance committee, and quality assurance committee. The five homes are each managed by an administrator, who provides day-to-day leadership for the facility.

The board office staffs 15 FTEs. The positions are as follows:

- Executive Director (hired to start Jan. 2008)
 - Deputy Executive Director (1.0)
 - Executive Assistant (1.0)
 - Legislative/Public Affairs Liaison (1.0)
 - Veterans Benefits, Safety, and Facilities Director (1.0)
 - Financial Management Director (1.0)
 - Legal Analyst (1.0)
 - Quality Management Coordinator (1.0)
 - Personnel Services Manager (1.0)
 - Information and Technology Systems Director (1.0)
 - Information Technology Specialists (5.0)
-
- **15 FTEs (14 currently filled)**

Budget

The total biennial operating budget for the Veterans Homes Board in FY 2006-07 from all sources of funds was \$133.9 million (53 percent state appropriations, 23 percent U.S. Veterans Affairs per diems, and 24 percent patient co-pays).¹⁰ Total expenditures for the Veterans Homes Board in FY2007 totaled \$70,045,320. See Appendix H for a table that displays expenditures by fund and category.

Table 1.0 and Figure 1.0 below display FY2007 operating budgets for the Veterans Homes Board facilities by each funding source (state appropriation, federal per diem and resident co-payment). The state appropriation accounts for half of the operating budget and resident co-payments and the U.S. DVA per diem each make up about 25 percent of the budget.

⁹ Minnesota Veterans Homes PowerPoint presentation given to the commission by Board Vice-Chairman, Dan Williams, May 31, 2007.

¹⁰ Veterans Homes Board, 2008-09 Biennial Budget, State of Minnesota, November 30, 2006 and Minnesota Department of Finance Budget Office (updated FY2007 expenditures), July 2007.

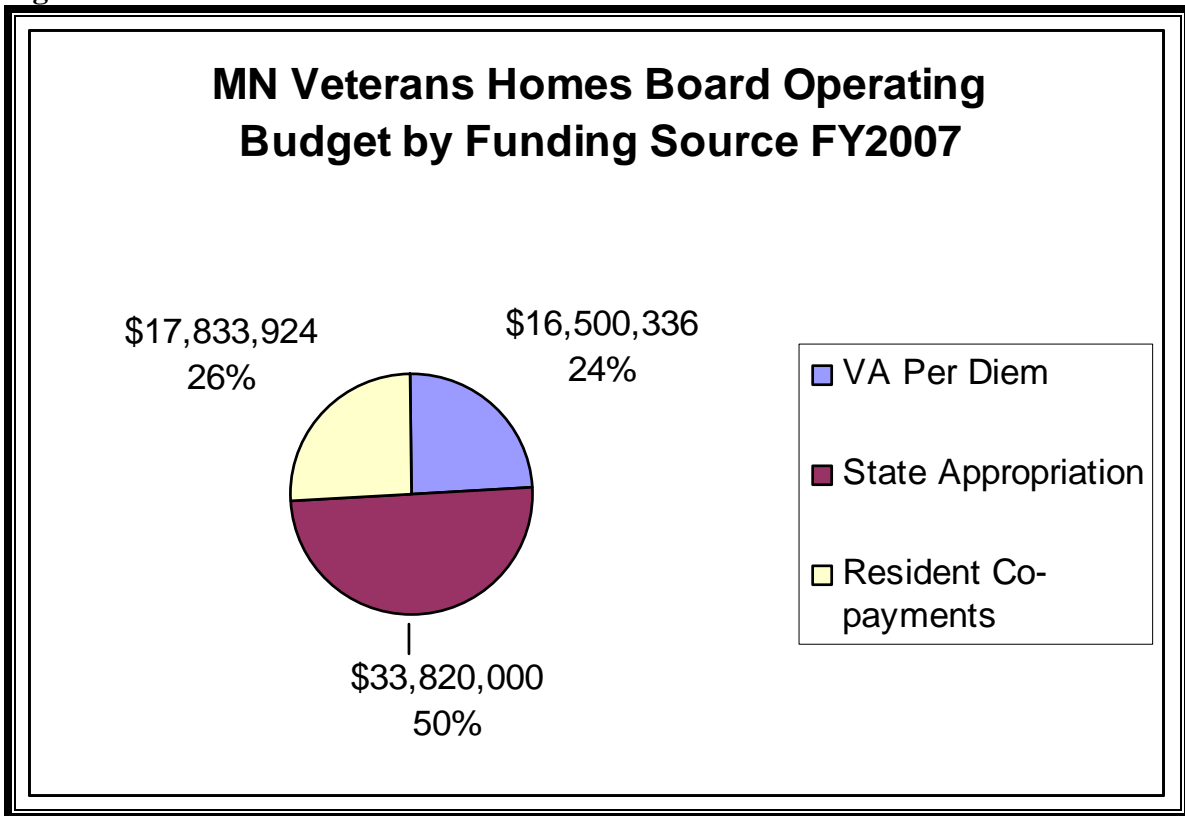
Table 1.0
Minnesota Veterans Homes Board FY2007 Operating Budget by Funding Source*¹¹

Home	VA Per Diem (Federal)**	State Appropriation**	Resident Co-Payment	TOTAL
Board of Directors	0	1,828,178	0	1,828,178
Minneapolis	8,633,492	15,684,160	9,301,874	33,619,526
Hastings	2,137,535	3,407,243	1,800,044	7,344,822
Silver Bay	1,720,168	4,348,835	2,334,882	8,403,885
Luverne	1,980,334	4,617,198	2,033,536	8,631,068
Fergus Falls	2,028,807	3,934,386	2,363,588	8,326,781
TOTAL	16,500,336 (24%)	33,820,000 (50%)	17,833,924 (26%)	68,154,260¹²

* As of 6/30/07

** Includes carry forward funds from FY2006

Figure 1.0



¹¹ Veterans Homes Board Office, July 2007.

¹² This total is slightly higher than the facilities expenditures above (\$66,413,983) because it includes carry forward funds from FY2006.

The Five Facilities

Each of the five veterans homes' facilities are managed by a home administrator who reports directly to the executive director.¹³ The administrator directs, administers, and coordinates all the activities of the home to carry out its objectives in providing quality resident care. They are accountable for all activities and departments that are subject to rules and regulations promulgated by government agencies.¹⁴ The five facilities are distinct in their own ways and differ according to a multitude of variables: geographic location in the state, proximity to hospital care, culture, staff, leadership, type of care provided (domiciliary vs. skilled nursing), and resources and services available, among many others. Several factors come into play at each of the homes that contribute to their unique environment, and ultimately, the quality of care delivered to the residents. See Appendix F for a brief summary of the four facilities in greater Minnesota.¹⁵

Eligibility for Admission into Minnesota Veterans Homes

Individuals seeking admission into a Minnesota veterans home facility must meet admissions requirements defined in Minnesota statutes and rules.¹⁶ Appendix G includes M.S. 198 and Minnesota rules pertaining to admission requirements. Eligibility criteria are summarized below:

- Served 181 consecutive days of active duty service with honorable discharge;
- Served in a Minnesota regiment, had service credited to Minnesota, or have been a resident of Minnesota preceding the date of application (at least one day);
- Spouses of eligible veterans over 55 years of age and resident of the state preceding the date of application; and,
- All applicants must demonstrate the need of institutional nursing home care (assessed by an appropriate medical provider).¹⁷

Priority will be given to veterans over non-veterans, veterans from sister facilities – if they require a change in level of care that the veterans homes can accommodate, and veterans transferred from other veterans homes.¹⁸ Service-disabled veterans and combat veterans receive priority in scheduling of hospital or outpatient medical appointments for VA health care, but this is not to be confused with nursing home care admissions at the veterans homes.¹⁹

¹³ Minnesota Veterans Homes PowerPoint presentation given to the commission by Board Vice-Chairman, Dan Williams, May 31, 2007.

¹⁴ Minnesota Department of Employee Relations, Veterans Home Salary Comparisons, provided definition of "Home Administrator," June 2007 (see Appendix G).

¹⁵ Information in this section was obtained from the MN Veterans Homes website: <http://www.mvh.state.mn.us/index.html>.

¹⁶ Minnesota Statute Sections 198.01, 198.022, and 198.03 and criteria in part 9050.0070 of the Minnesota Rules.

¹⁷ State of Minnesota, Veterans Home Board: Agency Profile, 2008-09 Biennial Budget, November 30, 2006.

¹⁸ Minnesota Veterans Homes Board Office, commission Request for Data, July 2007.

¹⁹ Department of Veterans Affairs, *Federal Benefits for Veterans and Dependents*, 2007 edition.

MINNEAPOLIS VETERANS HOME²⁰

Overview of Minneapolis Veterans Home

The Minnesota Veterans Home in Minneapolis, once called the Old Soldiers Home, was built in the late 1800's for indigent veterans of the Civil War. The home is located on a 51-acre wooded campus overlooking the Mississippi River near Minnehaha Falls. At the end of the 19th century the intent was to create a beautiful, comfortable community for veterans in need of care in their later years.

The Minneapolis Home operates 250 skilled care beds, 91 skilled care beds for dementia care and 61 domiciliary care beds. The domiciliary program is a rehabilitative program which enables residents to achieve their highest level of independence. The goal is to encourage the resident to return to a non-institutional setting or maintain a level of self-sufficiency in a less structured setting.

Medical services provided at the Minneapolis Home include 24-hour nursing services, social services, recreation therapy services, rehabilitation therapy services, mental health services, chaplain and spiritual care services, dietetic and nutritional services, pharmaceutical services, volunteer services, and assistance to apply for U.S. DVA benefits. Special features offered include: private and semi-private rooms, close proximity to the Minneapolis Veterans Affairs Medical Center (VAMC), transportation provided to the VAMC for clinic appointments, on-campus MTC bus line, library, coffee shop, barber/beautician, family lounge and resident and family councils.

Currently, the Minneapolis Home is managed by an interim-administrator, who has been in the position since February 2007.

There are currently 374 people on the waiting list for the Minneapolis Home. The approximate wait for skilled nursing care is anywhere from 8-12 months. Appendix I includes a table that provides waiting list information for all five homes.

To learn more about the operations of the Minneapolis Home, the commission explored various topics as questions were raised. Appendix H provides a compilation of information and data on the topics listed below:

- Expenditures – Minnesota Veterans Homes Board FY2006 and FY2007
- Expenditures – Minneapolis Veterans Home FY2006 and FY2007
- Minneapolis Veterans Home staffing
- Nurse staffing ratios
- Nursing salary comparisons
- Physician staffing model
- Staff turnover
- Staffing ratio data at Minnesota Veterans Homes
- Part-time vs. full-time nursing and HST positions at Minneapolis Home

²⁰ Minnesota Veterans Homes Board website, <http://www.mvh.state.mn.us>

- RN/LPN overtime (OT) hours at Minneapolis Home
- Minnesota Veterans Home salary comparison – nursing
- Minnesota Veterans Home salary comparisons – executive director and home administration

Recent Regulatory Problems²¹

The Minneapolis Veterans Home is a “licensed only” nursing home. In other words, it is not certified by Medicare to receive federal Medicare payments and, as a result, is regulated by a state license—not a federal Medicare certification process. The state license is issued by the Minnesota Department of Health (MDH), which regulates and inspects the home according to specifications in Minnesota Statutes Chapter 144A and Minnesota Rules, Chapter 4658. The Minnesota Veterans Homes are also required to meet the provisions of federal regulations adopted by the U.S. Department of Veterans Affairs. Regulations are similar to regulations which apply to facilities that accept Medicare payment, and the U.S. DVA conducts surveys of these facilities. The following summary of information pertains only to nursing home issues at the Minneapolis Home.

Between July 2005 and April 2007, two full licensure inspections were conducted by MDH. Sixteen onsite Office of Health Facility Complaints (OHFC) investigations were completed and seven were substantiated. A total of 66 correction orders were issued and 11 penalty assessments were issued which resulted in fines in the amount of \$42,300.

The 66 correction orders cited 54 different rule or statutory violations. The following highlights the issues the violations were related to:

- Thirty-five were nursing or care-related issues.
- Seven were quality of life or resident rights issues.
- Eight related to sanitation or physical plant issues.
- Four were miscellaneous records keeping issues, reporting requirements.

²¹ Unless otherwise noted, information in this section was obtained from the Minnesota Department of Health, OHFC, PowerPoint presentation to the commission, May 16, 2007.

Responses to Regulatory Problems 2005 – 2007

In 2005 the Governor requested that a comprehensive review of the Minnesota Veterans Homes, Veterans Homes Board, and Veterans Homes Board staff be conducted to better fulfill the Veterans Homes Board mission and oversee and guarantee that high-quality health care was being provided at the veterans homes. HDG, a senior living and health care management and consulting firm, and its subcontractor, Organizational Concepts International (OCI), were selected from a request for proposal (RFP) process conducted by the Board's special review committee. The primary objective was for HDG to perform a systemwide analysis of all five of the veterans homes in Minnesota relative to patient care, staffing, governance, quality assurance, and functions of the Board and Board office staff.

HDG completed the assessment between November – December 2005 and provided a comprehensive review report in January 2006 to the Board. The recommendations directed to the Minneapolis Home focused both on nursing/clinical operations and non-clinical issues. The nursing and clinical operations recommendations addressed a) implementing changes to their nursing structure, b) revising staffing policies to better meet residents' needs, c) using external experts to conduct mock surveys of the facility to ensure compliance, and d) changing the Minneapolis Home's structure into smaller distinct operating units. The non-clinical recommendations addressed a) recruiting a top-quality management team for the Minneapolis Home, b) creating an 18-month turnaround plan for the Minneapolis Home with milestones and metrics, c) relocating Board office staff onto the Minneapolis campus, and d) implementing a formal program to boost employee morale and celebrate successes of the facility. Most of these recommendations were classified as "critical" and HDG advised that implementation of them be of highest priority.

HDG also proposed several recommendations that applied to all of the homes. These recommendations focused on regionalizing salaries for union staff, effectively dealing with employees with performance issues, coordinating training responsibilities to facility staff, developing public affairs/development plans, and conducting department head meetings. In addition, HDG highlighted a number of recommendations specifically for Board office staff that applied to creating systems and processes; and clarifying roles and functions of board office staff, facility administrators and management teams. Likewise, recommendations directed to the Board concentrated on the Board's governing function, Board development and clarifying the Board's roles and responsibilities.

After HDG's January 2006 assessment report was completed, HDG consultants continued to provide oversight and consultative support to the Minneapolis Veterans Home the following year. Then, in January 2007, HDG conducted another site visit and survey of the Minneapolis Home. The areas of focus consisted of incontinence management and skin/pressure sore management (including assessment), care planning process, and implementation. It was during this period that three residents died at the Minneapolis Home and the Department of Health was ordered by the Governor to monitor the day-to-day operations of the home until consultants were hired to provide oversight. Governor Pawlenty also created the Veterans Long-Term Care Advisory

Commission shortly after in February under executive order 07-02. The commission was charged with providing recommendations in relation to the governance, management, and operations of the Minnesota Veterans Homes.

In March 2007, HDG was again selected from an RFP process to provide oversight consultation to the Minneapolis Home. HDG focused their oversight this time to address issues surrounding regulatory compliance; nursing quality assurance; accountability; and ongoing operational, process, procedural and policy changes. HDG provided written and oral summary reports to the Board and Board staff every couple of months to keep them updated and informed of their progress. Their reports summarized the services they provided and included recommendations that covered a broad range of regulatory and operational issues for the Minneapolis Home and the Board to address.

In June 2007, MDH initiated the proceedings to suspend, revoke, or not renew the Minneapolis nursing home license due to the facility receiving nine uncorrected violations in the four highest categories over the past two years. As a result, the Minneapolis Home entered into a stipulation of settlement, which placed the Minneapolis Home under a conditional license status for the next two licensure periods (until July 30, 2009). The stipulation requires additional monitoring of the home by an entity (other than HDG) under contract with MDH, and the Board is required to share more information regarding operations with both MDH and the monitoring entity. The monitoring agency is expected to be in place in November 2007. The Board expanded its contract with HDG, and HDG will continue providing consultation and support to the Board and the Minneapolis Home for the next year.

The U.S. DVA conducted an annual inspection of the Minneapolis Home in October 2007 and found about 10 rule violations; far fewer than the 31 violations the previous year. And, as of November 2007, the Minneapolis Home had no outstanding correction orders. The facility, however, is still subject to annual surveys by the department of health and the U.S. DVA.

VETERANS CURRENT UTILIZATION OF NURSING HOME CARE

Number of Minnesota veterans eligible

It is estimated, that on any given day, we might expect to see over 7,500 veterans over the age of 65 residing in a nursing home. Yet, the Minnesota Veterans Homes currently serve 531 veterans over age 65, which is only about 7 percent. And 530 individuals are on the waiting list to get into one of the five veterans homes.

Utilization estimates

Veterans in Minnesota are residing in the veterans homes at a remarkably lower rate than utilization rates²²would predict. Nursing home utilization is the percent of people within an age group who are in a nursing home on a given day. Data in Table 3.0 below highlight that 6.9 percent of Minnesota’s veterans that we might expect to see in nursing home care in the age cohort of 65+ are currently residing in a Minnesota Veterans Home, and 5 percent in the age cohort of 85+ are residing in a Minnesota Veterans Home.

The nursing home utilization rate in Minnesota for older persons has been declining for the past 20 years. According to the current utilization of veterans homes in Minnesota, this trend may be indicative of veterans as well.

Table 3.0 Nursing Home Utilization Rates

Age Cohort	# of Veterans in MN	Nursing Home Utilization Rates in 2005 ²³	# Veterans Eligible for Nursing Home based on Utilization Rates	# of Veterans residing in MN Veterans Homes
65+	157,330	4.92%	7,741	531 (6.9%)
85+	17,869	17.4%	3,109	155 (5.0%)

Veterans are being served in a variety of ways

If elderly veterans are similar in many respects to the elderly population at large, they are likely being served in a variety of other ways and accessing nursing home care services that are community-based, nonprofit, or privately operated in their communities so they can live longer in their homes and remain closer to their family. However, if that assumption is incorrect, veterans in Minnesota are perhaps not receiving the nursing home care that they deserve and are entitled to.

²² There are approximately 410,164 veterans living in Minnesota. Within this population, 157,330 are age 65 and over and 17,869 are 85 and over (Department of Veterans Affairs, Minnesota). To gain a better understanding of how many veterans in Minnesota – who we would expect to see in nursing home care – are utilizing nursing homes in the MN Veterans Homes system, we used nursing home utilization rates for two age cohorts to come up with an estimate for analysis.

²³ Source: Residents—MDH and DHS; Population, US Census Bureau, Department of Human Services, *Status of Long-Term Care in Minnesota 2005: A Report to the Minnesota Legislature*, June 2006.

THE VETERANS LONG-TERM CARE ADVISORY COMMISSION

The commission held nine meetings from May 16, 2007, to November 19, 2007, during which time it met with the Governor; Veterans Homes Board staff and leadership; veterans and their family members, residents and staff at the Minneapolis Veterans Home; state agency leaders; and veterans' service organizations.

Seek first to understand

The commission began its work by seeking first to understand. It heard presentations from leaders at the Minnesota Department of Health, consultants from Health Dimensions Group, the Commissioner of the Minnesota Department of Veterans Affairs, and previous Blue-Ribbon Commission members with extensive historical knowledge of the Veterans Homes. Agency leaders and Board members presented information on the veterans homes mission, governance, operations, management structure, funding, and key challenges and regulatory issues. The presentations helped the members understand the current governance and management structure of the Veterans Homes program.

The commission also conducted one meeting as a hearing to gather the perspectives of veterans and family members, union representatives, veterans organizations, professional organizations, and employees working at the Minneapolis Home. Organizations and individuals that provided oral testimony to the commission are listed in Appendix J.

In addition, the commission collected written testimony and developed an online survey for members of the public to provide input and offer recommendations for the commission to consider.

Consider the art of the possible

The commission also heard presentations from leaders at Stratis Health, Presbyterian Homes, Benedictine Health System, UCare, Ecumen, Tealwood Care Centers, Eldercare of Minnesota, and others to stimulate their thinking about innovative approaches to delivering long-term care services to Minnesota's veterans.

The commission developed key elements of a vision for the Minnesota Veterans Homes, based on all they had heard and learned during their deliberations. The commission's vision, which was shared with and supported by veterans service organizations on September 6, 2007, is included in Appendix K and provided the basis for the commission's conclusions and recommendations. For example, key points highlighted in the vision included:

- Creating regional hubs at the Veterans Homes campuses that provide the best in chronic disease management, nursing care, and supportive housing as well as access to a state-of-the-art continuum of quality care for veterans and their families.

- Offering veterans a variety of alternatives to institutional nursing home care to meet their needs (such as community services, adult day care, home services, local assisted living, and respite services).
- Building partnerships among the State Veterans Homes, U.S. DVA Medical Centers, the area Veterans Integrated Service Network, and other community organizations.

The last three meetings of the commission were devoted to developing the recommendations for this report. A table of the commission's meeting dates and topics is included in Appendix L.

Various reports and background materials were provided to the members to review. Appendix M provides a complete listing of the meeting materials and resources considered by the commission in its deliberations.

COMMISSION FINDINGS and RECOMMENDATIONS

Introduction

Recent regulatory problems at the Minneapolis Veterans home highlight some of the challenges faced by the facility and the Veterans Homes program overall. Failures in clinical systems have placed the Minneapolis facility's license at risk. Morale is low, operational systems are ineffective, and sustainable improvements seemingly evade the best efforts of senior managers and the Board of Directors. Communications between the Board and staff have broken down, and veterans and the public are getting mixed messages about conditions at the Minneapolis Home.²⁴

Although the Minneapolis facility is the only one of five homes experiencing serious regulatory problems, the commission believes that these recommendations will benefit all five homes including those in Silver Bay, Fergus Falls, Hastings and Luverne.

The commission heard testimony from several presenters about the excellent programs and commitment to quality at the Fergus Falls, Hastings, Luverne, and Silver Bay facilities. For example:

- Several members spoke about the leadership Silver Bay has shown in developing a model falls prevention program.
- The American Legion spoke of the excellent working relationship between the Fergus Falls facility and the U.S. DVA community-based outpatient clinics. Others noted the quality improvement program at Fergus Falls and its being one of the first to modify resident rooms for ceiling lifts.
- The Luverne administrator spoke with the chair about that facility's ten-year commitment to a person-centered care philosophy and related training for staff.
- Others spoke about the high levels of resident satisfaction and outstanding community involvement in each of the facilities.

It is largely because of the exemplary work in these facilities that the commission came to believe that Minnesota veterans could be served better if all five facilities embraced a regionally based continuum of care approach.

The commission believes the greatest opportunity lies in resolving the underlying problems related to the Minnesota Veterans Homes' governance and leadership, clinical operations, core organizational systems, and lack of strategic focus and direction. Figure 2 provides a diagram of how problems identified by the commission are interrelated and – if resolved – can greatly enhance the Veterans Home program.

²⁴ James E. Copher, Department Commander, The American Legion, Department of Minnesota, written testimony, September 3, 2007.

Figure 2
Challenges and Potential Solutions



The commission recommends an integrated approach that effects improvements in all four domains shown in Figure 2, including clinical operations, core organizational systems, and a revitalized strategic plan for the future. These changes must be driven by more effective governance and leadership that inspires and empowers people throughout the organization.

The commission also recommends action steps that should be initiated both in the near-term and long-term. Some of the benefits related to improvements (for example, in core operational and organizational systems) may be realized over the short term; however, other benefits related to strategic focus and direction are likely to take longer to achieve. For this reason it is critical that veterans and their families, veterans organizations, the Governor and the Legislature continue to support the Veterans Homes program well into the future.

It is important to note that the commission believes that resources are not the source of problems at the Minneapolis Home or the Veterans Home program, overall. Agency resources appear to be sufficient for the current VHP program. However, resources (staffing, funding, and others) must be allocated properly to implement the commission's recommendations and to meet the pressing needs of the program. More specifically, additional resources may be necessary at the agency level (central office) to strengthen key functions, especially during the next 3-5 year transition period. For this reason agency leadership must have the latitude to focus resources where they can have the greatest impact.

Recommendations to Strengthen Governance and Executive Leadership

The Governance and leadership of the Minnesota Veterans Homes will play a vital role in implementing the recommendations that follow. The Veterans Home program needs a true leader and visionary who can inspire the stakeholders and staff and who is strong enough to deal with the complex array of constituencies involved. This leader must work within an effective governance structure to rebuild the credibility of the Minneapolis facility and to enable all five facilities to serve veterans in an enhanced way.

Strengthening Governance

Despite the remarkable personal commitment of the individual Board members, and the acting executive director, the collective governance and leadership effort has failed to lead the enterprise in a unified way. In the words of the Disabled American Veterans, “This volunteer board has clearly gone beyond the call of duty.”²⁵ Yet, problems remain especially at the Minneapolis Home.

The commission observed that:

- The Board has struggled to establish a clear functional role for itself, shifting from a policy governing board, to an advisory board, to a hands-on administrative board.²⁶ One survey respondent noted that, “The current Board of Directors of the Minnesota Veterans Homes has confused the role of governance. They are overly involved in the operation of the Board office and the Minneapolis Home. The Board office is designed to operate the homes and the Board should limit its role to policy making, planning, and setting direction.”
- Respective roles and responsibilities among the Board, executive director, and the facility administrators are not clearly defined or understood. Communication breakdowns between Board members and the executive director have become the focus of media attention – rather than the Board’s vision for the future or its accomplishments.
- The Board has been unable to develop a new strategic plan to guide the program through its current transition. Some Board members explained the difficulty, noting the immediate regulatory pressures, the intense media attention, and the fact that they are a volunteer board.
- According to testimony by the American Legion, “Even though appointed by the Governor, a volunteer board, paid mileage and a meal per diem, that takes time away from their primary jobs and responsibilities to serve the state, is difficult to hold accountable.”²⁷

²⁵ William Woolie, State Commander and Dean Ascheman, State Senior Vice Commander of the Minnesota Disabled Veterans, written testimony to the Commission, September 1, 2007.

²⁶ Garber, Nathan; Governance Models: What’s Right for your Board?
<http://garberconsulting.com/governance%20models%20what's%20right.htm>

²⁷ James E. Copher, Department Commander, The American Legion, Department of Minnesota, written testimony, September 3, 2007.

- Questions regarding the qualifications of the Board members – particularly their health care and long-term care expertise – have been an ongoing concern of some veterans organizations.
- Under the current model, veterans’ services are being delivered by two distinctly different entities (Department of Veterans Affairs and Veterans Homes Board). Some veterans and family members find that navigating through two systems can be cumbersome, and a clear line of communication does not always exist.
- The DVA mission does not include providing long-term care, and the organization does not currently have expertise in health care or long-term care.
- A coalition of veterans organizations has endorsed a change in governance to the Department of Veterans Affairs (DVA). They noted that the DVA is highly regarded by veterans and veterans service organizations for their capability in responding to veterans needs.

The commission concluded that the following criteria should be used to judge the future governing structure for the Veterans Homes program. The governance model should:

- Clearly assign accountability and responsibility for the leadership of the Veterans Homes program.
- Set strategic direction for the entire organization.
- Actively seek health care expertise and stakeholder engagement.
- Promote interagency coordination.
- Provide built-in evaluation of the governance structure and performance.
- Continually develop governance and leadership expertise.

Recommended Action Steps:

- **Transfer the Veterans Home program (VHP) to the DVA.**

A change in structure is not the only answer. The VHP can succeed under a number of governing models. It is imperative, however, that responsibility and accountability for the VHP be clarified and strengthened. Responsibility is more diffuse for a volunteer board than it is for an agency commissioner. Accountability of a volunteer chair is less consequential than that of a paid member of the Governor’s cabinet. It is logical that state services to veterans be delivered through the only state agency with the mission to serve veterans. This also creates the potential for enhanced coordination across the variety of services to veterans.

The commission carefully considered the pros and cons of transferring the VHP to the DVA; and while the recommendation indicates that the pros outweighed the cons, members *did* acknowledge the cautions that will need to be taken into account when implementing this step. As stated above, transferring the governance responsibility of the veterans homes to the DVA will not guarantee results. Instead, the report outlines many other critical recommended action steps that will need to be executed in tandem with the transfer of governance. To place all attention and effort on the governance structure would be a grave mistake.

For example, members expressed concern about the lack of health care expertise currently in the DVA and, others were similarly apprehensive about the stability of a

politically appointed deputy commissioner position (see recommendation below). Therefore, the commission recommends several important steps, which are included further in the report that must be put in place as part of this approach. A couple of these steps include establishing an advisory body composed of health care and long-term care experts to advise the commissioner of DVA and creating interagency agreements with other state agencies. Clearly, it will be of utmost importance for the DVA to make effective use of the health care expertise and the many resources available to them.

- **Restructure the DVA to create a deputy commissioner of veteran health care, which is the equivalent of the existing executive director position.** The deputy commissioner of veteran health care would be responsible for supervising the Veterans Home program and would report directly to the commissioner of the DVA. This would:
 - Ensure a clear and direct line of accountability.
 - Provide the deputy commissioner of veteran health care with direct access to the highest levels of the agency; and
 - Create a health care focus within the DVA organizational structure.

- **Clarify and communicate the chain of command so that it is clear that:**
 - The commissioner of DVA hires and holds the deputy commissioner of veteran health care accountable for the success of the VHP.
 - The deputy commissioner of veteran health care hires and supervises a central staff responsible for the essential support functions (such as quality improvement, information technology, fiscal management, and human resources).
 - The deputy commissioner of veteran health care hires and supervises facility administrators, who in turn are responsible for the operations of the facilities.

- **Revise the DVA’s mission and duties in statute to explicitly include post-acute health care and long-term care.**

- **Establish in statute a new Veteran Health Care Board which would replace the existing Veterans Homes Board.**
 - The Veteran Health Care Board shall be appointed by the Governor using an open-appointment process, and be composed of nine voting members;²⁸
 - The Governor will *actively* recruit members while consulting with the commissioner of DVA, veterans organizations, health care experts in the community, and members of the current Board, to identify the best possible candidates to serve on the Board;

²⁸ Current statute provides for a chair and “eight public members experienced in policy formulation with professional experience in health care delivery; and at least five members who must be members of congressionally chartered veterans organizations or their auxiliaries that have a statewide organizational structure and state level officers in Minnesota.” (M.S. 198.002, Subd. 2).

- Members terms should be staggered such that Board turnover does not exceed one-fourth of the total membership in a given year;
 - Strengths of the Veteran Health Care Board will be clearly demonstrated by the high levels of health care expertise of its members, and the active involvement and participation from the veteran community; and
 - The Board must work closely with the commissioner and the deputy commissioner of veteran health care, especially during the next 3-5 years.
- **Establish membership of the Veteran Health Care Board. The nine member Veteran Health Care Board membership must be composed primarily of health care and long-term care experts and fairly represent the geographic areas of the state. Specifically, membership shall include:**
 - A chair, who must be designated by the Governor. A veteran is preferred, but not required;
 - Seven members with extensive expertise in health care delivery, long-term care, and veterans services (it is preferred, but not required, that one of these members be a person whose family member is being served by the Veterans Home program); and
 - One licensed clinician (a licensed physician, physician assistant, or a nurse practitioner).
- **Establish in statute the roles and purpose of the Veteran Health Care Board. The Health Care Board would advise the commissioner of the DVA in:**
 - Providing the VHP with ongoing access to the best health care advisors the Governor is able to appoint;
 - Developing and promoting a new vision for the program;
 - Developing and implementing a new strategic plan (the Health Care Board's placement at the commissioner level would give it access to information about all veterans services which might complement and support the strategic direction of the VHP. See Appendix N for an illustration of the Veteran Health Care Board's relationship with the DVA); and
 - Establishing subcommittees or ad hoc task forces composed of Health Care Board members and other stakeholders. These groups may be similar in structure to the current Board's standing committees and would work on defined tasks for a limited period of time. For example, subcommittees or ad hoc task forces could give focused attention to:
 - Clinical performance and a system-wide quality improvement plan;
 - The culture and working environment of the facilities; and
 - Other operational and organizational aspects.
- **Establish formal interagency agreements between the DVA and partner agencies, including departments of human services and health, the housing finance agency, and the board on aging.**
 - The purpose of the agreements would be to ensure that the DVA and the Health Care Board benefit from the specialized expertise of these agencies.

- The signatories to the agreements must be high-level individuals (commissioners or assistant commissioners) who will be held accountable by the Governor and their agencies for the successful implementation of the commission's recommendations.
- **Establish in statute that the governance structure of the VHP, including the Veteran Health Care Board, will be evaluated within five years to assure continued accountability and active involvement of health care experts and stakeholders in the governance structure.**

Strengthening Executive Leadership

Members of the Veteran Home Board met with the commission in August to discuss efforts to strengthen governance and the executive leadership of the program. The Board updated the commission on its recruitment process for a permanent executive director and discussed the desirable attributes of a future executive director.

At that time, the commission recommended that the Board hire an executive director who exhibited the following qualifications and qualities:

- An “outward looking” leader who would draw upon the administrative, financial, and clinical expertise of the broader long-term care community.
- A person who would establish mutually beneficial partnerships with the VA Medical Centers, Veterans Integrated Service Networks, University of Minnesota, and other community and clinical quality improvement resources.
- An innovative leader who believes in “resident-centered care” and who would champion the Veterans Homes’ commitment to quality improvement.
- Someone who is “forward-thinking” and would be able to embody the Veterans Homes’ mission and communicate a new vision to guide the organization in the future.

On October 18, 2007, the Board announced the appointment of its new executive director, Gilbert Acevedo (See Appendix O for press release). Mr. Acevedo’s appointment was met with the enthusiastic support of Minnesota’s veterans service organizations. The Board’s recruitment and hiring of an executive director is a positive step in a continuing effort to strengthen the executive leadership of the Veterans Home program.

Strengthening Leadership in the Minneapolis Facility

The key ingredient to success in the Minneapolis facility is leadership that is visible and engages frontline workers in improving care.²⁹ Leadership is akin to fuel for a vehicle; without it, the organization will simply not move forward.

A past administrator of the Minneapolis Home said “The Veterans Homes, particularly Minneapolis, have experienced barriers to moving from strategy to results. A sense of stagnation has developed. Although very well meaning and devoted to the care of the

²⁹Mike Buesing and Eliot Seide, American Federation of State, County and Municipal Employees, Letter of Testimony to the Governor’s Veterans Long-Term Care Commission, June 27, 2007.

veterans in the Minneapolis Home, there is a feeling among many staff and others that things won't change."

Through testimony, the commission also heard directly from veterans and employees who said:

- There has been a history of high turnover in the executive director and other leadership positions at the Minneapolis Home. Some have suggested that the current salary range has been a significant impediment to competitive recruitment and retention of capable executive leadership.
- According to the American Federation of State, County and Municipal Employees, "A revolving door of top managers has constantly changed visions for the [Minneapolis] facility."³⁰
- "The lack of effective communication is one of the main reasons why the [Minneapolis] Home has been plagued with problems that seem to be solved, only to reappear at a later date. In order to be successful, a spirit of collaboration must prevail. Under this model of leadership all parties that are involved are present at the earliest stages of the planning or decision making process."³¹

There is hope, and employees want to be part of the solution. One family member testified about the care a nurse provided to her father in the Minneapolis facility by saying, "It is clear to me that for her, the residents are like her extended family whom she continues to care for – no matter what it takes."³²

Recommended Action Steps:

An extraordinary multi-year effort will be required to implement these recommendations and realize the full promise Minnesota has made to its veterans. Clearly, the new executive director cannot do it alone. The Governor, the Legislature, the DVA, the proposed Veteran Health Care Board, and all of the employees of the VHP will play vital roles in leading the way.

- **Establish appropriate executive leadership compensation.** In order to attract and retain highly skilled and talented executive leadership in the future, the compensation for these positions must be commensurate with similar positions in the market. The commission recommends that compensation for the deputy commissioner and the administrator of the Minneapolis facility be given special consideration when determining compensation level.
- **Establish a strong leadership team in Minneapolis.** The senior leadership positions with the Minneapolis Home should be filled immediately with competent leaders who are committed to working with the other agency leaders *over the long haul*. The leadership team in Minneapolis must have a clear charge,

³⁰ Ibid.

³¹ Shawn Berry, Health Service Technician, Minneapolis Veterans Home, written testimony, June 28, 2007.

³² Diane Windham, "Testimony on Behalf of Ted Barott: Observations Regarding Care Provided at the Minneapolis Veterans Home," June 28, 2007.

be visible and engaged with employees and veterans, and they must get people excited about the mission.

- **Establish practical ways for the administrators, home staff, and the deputy commissioner to communicate frequently and develop as a team of leaders.** They must work together to achieve improvements in both internal and external benchmarks for employee, resident, and family satisfaction across all five facilities.
- **The administrators of the five facilities can also help lead by:**
 - Actively engaging family and resident councils, employees and leadership in promoting and building a resident-centered approach at the facilities.
 - Creating a positive, healthy work environment at the facilities.
 - Informing the Veteran Health Care Board and deputy commissioner about the needs of their facilities.
- **All employees of the Veterans Home program can help lead the way by:**
 - Drawing on their own personal commitment to veterans.
 - Taking responsibility for learning about the new direction of the VHP and looking for ways to personally contribute to the cause.
 - Sharing and celebrating successes.
- **The commissioner of the DVA, the deputy commissioner of veteran health care, and the proposed Veteran Health Care Board must help lead this effort by mobilizing a diverse range of expertise (health care, veterans benefits, long-term care, housing, organizational performance, and other areas) to help the VHP achieve its potential.**
- **The Governor and the Legislature, together, must act urgently to implement these recommendations.** For example, the Governor must immediately restructure the Veterans Home program within state government, clarify and strengthen the chain of command, and hold people accountable. The Legislature must maintain the high commitment it has already shown through increased appropriations to veterans programs and implement the recommendations which require legislative action.

Recommendations to Achieve and Sustain “State-of-the-Art” Clinical Operations

The Board’s current efforts are largely aimed at fixing the care problems identified at the Minneapolis Veterans Home. Currently, there are no outstanding correction orders at the Minneapolis facility. However, without established systems of care, continued compliance is not attainable.

Reliable clinical operations are essential to ongoing compliance, and they are the required credentials for mutually beneficial partnerships with the U.S. DVA Medical Centers and other acute care and post-acute care providers.

The commission heard presentations from a number of quality improvement (QI) experts and identified the common ingredients that appear to be present in facilities that have strong clinical operations. For example, they have a systemwide quality improvement model in place; performance measures include quality improvement metrics; they utilize modern technology systems to monitor QI efforts; leadership supports the efforts; quality improvement plans and systematic processes are integrated across all functions; and staff receive ongoing training to sustain the efforts.

The following examples highlight the need for the Minnesota Veterans Homes program to continue emphasis on building reliable clinical operations:

- Staff from the Minneapolis facility said, “In general, the quality of care is good; however, systems and adherence to standards of care have become lax because of [lack of] education and poor performance, divisive culture, and ineffective leadership...”.
- Each home is equipped with the software and programs to process admissions, complete assessments, create care plans, and document physician orders and progress notes; however, the software is not consistently used, and not all staff have been fully trained in its use.
- The five facilities have distinct employment arrangements with medical providers, which results in providing varying hours of physician coverage. For example, the Minneapolis Home contracts with seven salaried physicians from the Minneapolis VA Medical Center. In contrast, Silver Bay contracts with a physician from the Bay Area Clinic for 10 hours/week and Fergus Falls receives MD and physician coverage from Lake Region Clinic for 30 hours/month.
- The five facilities utilize a mixed system for prescription and pharmacy tracking. Minneapolis, which also does processing for Hastings, uses a program called “QS/I.” Luverne and Silver Bay use a program called “PharmaServe.” And Fergus Falls uses Medispan, which is a portion of Momentum Health Care software.

The Minneapolis facility is taking steps toward adapting a quality process within their campus. And with the assistance of their current consultant, ambitious efforts are underway to computerize and standardize clinical systems throughout the Minneapolis

facility. The commission's recommendations reinforce these efforts, and emphasize the critical need for improved and sustainable systems of care throughout the five facilities.

Recommended Action Steps:

- **Create a customized transition plan for the Minneapolis facility.** This transition should include continued monitoring of the Minneapolis facility as required by the Minnesota Department of Health in the current stipulation settlement and other support.
- **Strengthen delivery of primary health care for veterans.** The U.S. Department of Veterans Administration program in the region, working in partnership with the state of Minnesota, is responsible for the delivery of primary health care, chronic disease management, and primary mental health services to veterans served by the Veterans Home program. The Veterans Administration has substantial expertise in these areas, including Alzheimer's care, brain injury programs, and others. To date, residents of the Minneapolis Veterans Home have not received the full benefit of this capability. The commission recommends that the state work with the leadership at the VISNs to ensure that delivery of primary care to residents of state veterans homes be seen as an integral part of the VISN programs.
- **Hire a medical director at the agency level and clinical directors at the facility level within the organization.**
 - Each facility should designate a clinical director.
 - The agency level medical director should be hired by the deputy commissioner to provide strong clinical leadership, direction, and oversight to the clinical directors at each of the five facilities.
 - The agency medical director must be a licensed physician. The facilities' clinical director may be a licensed physician, certified-nurse practitioner (CNP) or a certified physician assistant (PA-C).
 - The clinical director at the Minneapolis facility should be a full-time licensed physician, since the issues are particularly complex and require clear authority and responsibility.
- **Develop a clinical leadership team at each Home, composed of the clinical director, primary care physicians, nurse practitioners, director of nursing and social work, pharmacist, and other key stakeholders as appropriate.**
 - Task the team to work within a sustainable clinical improvement framework to successfully execute the quality improvement plan at their facility.
 - Clarify the roles and responsibilities of each member of the clinical leadership team in writing.
 - Monitor the teams' ability to develop and implement and evaluate effective systems of care within their facility and share their successes across all five facilities.
 - Hold the agency medical director accountable for developing and maintaining a collaborative partnership between the Minneapolis Veterans Home and the Minneapolis U.S. DVA Medical Center so that as the Medical Center adopts

progressive improvements in the range and delivery of long-term care services, the Minneapolis Veterans Home is included and adopts the same improvements.

- Require the clinical teams to have a clear and highly functioning relationship with the VA Medical Centers and other long-term care resources in the broader community (for example, Stratis Health; the University of Minnesota; and the Veterans Affairs Geriatric Research Education and Clinical Center.).

- **Select and embrace a quality improvement approach and implement it consistently across all five facilities through a quality improvement plan. (A number of different approaches are currently being used by the industry, such as Baldrige, Six Sigma, LEAN, Balanced Scorecard, and TQI/TQM).**
 - Create the infrastructure to support continuous quality improvement internally so that the improvement plan is developed and owned by internal stakeholders (for example, Board, executive director, administrators, clinical teams, and frontline staff).
 - Establish performance measures for the facilities' quality improvement plan.
 - Implement a modern information system that will allow the facilities to set measurable targets and track performance over time.
 - Integrate quality improvement systems into the daily operations and core processes at each facility

- **Update the Veterans Homes' electronic capabilities, both hardware and software, and integrate the systems with the VA Medical Center systems to allow for better access to medical records for both parties when treating the resident (of Veterans Homes) and patient (of VA Medical Center).**

- **Provide ongoing training and develop staff and clinical teams based on the improvement plan's goals and targets.**

Recommendations to Improve Core Organizational Systems and Performance

The commission called upon long-term care experts to help them identify the common characteristics of the most successful post-acute care organizations. Not surprisingly, strong leadership and a positive culture consistently topped the list. The commission went beyond these more obvious factors and found that the best performing multi-facility organizations:

- Centrally manage key administrative functions and achieve economies of scale in areas such as fiscal management, human resources, and information technology.
- Have a core of central staff responsible for system-wide performance goals (such as clinical quality improvement).
- Send these subject matter experts to work side-by-side with the facility administrators and staff to help achieve performance targets.
- Actively seek and disseminate best practices across all facilities.

When the commission reviewed how the VHP manages key administrative functions, it found that the Veterans Home program is out of synch with the best performers. The commission estimates that 3 – 5 percent of total revenue is typically needed to manage an organization’s resources across multiple facilities. Expenditures for the Veterans Homes Board (Board office) in FY2007 were \$1,469,000. This is slightly over 2 percent of total expenditures.³³

Recommended Action Steps:

- **Restructure staff and budget, and consider the need for increased appropriations, so that central office staff have the capacity to provide value-added support at the facility level that results in measurable improvements in targeted areas.**
- **Develop a “balanced scorecard” for each of the five facilities to provide useful information on key areas of performance.**
- **Use the performance measurement system to set and monitor performance targets, catch early warning signs of trouble, and problem solve where performance deficits are identified.**

³³Minnesota Department of Finance, Expenditures in FY 07 for Minnesota Veterans Homes Board, October, 2007.

Recommendations to Achieve Focus and Strategic Direction

The Veterans Homes have a powerful mission and enjoy the active support of veterans' organizations and their communities. A key challenge, now, is to harness the support of veterans and employees to create excitement and a sense of hopeful possibility for an enhanced mission across all five facilities.

The Veterans Home program has not fully experienced the transition experienced by the long-term care system at large.³⁴ The commission heard from many people and noted that:

- The Veterans Homes program – and especially the Minneapolis Home – has been described as “stuck in a 1950’s model of nursing home care,” while the rest of the long-term care industry has been through a major transition.
- According to one family member, “Families who choose veterans’ benefits instead of Medical Assistance for their loved ones’ nursing home needs are held hostage to the MVH [Minnesota Veterans Home] system.”³⁵
- The Minneapolis facility and the Veterans Home program overall lacks a shared strategy and compelling vision of what all five campuses might look like in the future.

Veterans want what is best for veterans and eagerly support new and creative approaches. In written testimony to the commission, the American Legion said, “All involved need to think outside the box and imagine veterans homes co-located with Federal VA Community Based Outpatient Clinics, such as at the Fergus Falls Veterans Home.”³⁶ The Veterans of Foreign Wars applauded “efforts to think outside the box and envision a future which is integrated with all of the veteran and non-veteran world of health care delivery.”³⁷

Developing a revitalized strategic plan or a “roadmap to the future” is a critical step toward repositioning the Minnesota Veterans Home to achieve its mission. The “roadmap” needs to redefine the way it meets the needs of Minnesota veterans and their families. It should also reflect the policy shift that has occurred in long-term care for non-veterans and speak to the full spectrum of long-term care needs of veterans from World War II to those now returning from Iraq.

³⁴ A Blueprint for 2010: Preparing Minnesota for the Age Wave; Report on Transform 2010; Minnesota Departments of Human Services and Health, Minnesota Board on Aging, June 2007.

³⁵ James Stromberg (father resides at Minneapolis Veterans Home) – testimony provided to commission.

³⁶ James E. Copher, Department Commander, The American Legion, Department of Minnesota, written testimony, September 3, 2007.

³⁷ Bjorkman, Robert; Department of Minnesota, Veterans of Foreign Wars; letter to Commission; September 14, 2007

Recommended Action Steps:

- **Ask veterans and their families what they need. Through surveys and other research, distinguish the needs among the various generations of veterans.**
- **Involve health and long-term care experts, the Legislature, and other state agencies in defining the future vision and in taking steps to replicate the long-term care policy shift that has occurred in the broader long-term care system.**
- **Develop a vision for all five facilities as a preferred place for veterans to go for:**
 - **Professional Care Planning and Coordination.** Anyone who has helped a loved one access long-term care knows that it can be a trying process. The campuses would be a preferred place for veterans and families to go for professional assistance in the development of a plan of care that could in many cases allow veterans to access community based services allowing them to live independently in their own homes. Facilitating access to a variety of care and support options is especially important as over 550 individuals are on the waiting list at the veterans homes.
 - **Alternatives to Institutional Care.** The campuses would become regional points of entry to a state-of-the-art continuum of quality care. Services could include geriatric evaluation and other assessments, community services, adult day care, home services, local assisted living, respite services, and others—including skilled nursing care at the veterans homes.
 - **New Housing with Services Options.** The five campuses would provide new housing options with supportive services. The transformed campuses should embody principles of privacy, small scale normal living environments, quality of life emphasis, state-of-the-art architectural design and use of technology. Redesign should rebalance resources to achieve a much greater emphasis on supportive housing and assistive living rather than nursing homes. These new housing and support options would be designed to serve a new generation of younger veterans as well.
 - **Excellence in Chronic Disease Management, Nursing and Rehabilitative Care.** The campuses would be highly integrated with the VA Medical Centers (Minneapolis, St. Cloud, Fargo and Sioux Falls) and provide veterans seamless access to the Veteran Integrated Service Network, community-based outpatient clinics, and rehabilitative services. The campuses should also work closely with the University of Minnesota's academic and research programs. This is especially important as returning veterans present new acute, post-acute and rehabilitative care challenges.

- **Develop a strategic plan that is grounded in the current mission and provides for measured progress toward the new vision. Strategies must be “outward looking” and address the broad goals to:**
 - Build partnerships – consistent with the provisions of the Millennium Health Care Act – to create regional hubs that provide resources and offer a full spectrum of quality care for veterans and their families.³⁸
 - Emphasize mutually beneficial partnerships among the State Veterans Homes, Veterans Administration Medical Centers, Veterans Integrated Service Networks, and other veterans information referral and supportive resources.
 - Seek federal waivers to demonstrate new patterns of housing with services and other alternative forms of long-term care, consistent with the policy shift that has taken place in the civilian long-term care system.
 - Provide helpful advice on how families could coordinate VA benefits with other insurance and public programs so that veterans receive the benefits to which they are entitled.
 - Explore the feasibility of securing some level of Medicare funding for services currently being provided to Minnesota veterans. Assist veterans in accessing all Medicare-funded services to which they may be entitled.

- **Develop and implement a set of action plans based on the strategic goals and vision.** The action plans should clarify accountability and ownership by key personnel who are responsible (and held accountable) for implementing each element of the action plan.

- **Review and update the current admissions policies for the Veterans Homes to accurately reflect the strategic vision of the organization.** For example, the DVA should further explore the option of giving service-disabled veterans priority in the Veterans Homes admissions process.

- **Implement systems to provide the Board with timely feedback about what is working or not working at individual facilities and across the entire agency.**

The Veterans Homes program has a unique window of opportunity to build on its mission – and on renewed public support for veterans – to create a new vision for the Veterans Homes.

³⁸ <http://www.govtrack.us/congress/bill.xpd?bill=h106-2116&tab=summary>

APPENDIX A

GOVERNOR PAWLENTY'S EXECUTIVE ORDER

GOVERNOR PAWLENTY SIGNS EXECUTIVE ORDER CREATING VETERANS LONG TERM CARE COMMISSION -- February 28, 2007

EXECUTIVE ORDER 07-02

The following is the text of Executive Order 07-02, which establishes the Governor's Veterans Long Term Care Advisory Commission:

I, TIM PAWLENTY, GOVERNOR OF THE STATE OF MINNESOTA, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this executive order:

WHEREAS, Minnesota veterans have served our country through extraordinary sacrifice to protect our liberty and freedoms and it is incumbent upon the state to ensure that their long term medical needs are met in settings that provide high quality care and services; and

WHEREAS, Minnesota established the veterans homes to provide for the long term care needs of veterans and there are currently five homes that provide services for over 850 veterans and their qualifying spouses around the state; and

WHEREAS, under current law, the veterans homes are administered and governed in accordance with Minnesota Statutes, Chapter 198; and

WHEREAS, the needs of Minnesota veterans and methods for providing appropriate long term care are changing and the state must ensure that the governance and administration of the Veterans Homes are structured in a manner that best ensures the provision of quality care to qualified veterans; and

WHEREAS, it is important to explore the most effective means and governance models for meeting the long term care needs of Minnesota's veterans and to obtain insight and recommendations from a variety of professionals experienced in providing quality long term care and individuals familiar with the current and anticipated future needs of veterans.

NOW, THEREFORE, I hereby order the creation of the Governor's Veterans Long Term Care Advisory Commission ("Commission").

1. The Commission will be comprised of 7 public members appointed by the Governor as follows:
 - a. Four members should have significant knowledge and/or experience in the operation, administration or governance of long term care facilities.
 - b. Three members should have significant knowledge and experience in the long term care needs specific to veterans and be familiar with current standards and requirements applicable to facilities serving veterans.

- c. The Governor will designate a public member to serve as the chair.
 - d. Members will serve at the pleasure of the Governor and the Governor will fill any vacancies.
 - e. Commission members will serve voluntarily for a one-year term and are not eligible for per-diem or payment of expenses.
2. The following public members will serve as ex officio members of the Commission:
 - a. A member of the Veterans Homes Board selected by the Governor;
 - b. The Commissioner of Veterans Affairs, the Adjutant General and the Commissioner of Health, or their designees.
 - c. The Speaker of the House of Representatives and the Minority Leader of the House of Representatives may each appoint a member to serve as an ex officio member of the Commission.
 - d. The Senate Majority Leader and the Senate Minority Leader may each appoint a member to serve as an ex officio member of the Commission.
 - e. The Senate or House of Representatives may, pursuant to their own rules and practices, allow for per diem or other payment of expenses to legislative ex officio members from legislative funds.
 3. The Commission will provide recommendations to the Governor on long term care operations, administration, management and governance models which incorporate the best examples of innovative approaches to maximizing quality of care and quality of life for veterans, including:
 - a). Reviewing the current problems faced at some of the Veterans Homes, in particular the Minneapolis Veterans Home, regarding patient care;
 - b). Reviewing the current standards and legal requirements for providing long term care to veterans;
 - c) Surveying the methods used within Minnesota and in other states to successfully deliver high quality long term care services;
 - d) Surveying the service delivery and governance models currently used across the country to deliver long term care services to veterans and analyze which methods are the most successful in meeting the needs of veterans;
 - e.) Identifying practices, methods or other areas that Minnesota could adopt to improve the quality of care delivered to veterans; and
 4. The Commission will begin meeting as soon as possible following the completion of the open appointments process.

Pursuant to Minnesota Statutes 2006, section 4.035, subdivision 2, this Executive Order will be effective fifteen (15) days after publication in the State Register and filing with the Secretary of State and will remain in effect until June 30, 2008.

APPENDIX B COMMISSION MEMBERS' BIOGRAPHIES

Jim Birchem, of Little Falls, is a member of the American Legion and President and CEO of Eldercare of Minnesota which owns four nursing homes and eight assisted living facilities.

Nancy Feldman, of Minneapolis, is President and CEO of UCare Minnesota, the state's fourth largest health plan serving 130,000 senior, disabled and low income individuals.

Leslie Grant, of Minneapolis, is Associate Professor of Healthcare Management in the Division of Health Management and Policy and the Director of the Center for Aging Services Management at the University of Minnesota.

Rosalie Kane, of Minneapolis, is a University of Minnesota professor of public health and member of the Center for Biomedical Ethics, School of Social Work and the Center on Aging.

Tom Mullon, of Eagan, is a member of the American Legion and was formerly the Director of the Federal Veterans Administration Medical Center and Administrator of the Minneapolis Veterans Home.

Kathryn Roberts, of Stillwater, is President and CEO of Ecumen which employs over 4,000 staff and operates independent and assisted living housing, care centers, home health care and a wide variety of community-based services in 90 communities in the mid-west. Prior to joining Ecumen, Roberts held a number of leadership positions in state government as well as in not-for-profit organizations.

Dale Thompson (chair of the commission), of Blaine, is President and CEO of the Benedictine Health System based in Duluth, which owns and/or manages 10 acute-care hospitals and more than 50 long-term care facilities including nursing homes, assisted living and independent senior housing options in eight states.

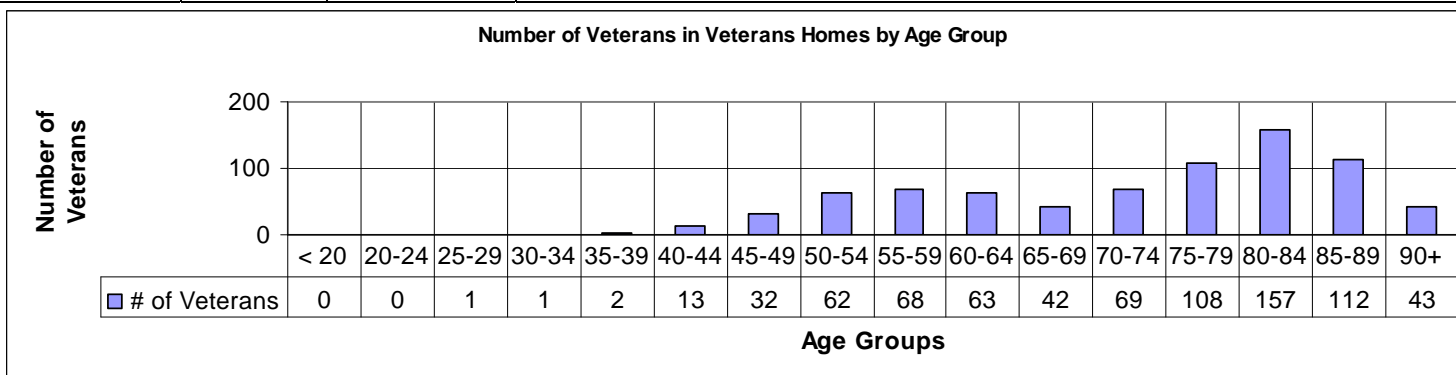
EX-OFFICIO COMMISSION MEMBERS:

- Clark Dyrud, Commissioner of Veterans Affairs;
- General Larry Shellito, Adjutant General of the Minnesota National Guard;
- Dianne Mandernach, Commissioner of Health, or their designees;
- Dan Williams, of Vadnais Heights, representing the Veterans Homes Board;
- Representative Erin Murphy, member of the House of Representatives appointed by the Speaker;
- Representative Dan Severson, member of the House of Representatives appointed by the House Minority Leader;

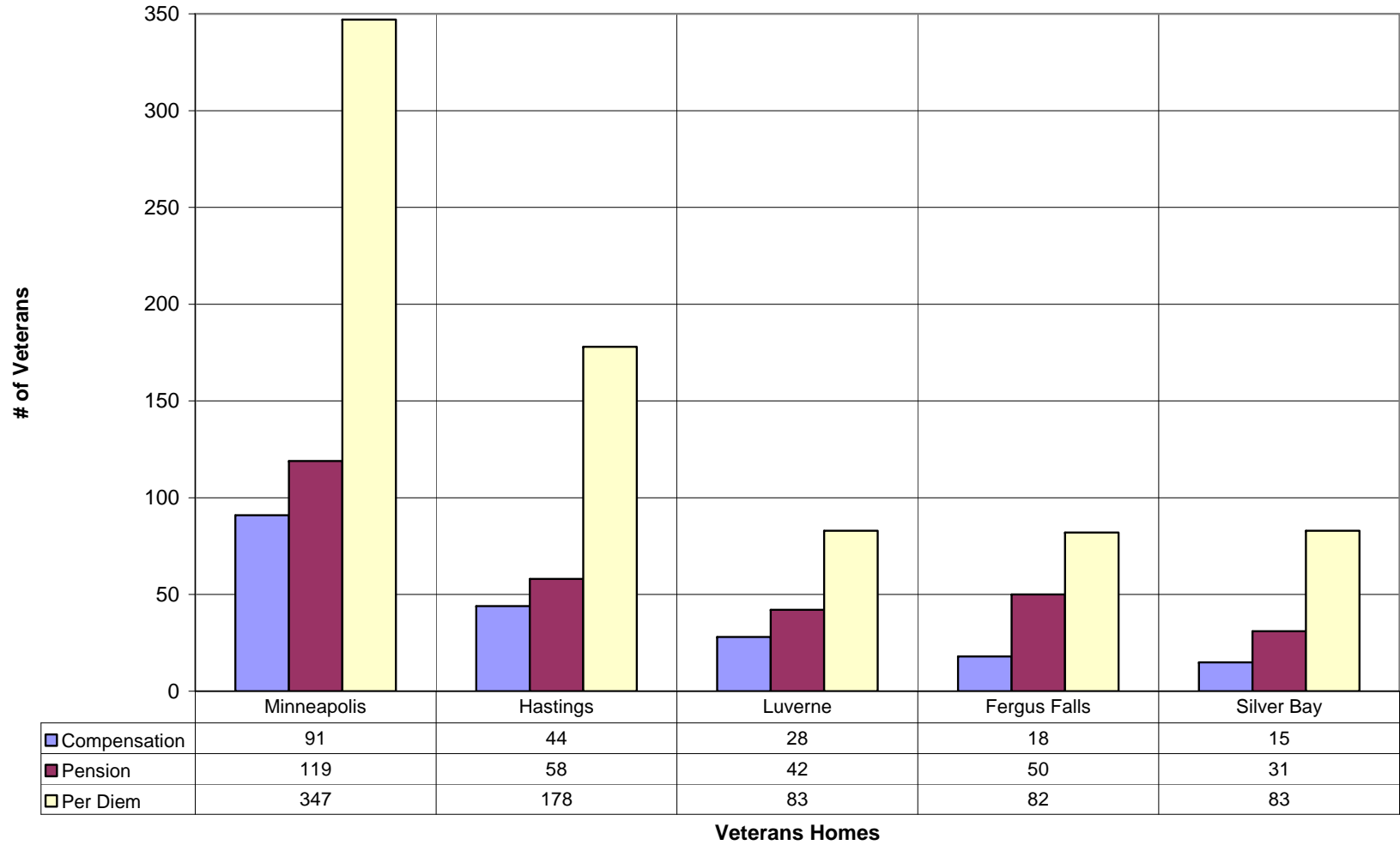
- Senator Sharon Erickson Ropes, member of the Senate appointed by the Senate Majority Leader; and,
- Senator Dick Day, member of the Senate appointed by the Senate Minority Leader.

APPENDIX C: VETERANS HOMES POPULATION AND BENEFITS Source: Minnesota DVA

Veterans	Age Groups																Total
Veterans Homes	< 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+	Total
Minneapolis						6	8	17	24	27	20	31	60	84	54	16	347
Hastings			1	1	2	7	24	42	41	25	9	13	6	5	0	2	178
Luverne								1	1	4	4	8	11	28	18	8	83
Silver Bay								2	1	1	5	8	19	23	19	4	82
Fergus Falls									1	6	4	9	12	17	21	13	83
Total in MN Veteran's Homes			1	1	2	13	32	62	68	63	42	69	108	157	112	43	773
Total MN Veterans	249	4,234	10,095	13,227	20,233	26,790	30,246	33,153	59,756	54,851	38,386	38,123	35,975	26,977	13,942	3,927	410,164
% in Veterans Homes	0	0	<.01	<.01	<.01	0.05	0.11	0.19	0.11	0.11	0.11	0.18	0.3	0.58	0.8	1.1	0.18
Veteran Benefits	Must be Service Connected	Needs Based	Definitions														
Compensation	Yes	No	Compensation is a Veterans Administration entitlement paid to veterans for accidents, illnesses, and other physical or mental conditions that occur in service or as a result of service.														
Pension	No	Yes	Pension is a monthly Veterans Administration payment to low-income veterans who are totally and permanently disabled for reasons other than the veterans' own willful misconduct.														
Per Diem	No	No	Per Diem is a per patient (day) payment from the Veterans Administration for primary medical care of a veteran in a state nursing home														



Benefits Received By Veterans In Veteran's Homes



Veterans Benefits³⁹

Per diem is a per patient (day) payment from the U.S. Veterans Administration (VA) for primary medical care of a veteran in a state nursing home.

Eligibility Criteria: Veteran (or spouse) receiving care in a state nursing home program. Nursing homes can contract with the VA to receive federal per diem reimbursements under the VA nursing home and community nursing home program.

Amount: The current per diem amount provided for veterans residing in a Minnesota veterans home is \$67.71/resident/day for skilled nursing home care and \$31.30/resident/day for domiciliary care.⁴⁰

Benefits provided (services covered) by federal per diem: Primary medical care.

Pension is a monthly VA payment to low-income veterans who are totally and permanently disabled for reasons other than the veterans' own willful misconduct. Pensions are needs based and is not a service connected benefit.

Eligibility Criteria:

- Veteran discharged from service under conditions other than dishonorable;
- Served at least 90 days of active military service-- 1 day of which was during a war time period;
- Countable family income is below a yearly limit set by Congress; and,
- Age 65 or older, or, permanently and totally disabled, not due to own willful misconduct.

Amount: Monthly amount is income based according to means formula. Veteran alone-\$10,929; Housebound- \$13,356; Aid & Attendance -\$18,234.

What can pension be used for? Veteran residing in a veterans nursing home is able to keep the first \$90.00 of their pension benefit; the rest is applied to medical care. If an individual is not receiving nursing care, the pension amount will be lower. Veteran can receive pension while living in nursing home or residing at home (personal income).

Compensation is a VA entitlement paid to veterans for accidents, illnesses, and other physical or mental conditions that occur in service or as a result of service. Compensation is not needs based and is a service-connected benefit.

³⁹ Unless otherwise noted, information in this section was obtained from Department of Veterans Affairs website, <http://www.vba.va.gov/bln/21/index.htm> and reviewed by Minnesota Veterans Homes Board Office.

⁴⁰ Minnesota Veterans Homes, PowerPoint presentation given to Commission by Veterans Homes Board Vice-Chairman, Dan Williams, May 31, 2007.

Eligibility Criteria: Veteran involved in accident or illness, or other physical or mental conditions occurred to them as a result of service.

Amount: Monthly amount ranges from 10 percent (\$115)—100 percent (\$2, 471) depending on severity of injury and limitations for gainful employment. Exceptions apply for veterans who can prove they need daily cares because of injury due to military. In this case, amount could exceed 100 percent.

What can Compensation be used for? Compensation is considered personal income and has no limitations for how it can be spent.

Aid and Attendance (A&A) is a benefit paid in **addition** to monthly pension and may not be paid unless the veteran is eligible for pension benefit (criteria listed above).

Eligibility Criteria:

1. The veteran requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting himself/herself from the hazards of his/her daily environment, or,
2. The veteran is bedridden, in that his/her disability or disabilities requires that he/she remain in bed apart from any prescribed course of convalescence or treatment, or,
3. The veteran is a patient in a nursing home due to mental or physical incapacity, or,
4. The veteran is blind, or so nearly blind as to have corrected visual acuity of 5/200 or less in both eyes or concentric contraction of the visual field to 5 degrees or less.

Amount: Income based. Maximum amount is \$18,234 per year for single veteran.

What can Aid & Attendance be used for? Must be admitted to a nursing home and prove to VA that assistance with daily living is needed. In rare cases, veterans living at home have received Aid & Assistance because they received daily nursing care. Aid & Attendance cannot be received if only assisted living is needed for resident care.⁴¹

Housebound is a benefit paid in addition to monthly pension. Like Aid & Assistance, Housebound benefits may not be paid without eligibility to pension. Housebound benefit is awarded when a resident has need for some assistance and is confined to home.

⁴¹ Minnesota Veterans Homes Board Office, July 30, 2007.

Eligibility Criteria:

1. The veteran has a single permanent disability evaluated as 100 percent disabling and, due to such disability, he/she is permanently and substantially confined to his/her immediate premises, or,
2. The veteran has a single permanent disability evaluated as 100 percent disabling and, another disability, or disabilities, evaluated as 60 percent or more disabling.

A veteran cannot receive both Aid and Attendance and Housebound benefits at the same time. A veteran can receive only one benefit from the VA deemed as the "greater benefit." For example, a veteran cannot receive both Aid & Attendance and a service connected benefit. The greater benefit would be awarded—but, in all cases the veteran retains the service connected status but is awarded Aid & Attendance because it is a larger benefit amount.

APPENDIX D

VETERANS HOMES BOARD MEMBERSHIP STATUTES

Old Statute re: Membership of Veterans Home Board:

Nine Voting Members appointed by the Governor:

- Chair;
- Three public members experienced in policy formulation with professional experience in health care delivery; and
- Five members experienced in policy formulation with professional experience in health care delivery who are members of congressionally chartered veterans' organizations or their auxiliaries that have a statewide organizational structure and state level officers in Minnesota.

Ex-officio members:

- Commissioner of Veterans Affairs,
- Chair of committee dealing with veterans affairs from each house of the Legislature – if that person is a veteran.

Current Statute⁴² effective July 1, 2007 re: Membership of Veterans Home Board:

Nine voting members appointed by the Governor:

- Chair (must be a veteran);
- Eight public members experienced in policy formulation with professional experience in health care delivery; and
- At least five members who must be members of congressionally chartered veterans organizations or their auxiliaries that have a statewide organizational structure and state level officers in Minnesota.

Ex-officio Members:

- Commissioner of Veterans Affairs,
- The chair of the committee that deals with veterans affairs or the chair's designee (from each house of the Legislature).

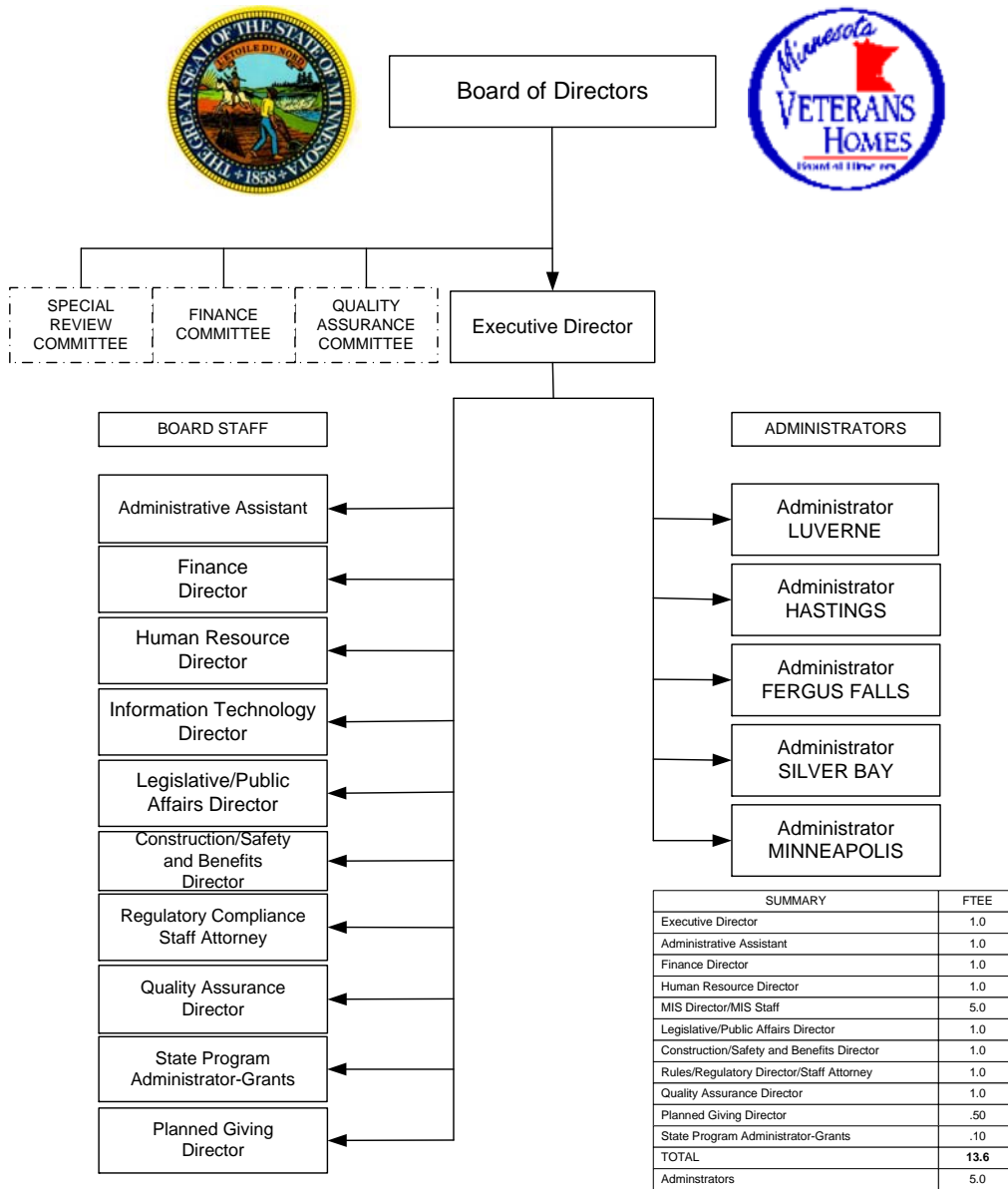
⁴² Source: Laws of Minnesota 2007, Chap. 45, Article 2, Sections 4 and 5, (the Omnibus Agriculture and Veterans Affairs Bill of 2007 - HF2227), <http://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=H2227.4.html&session=ls85>

Table 4.0 Veterans Homes Board Membership (excluding Ex-officio members)

Appointed Board Members	Policy formulation with professional experience in health care delivery (based on bio-sketch provided on Veterans Homes Board website)	Member of congressionally chartered veterans organization or their auxiliaries	Veteran	Term Expires
Jeffrey Johnson, Chair	X	X	X	1/05/09
Dean Ascheman		X	X	1/05/09
Robert Erickson			X	1/07/08
<i>Lawrence Greenberg (replaced by Gail)</i>			X	
Bryon Opstad	X	X	X	Appointed in 2002
William Tendle	X		X	1/02/10
Violet Wagner	X	X	X	1/05/09
Dan Williams, Vice-Chair			X	1/01/07
William Wroolie		X	X	1/04/10
Gail I.Sheridan (new appointment, July 2007)	X		X	2011
Totals	5	5	9	
NEW Statute Requirement	8	At least 5	Chair must be a veteran	
OLD Statute Requirement	8	5	None	

APPENDIX E VETERANS HOMES ORGANIZATIONAL CHART

MINNESOTA VETERANS HOMES Organizational Chart



APPENDIX F VETERANS HOMES FACILITIES

Fergus Falls

The Veterans Home in Fergus Falls offers a state of the art facility for veterans and their spouses, providing skilled nursing care for 85 residents. Fergus Falls is also recognized for its award-winning nursing care approaches. The mission of the Fergus Falls Veterans Home is to CARE: **C**reatively deliver focused care, **A**cknowledge military heritage, **R**econnect residents with the community, and **E**nhance life's experiences.

Hastings

The Hastings Veterans Home is located 21 miles from St. Paul on 128 wooded acres next to the Vermillion River. The home provides 200 domiciliary beds to veterans meeting the requirements. Among the services offered to residents is a vocational work program at the Fort Snelling National Cemetery so residents have seasonal job opportunities. In addition, they currently have a bonding request to begin construction of a 30-bed supportive housing building that would offer self-sufficient single and double room apartments for residents.

Luverne

The Minnesota Veterans Home in Luverne is located on the north edge of Luverne along U.S. Highway 75 overlooking Blue Mounds State Park. The home is 35 miles from Sioux Falls, South Dakota, and the Sioux Falls Veterans Affairs Medical Center. Luverne provides 85 skilled nursing care beds, including the new addition of an Alzheimer's/dementia dayroom.

Silver Bay

The Silver Bay Veterans Home is located on the scenic North Shore of Minnesota, overlooking Lake Superior. The home provides skilled nursing care for 85 residents, which includes 25 beds designed for residents with dementia.

APPENDIX G

ELIGIBILITY CRITERIA for ADMISSIONS into VETERANS HOMES

Minnesota Office of the Revisor of Statutes, Chapter 198

198.022 ELIGIBILITY OF SPOUSES AND SURVIVING SPOUSES.

The board is authorized to admit eligible spouses of those veterans who are or if living would be, eligible for admission to the homes.

(1) Except as provided in section [198.03](#), all applicants for admission to one of the Minnesota veterans homes must be without adequate means of support and unable by reason of wounds, disease, old age, or infirmity to properly maintain themselves.

(2) Veterans must have served in a Minnesota regiment or have been credited to the state of Minnesota, or have been a resident of the state in accordance with board rules preceding the date of application for admission.

(3) Spouses and surviving spouses of eligible veterans must be at least 55 years of age, have been residents of the state of Minnesota in accordance with board rules preceding the date of application for admission, and meet the criteria for admission to a home established in the rules of the home in accordance with this chapter and the applicable statutes and rules of the Department of Health.

198.03 MAINTENANCE CHARGES.

*Subdivision 1. **Discretionary admission.** Any person otherwise eligible for admission to the Minnesota veterans homes, except that the person has means of support, may, at the discretion of the board, be admitted to one of the Minnesota veterans homes upon entering into and complying with the terms of a contract made by the person with the board, providing for reasonable compensation to be paid by such person to the state of Minnesota for care, support, and maintenance in the home. Any earnings derived by the person from participating in a work therapy program while the person is a resident of the home may not be considered a means of support. Rebates of federal taxes and state taxes may not be considered a means of support.*

9050.0050 PERSONS ELIGIBLE FOR ADMISSION. Minnesota Rules, Table of Chapters, Chapter 9050.0050 Persons Eligible for Admission

*Subpart 1. **General qualifications.** A person seeking admission to a board-operated facility must meet the admission requirements in Minnesota Statutes, sections [198.01](#), [198.022](#), and [198.03](#), and the criteria in part [9050.0070](#). The person must also provide current evidence of medical need for admission and financial information as specified in parts [9050.0800](#) to [9050.0900](#).*

For purposes of subparts 2 to 4, an applicant or resident has adequate means of financial support if the applicant or resident is financially able to live independently. A person is financially able to live independently if the person has assets in excess of \$3,000 or income sufficient to meet basic needs.

*Subp. 2. **Veterans.** A person must meet the criteria in Minnesota Statutes, sections [197.447](#) and [198.022](#), paragraphs (1) and (2), to be eligible for admission to a board-operated facility as a veteran.*

*Subp. 3. **Nonveterans.** A person who is not a veteran must meet the criteria in Minnesota Statutes, section [198.022](#), paragraphs (1) and (3), to be eligible for admission to a board-operated facility.*

*Subp. 3a. **Residency.** For purposes of determining residency under Minnesota Statutes, section [198.022](#), paragraphs (2) and (3), a person is a resident of Minnesota if:*

- A. the person currently resides in Minnesota and intends to reside in the state permanently; and*
- B. the person does not own or maintain a home in another state.*

*Subp. 4. **Exceptions.** An applicant otherwise eligible for admission to a board-operated facility under subpart 2 or 3 who has adequate means of support may be admitted to a board-operated facility if the applicant complies with the requirements in Minnesota Statutes, section [198.03](#). An applicant seeking admission under Minnesota Statutes, section [198.03](#), and this subpart must not have past unpaid bills to the state for maintenance charges for prior residence in a board-operated facility. An applicant who has past unpaid bills to the state for maintenance charges for prior residence in a board-operated facility must satisfy the past debt for maintenance charges before that applicant will be placed on the active waiting list. For the purpose of this part "satisfy" means that the applicant has either paid the debt or entered into an agreement to repay the debt. The agreement must conform with Minnesota Statutes, section [198.03](#), subdivision 3. STAT AUTH: MS s [198.003](#) HIST: 14 SR 2355; 18 SR 2254; 20 SR 2095, Current as of 07/13/07*

APPENDIX H BUDGET AND STAFFING INFORMATION, MINNESOTA VETERANS HOMES AND MINNEAPOLIS VETERANS HOME

Table 5.0 below displays expenditures of the Minnesota Veterans Homes Board by fund and category. The majority of funding for FY2007 came out of the General Fund and was transferred into the Special Revenue Fund; only \$289,707 came directly from the General Fund.

Expenditures – Minnesota Veterans Homes Board FY2006 and FY2007

Table 5.0 ⁴³

Homes & Veterans Home Board Office	FTEs - 2007	FY2006	FY2007
Board of Directors (Veterans Home Board Office)	13	\$1,994,000	\$1,468,790
Minneapolis Veterans Homes	512	\$35,666,000	\$35,444,183
Hastings Veterans Home	101	\$8,151,000	\$7,145,059
Silver Bay Veterans Homes	104	\$7,352,000	\$7,534,397
Luverne Veterans Home	112	\$7,133,000	\$7,496,419
Fergus Falls Veterans Home	113	\$7,145,000	\$7,325,135
Total	955	\$67,441,000	\$66,413,983⁴⁴
Expenditures by Fund—Agency			
		FY2006	FY2007
Direct Appropriations			
General	0		\$289,707
Statutory Appropriations			
Misc. Special Revenue		\$64,806,000	\$67,104,917 ⁴⁵
Federal (grants)		\$237,000	\$247,886
Miscellaneous Agency		\$1,877,000	\$1,726,299 ⁴⁶
Gift		\$521,000	\$676,512
Total		\$67,441,000	\$70,045,321⁴⁷
Expenditures by Category—Agency			
Total Compensation		\$51,118,000	\$54,165,710
Other Operating Expenses		\$14,526,000	\$14,223,255
Capital Outlay & Real Property	0		\$29,320
Payments to Individuals		\$1,791,000	\$1,627,035
Local Assistance		\$2,000	0
Other Financial Transactions		\$4,000	0
Total		\$67,441,000	\$70,045,320

⁴³ State of Minnesota, 2008-09 Biennial Budget January 22, 2007; Minnesota Department of Finance provided updated expenditures for FY2007.

⁴⁴ This total differs slightly from the totals listed below because it accounts only for money used to operate the facilities. This total does not include gifts or Miscellaneous Agency funds, for example.

⁴⁵ This figure includes state appropriations, VA per diems, resident co-payments and funds from Minneapolis and Hastings property leases.

⁴⁶ This is a revolving fund that consists of resident and canteen funds.

⁴⁷ Approximately 95 percent of the total expenditure is used for operating funds.

Expenditures – Minneapolis Veterans Home FY2006 and FY2007

Table 6.0

<i>Expenditures by Fund-Minneapolis Home⁴⁸</i>		
Direct Appropriations	FY-2006	FY-2007
General		less than 1 percent ⁴⁹
Statutory Appropriations		
Misc. Special Revenue	\$34,363,598	95 percent
Federal	\$228,992	less than 1 percent
Miscellaneous Agency	\$830,304	2 percent
Gift	\$240,730	1 percent
Total	\$35,663,625	\$36,882,061
<i>Expenditures by Category—Minneapolis Home</i>		
Total Compensation	\$27,242,363	\$28,901,678
Other Operating Expenses	\$7,578,478	\$7,228,056
Capital Outlay & Real Property		
Payments to Individuals	\$840,305	\$752,327
Local Assistance	\$2,479	
Other Financial Transactions		
Total	\$35,663,625	\$36,882,061

Staffing

The Minneapolis Veterans Home employees 512 FTEs. That includes 64.02 FTE RNs, 31.64 FTE LPNs, 133.84 FTE HSTs. Roughly 73 employees speak English as a Second Language (ESL). The Board has worked with the unions and the Department of Employee Relations to develop a language work rule to clarify communication expectations for employees at the Minneapolis Home and held a skills fair in September that brought in the Minnesota Literacy Council and other resources for employees who speak English as a Second Language. In addition, the Minneapolis Home developed a test for food service workers (FSWs), general maintenance workers (GMWs) and health service technicians (HSTs) that will be given prior to interviewing. They planned to use the test for the first time in August 2007.

⁴⁸ Minnesota Department of Finance, Budget Office, July 2007.

⁴⁹ Exact expenditures (by fund) were not obtained. Percentages provided are accurate. About 95 percent of the Minneapolis Veterans Homes expenditures are provided by the Miscellaneous Special Revenue Fund, whereas less than 1 percent of expenditures are provided by federal dollars and the State's General Fund.

Nurse Staffing Ratios

The total hours per resident day for nursing staff at the Minneapolis Home is 3.65 (RN, LPN and HST). Based on the ratio provided by the Centers for Medicare and Medicaid Services (CMS) study⁵⁰, nursing time provided to residents at the Minneapolis Home is slightly lower than the CMS threshold (3.65 compared to 4.1).

As of July 2007, there were 64.02 RN FTEs employed at the Minneapolis Home, 52 percent worked full-time and 48 percent worked part-time. There were 40.52 (63 percent) FTE RNs providing direct-care nursing, 5.20 (8 percent) FTE RNs providing non-direct care nursing and 18.30 (29 percent) FTE administrative RNs. Sixty-eight percent of direct-care RNs worked part-time and 32 percent worked full-time. For non-direct care RNs, 77 percent worked full-time and 23 percent worked part-time. Lastly, 87 percent of administrative RNs worked full-time and 13 percent worked part-time.

In FY2007, RNs at the Minneapolis Home worked a total of 2,028 hours of overtime. This included 1,865.25 voluntary hours and 162.75 mandated hours. LPNs worked 4,760 hours of overtime which included 4,612.75 hours of voluntary overtime and 147.25 of mandated hours.

The following Table (7.0) provides a break-down of the number of full and part-time nursing staff for direct-care, non-direct care and administrative nursing staff at the Minneapolis Home. Pages 51-52 include a comparison of the number of full-time and part-time nursing and HST positions at the Minneapolis Home and RN/LPN overtime hours for FY2007.

**Table 7.0
RN Staffing: Full and Part-Time/Direct and Non-Direct Care at Minneapolis Veterans Home⁵¹ (FY2007 data)**

<p>Total RN Direct Care—40.52 FTEs 13.00 full-time = 32% 27.10 part-time = 67% .42 casual/intermittent (part-time) = 1%</p>	<p>Total RN Non-Direct Care—5.20 FTEs 4.0 full-time = 77% 1.20 part-time = 23%</p>
<p>Total RN Administration—18.30 FTEs 16.00 full-time = 87% 2.30 part-time = 13%</p>	<p>RN Direct Care = 63% RN Administrative = 29% RN Non-Direct Care = 8%</p>
<p>Total RN---64.02 FTEs 33.00 full-time = 52% 31.02 part-time = 48%</p>	

⁵⁰ A study conducted by the Centers for Medicare and Medicaid Services (CMS) in 2002 identified 4.08 hours of nursing care (RNs, LPNs, and CNAs/HSTs) per resident per day as the threshold necessary to "improve outcomes and avoid selected problems" in long-term care residents. This includes 2.78 hours per day of care by nursing assistants for each resident and 1.3 hours per day by licensed staff (including .75 from an R.N.) for each resident, MN Board of Aging website: http://www.mnaging.org/admin.oom_federal%20study.htm, retrieved July 24, 2007.

⁵¹ Minnesota Veterans Homes Board Office, Commission Request for Data, July 2007.

Nursing Salary Comparisons

The Department of Employee Relations (DOER) did a comparison for all positions within the nursing care chain of command at the Minneapolis Veterans Home.⁵²

In the analysis, salary ranges for nursing staff at the Minneapolis Veterans Home were compared to salary ranges for other profit and not-for-profit facilities engaged in nursing home and long-term or continuing care services.

Salary ranges (with the exception of LPN positions) at the Minneapolis Veterans Home were significantly higher when compared to similar positions within regions geographically close to Minnesota and also when compared within Minnesota and within Minneapolis. Salary ranges for Minneapolis Veterans Home LPN positions were similar and in some case slightly lower when making the same comparisons. In addition, the state benefit package (insurance, leave time, etc.) was equal to or better than those of the comparable facilities.

State nursing salary ranges are higher when compared only to ranges for nursing home or continuing care facilities. This is most likely explained by the following points:

1. Salaries for the nurses in the Minnesota Veterans Homes are set by the state.
2. The state's nursing salary applies to a variety of state nursing job responsibilities (public health nurses, clinics and nursing homes).
3. The state's effort to maintain internal equity across the spectrum of nursing responsibilities dictates a higher salary level when compared to nursing salaries only in nursing homes or continuing care facilities.

In summary, salaries for nursing staff at the Minneapolis Veterans Home compare very favorably to all facilities surveyed as part of the AAHSA Surveys. See Page 53 for the salary comparison summary and analysis provided by DOER.

Physician Staffing Model

The five facilities have distinctive employment arrangements with medical providers, including contracts with hospitals and clinics, which results in providing varying hours of physician coverage to the residents each month. The Minneapolis Home employs seven salaried physicians, under a medical specialist plan/contract, who are also employed at the VA Medical Center. This equates to 1.1 FTE of physician time at the Minneapolis Home. In addition, the Minneapolis Home has .5 FTE medical director time and 3.6 FTE of nurse practitioner time.⁵³ In contrast, Silver Bay contracts with a physician from the Bay Area Clinic for 10 hours/week and Fergus Falls receives MD and physician coverage from Lake Region Clinic for 30 hours/month.

Staff Turnover

Table 8.0 provides turnover rates at the Minneapolis Home in comparison to the other four facilities annualized for FY2007. The facility average turnover rate was 27.8 percent, which was the highest among all of the veterans homes that year. The position

⁵² Minnesota Department of Employee Relations, Minneapolis Veteran's Home Salary Comparison, July 11, 2007.

⁵³ Zimmer, Debra; medical director, Minneapolis Veterans Home; October 26, 2007.

with the highest turnover at the Minneapolis Home was food service worker (52 percent), followed by health service technician (35 percent). In comparison to the average rates of turnover for nursing positions in the metro-area, the turnover rates in Minneapolis were lower than the metro average in FY2007.

Table 8.0
Turnover Annualized at Minnesota Veterans Homes- FY2007⁵⁴

Home	RN	LPN	HST	GMW	FSW	Other	Facility Average
Fergus Falls	0%	37%	13%	0%	5%	0%	9%
Hastings	0%	1%	0%	0%	0%	1%	.33%
Luverne	7%	0%	13%	33%	8%	5%	11.8%
Minneapolis	21%	33%	35%	11%	52%	15%	27.8%
Silver Bay	0%	0%	1%	0%	0%	1%	.33%
Metro Average (MN)	34.2%	39.90%	42.90%	NA	51.30%	NA	NA
Out-state Average (MN)	28.60%	29.90%	47.60%	NA	42.30%	NA	NA
Average for Agency	5.6%	14.2%	12.4%	8.8%	13%	4.4%	9.85%

Key:

GMW-General Maintenance Worker (janitorial)

FSW- Food Service Worker

NA- not available

⁵⁴ Minnesota Veterans Home Board, July 2007 board meeting report.

Staffing Ratio Data at Minnesota Veterans Homes

Silver Bay

FY2007 Data

87 Bed Skilled Nursing Avg daily census 78.5	Productive Hours	FTE	Hours per Resident Day	Hours per Standardized Res Day
RN Total	16,925.75	8.14	0.59	0.23
LPN Total	13,775.00	6.62	0.48	0.19
HST Total	70,274.50	33.79	2.45	0.95
Total Productive Nursing	100,975.25	48.55	3.52	1.37

	FTE
RN Direct Care	9.25
RN Administration *	3.75

* DON	1.00
* RN Supervisor/Infection Control	2.00
* Education	0.75
*FTE RN ADMINISTRATION	3.75

Case Mix Average	
A-K	2.57
(G-H; High ADL with Behavior)	
Behavior Average	2.17
(Needs frequent intervention for behaviors)	

Physician Coverage

Primary Coverage: Contract with Bay Area Clinic for 10 hours per week

Emergency Coverage: Contract with Lakeshore Hospital for off hours emergency coverage

Medical Director: Employee (local MD 0.2 FTE)

We do not have "red carpet" admissions

We give priority to veterans on the list over non veterans

We give priority to veterans from our sister facilities if they require a change in level of care that we are able to provide

Source: Minnesota Veterans Homes Board, July 2007.

Hastings

FY2007 Data

Average daily census in June 175	Productive	FTE	Staffing
	Hours		Ratio
MD including contract	443.5	0.21	0.00
Nurse Practitioner	1399.25	0.67	0.00
RN Total	5643.25	2.71	0.02
LPN Total	20777.50	9.99	0.06
HST Total	9805.25	4.71	0.03
	38068.75	18.30	0.11

	Productive	FTE	Hour per	Hour per
	Hours		Resident	Standardized
			Day	Res Day
RN Total	5643.25	2.71	0.09	0.08
LPN Total	20777.50	9.99	0.33	0.29
HST Total	9805.25	4.71	0.16	0.14
Total Productive Nursing	36226.00	17.42	0.57	0.51

FTE	
RN Direct Care	2.90
RN Administration *	2.80

* Admin Supervisor	1.00
* Care team Coordinator	1.00
* Infection Control/Continuous Improvement	0.80
*FTE RN ADMINISTRATION	2.80

Case Mix Average	
A-B	1.13
Behavior Average	1.86
(Needs regular intervention for behaviors)	

Source: Minnesota Veterans Homes Board, July 2007.

Fergus Falls

FY 2007 Data MVH -FF

85 bed skilled nursing Avg daily census 84.5	Productive Hours	FTE	Hour per Resident Day	Hour per Standardized Resident Day
RN Total	17,472.00	8.40	0.57	0.22
LPN Total	11,648.00	5.60	0.38	0.14
HST Total	71,020.00	34.14	2.30	0.88
Total Productive Nursing	100,140.00	48.14	3.24	1.24

	FTE
RN Direct Care	8.40
RN Administration *	4.00

* DON	1.00
* ADON	1.00
* EDUCATION/INFECTION CONTROL	1.00
*EVENING SUPERVISOR	1.00
*FTE RN ADMINISTRATION	4.00

Case Mix Average	
A-K	2.61
(G-H; High ADL with Behavior)	
Behavior Average	1.24
(Needs regular intervention for behaviors)	

We do not have "red carpet" admissions

We do give priority to veterans on the list over non veterans

Residents from sister facilities who require a change in level of care can move to the top of our list.

Source: Minnesota Veterans Homes Board, July 2007.

Luverne

FY 2007 Data

85 bed skilled nursing Average daily census 83.4	Productive Hours	FTE	Hours per Resident Day	Hours per Standardized Res Day
RN Total	17472.00	8.40	0.57	0.22
LPN Total	8056.25	3.87	0.26	0.10
HST Total	73714.00	35.44	2.42	0.91
Total Productive Nursing	99242.25	47.71	3.26	1.23

FTE	
RN Direct Care	10.08
RN Administration *	4.20

* DON	1.00
* ADON	1.00
* EDUCATION/INFECTION CONTROL	0.80
*EVENING SUPERVISOR	1.40
*FTE RN ADMINISTRATION	4.20

Case Mix Average	
A-K	2.66
(G-H; High ADL with Behavior)	
Behavior Average	1.95
(Needs regular intervention for behaviors)	

Physician Coverage

Primary Care: Contract with Sanford Clinic Luverne for 4 hours every Tuesday and Friday

Medical Director: Contract with MD from the Sioux Falls VA for 6 hours per month (every other Wednesday)

We do not have "red carpet" admissions

Source: Minnesota Veterans Homes Board, July 2007.

Minneapolis (Source: Minnesota Veterans Homes Board, July 2007)

FY 2007 Data-NCU

Resident Days	Productive	FTE	Hour per	Hour per
117170 In June 2007:	Hours		Resident	Standardized
Average daily census-skilled care 304			Day	Res Day
Average daily census-dom.care 58				
RN Total	83399.68	40.10	0.71	0.27
LPN Total	65811.20	31.64	0.56	0.21
HST Total	278387.20	133.84	2.38	0.89
Total Productive Nursing	427598.08	205.58	3.65	1.36

	FTE	Full time	Part Time
RN Direct Care	40.10	13.00	27.10
RN Casual (Intermittent)	0.42	0.00	0.42
RN Administration	18.30	16.00	2.30
TOTAL RN NURSING	58.82	29.00	29.82
Non-Direct RN	5.20	4.00	1.20
TOTAL RN	64.02	33.00	31.02

DON	1.00
ADON	3.00
RN MANAGERS NCU	8.00
RN SUPERVISORS (OD s)	3.30
MDS COORDINATORS	3.00
DIRECT CARE ADMINISTRATION	18.30
QUALITY DIRECTOR	1.00
EDUCATION/INFECTION CONTROL	1.00
STAFF EDUCATION	2.00
NURSE SPECIALISTS (ADMISSIONS)	1.20
NON-DIRECT RN	5.20

Case Mix Average	
A-K	2.68
(G-H; High ADL with Behavior)	
Behavior Average	1.63
(Needs regular intervention for behaviors)	

Behaviors 0-1	Behaviors 2-4
150	171

	<u>Aggregate</u>
RN/RESIDENT RATIO	11
LPN/RESIDENT RATIO	15
HST/RESIDENT RATIO	3
Nurse Practitioner Resident Ratio	80
Average ratio of MDs to residents (MD Case Load)	39
LEP Employees-estimate	73

We do not have "red carpet" admissions

We do give priority only to veterans being transferred from other Veterans Homes

This information is based on Fiscal Year 2007 data

Part-Time vs. Full-Time Nursing and HST Positions at Minneapolis Home⁵⁵

Comparison of Part-time and Full-time LPNs

Classification	Number as of 11-30-06	Number as of 06-30-07
Part-time LPNs	39	33
Full-time LPNs	16	13
Intermittent LPNs	4	2

Comparison of Part-time and Full-time RNs

Classification	Number as of 11-30-06	Number as of 06-30-07
Part-time RNs	34	33
Full-time RNs	20	18
Intermittent RNs	5	3

Comparison of Part-time and Full-time HSTs

Classification	Number as of 11-30-06	Number as of 06-30-07
Part-time HSTs	105	96
Full-time HSTs	64	67
Intermittent HSTs	8	6

RN/LPN Overtime (OT) Hours at Minneapolis Home

2006	RN MANDATE D OT HOURS	RN VOLUNTAR Y OT HOURS	RN TOTAL OT	LPN MANDATE D OT HOURS	LPN VOLUNTAR Y OT HOURS	LPN TOTAL OT
JUL	0	316	316	0	462	462
AUG	0	234	234	0	486	486
SEP	0	81	81	0	296	296
OCT	0	121	121	0	276	276
NOV	77.5	62.50	140	31	258	289
DEC	7.75	132.25	140	77.5	298.50	376
2007						
JAN	15.5	81.50	97	0	400	400
FEB	38.75	137.25	176	23.25	265.75	289
MAR	0	305	305	0	535	535
APR	7.75	148.25	156	7.75	466.25	474
MAY	0	144	144	0	382	382
JUN	15.5	102.50	118	7.75	487.25	495
Totals	162.75	1865.25	2028.00	147.25	4612.75	4760.00

⁵⁵ Data in both tables were provided by the Minnesota Veterans Homes Board, July 2007.

Minnesota Veterans Home Salary Comparison – Nursing⁵⁶

Introduction:

This document contains salary comparisons for all positions within the Nursing Care chain of command at the Minneapolis Veteran’s Home (Assistant Administrator to Human Services Technician). Salary comparisons for executive level positions above the Assistant Administrator (Administrator and Executive Director) are made in a separate document.

The following salary comparisons were taken from the AAHSA Nursing Home Survey (2006-2007).

- 2,522 nursing homes participated in the survey
- The survey looked at “For-Profit” and “Not-For-Profit” Categories

Another survey, the AAHSA Continuing Care Retirement Community Salary Survey (CCRC) (2006-2007) was also reviewed, however, the salary data did not differ significantly from the Nursing Home Survey so specific comparisons are not included in this document.

Survey Definitions (positions comparable to those at Mpls. Veterans Home) :

Assistant Administrator: Reports to the Administrator. Assists in the administrative functions of the operations.

Director of Nurses: Responsible for administration of nursing services. Directs, plans, and coordinates service activities of professional nursing and auxiliary nursing personnel in rendering resident care. Interprets policy and regulations to all nursing personnel and ensures compliance. Analyzes and evaluates nursing and related services rendered to ensure quality of resident care.

Assistant Director of Nurses: Second highest level position in the Nursing Department. Reports to the Director of Nurses. This position takes in some of the responsibilities of the Nursing Department as may be delegated. Provides assistance in the functioning of the Nursing Department.

Nursing Supervisor (RN): Supervises and coordinates activities of personnel assigned to a specific shift. Communicates and applies policies, practices, procedures, objectives, and goals necessary for attainment of satisfactory resident care. Demonstrates clinical expertise of Standards of Practice accorded by license as a Registered Nurse.

Staff Nurse (RN): Renders professional nursing care to patients within an assigned unit. Performs nursing techniques for the comfort and well-being of the patient. Administers prescribed medications. Maintains patients’ medical records on nursing observations. May assist physician during treatment and examination of patient.

⁵⁶ Minnesota Department of Employee Relations, Minneapolis Veterans Home Salary Comparison, July 11, 2007.

Practical Nurse (LPN): Performs assigned nursing procedures for the comfort and well-being of patients such as assisting in admission of new patients, bathing and feeding, making beds, helping patients into and out of bed, and collecting specimens. Administers specified medication. Provides a wide variety of patient care activities as accorded by licensure.

Certified Nurse Aide: performs various resident care activities and related nonprofessional services essential to caring for personal needs and comfort of residents. Function may not exceed Standards of Practice as accorded by Certification.

Region Comparisons: The survey offered comparisons by Regions. Regions 4 and 6 were used for the purpose of this analysis due to their proximity to Minnesota. Region 4 = Wisconsin, Illinois, Michigan, Indiana, Ohio (Nursing Home Survey responses 20.30%)

Region 6 = Minnesota, North Dakota, South Dakota, Nebraska, Kansas, Missouri, Minnesota (Nursing Home Survey responses 14.55%)

I. NURSING HOME SURVEY

Assistant Administrator Salary Comparisons:

Current Minnesota Asst. Administrator position salary range 21M 68,403-97,906

Regional Average Pay Ranges (All Ass't Administrator positions covered by the Survey):

	Average Minimum	Average Maximum
Region 4	44,537	62,080
Region 6	Not Available	
Nation	43,332	75,974

Salary Comparison by # of Beds:

Not-for-Profit (100 Beds and Over):

	50 th Percentile	75 th Percentile*
Region 4	64,788	78,000
Region 6	Not Available	
Nationwide	63,523	77,106

Not-for-Profit (All Bed Sizes):

	50 th Percentile	75 th Percentile
Region 4	62,400	70,747
Region 6	47,662	56,089
Nationwide	61,705	74,941

Note: Salaries for Combined For-Profit and Not-for-Profit were somewhat lower.

Salary Comparison by State:

	50 th Percentile	75 th Percentile	Maximum
MN	Not Available		
WI	42,806	45,182	52,000
MI	58,000	65,000	78,000
IL	54,340	71,400	82,588
Nation	53,591	65,000	104,000

National Average: 55,134

Salary Comparison Within Mpls.

	50 th Percentile	75 th Percentile	Maximum
Minneapolis	45,198	50,896	52,000

Director of Nurses:

Current Minnesota salary range for Mpls. Director of Nurses 65,897-94,503

Regional Average Pay Ranges (all Dir. of Nurses positions covered by Survey):

	Average Minimum	Average Maximum
Region 4	55,198	77,834
Region 6	45,452	67,191
Nation	57,756	87,454

Salary Comparison by # of Beds:

Not-for-Profit (100 Beds and Over):

	50 th Percentile	75 th Percentile
Region 4	70,360	77,269
Region 6	59,300	66,560
Nationwide	69,613	78,409

Not-for-Profit (All Bed Sizes):

	50 th Percentile	75 th Percentile
Region 4	67,500	74,984
Region 6	53,274	59,821
Nationwide	66,200	76,512

Salary Comparison by State:

	50 th Percentile	75 th Percentile	Maximum
MN	59,670	66,560	83,000
WI	65,254	73,108	81,370
CO	70,741	74,547	84,718
MI	68,571	75,438	82,805
IL	69,388	75,000	108,806
Nation	68,959	77,253	175,000

National Average Salary: 69,812

Salary Comparison Within Minneapolis:

	50 th Percentile	75 th Percentile	Maximum
Minneapolis	64,106	70,311	81,744

Assistant Director of Nurses

Current salary range for Mpls. Asst Dir. of Nurses: 54,747-81,954

Regional Average Pay Ranges (All Asst Dir. of Nurses positions covered by Survey)

	Average Minimum	Average Maximum
Region 4	46,786	66,099
Region 6	41,172	58,301
Nation	40,556	71,682

Salary Comparison by # of Beds

Not-for-Profit (100 Beds and Over)

	50 th Percentile	75 th Percentile
Region 4	57,383	64,776
Region 6	52,600	55,411
Nation	58,500	66,955

Not-for-Profit (All Bed Sizes)

	50 th Percentile	75 th Percentile
Region 4	56,225	62,000
Region 6	48,479	54,849
Nation	57,680	65,000

Salary Comparison by State

	50 th Percentile	75 th Percentile	Maximum
MN	53,040	58,822	68,817
WI	58,370	62,010	69,800
IA	44,327	46,850	58,400

National Average: 58,052

Salary Comparison within Minneapolis

	50 th Percentile	75 th Percentile	Maximum
Minneapolis	53,852	59,676	68,817

Nursing Supervisor

Current salary range for Mpls. RN Supervisor: 48,922-73,706

Regional Average Pay Ranges (All Nursing Supv. positions covered by Survey)

	Average Minimum	Average Maximum
Region 4	44,889	60,818
Region 6	40,289	56,597
Nation	42,481	64,845

Salary Comparison by # of Beds

Not-for-Profit (100 Beds and Over)		
	50 th Percentile	75 th Percentile
Region 4	54,998	58,522
Region 6	47,800	53,506
Nation	56,180	62,471

Not-for-Profit (All Bed Sizes)

Salary figures were the same or just slightly below above figures.

Salary Comparison State and City

	Average Salary	Maximum Salary
Minnesota	53,622	80,000
Minneapolis	50,490	60,174

Staff Nurse (RN)

Current salary range for Mpls. RN: 47,523-70,345

Current salary range for Mpls RN Sr: 49,423-73,164

Regional Average Pay Ranges (Staff Nurse RN)

	Average Minimum	Average Maximum
Region 4	42,449	55,186
Region 6	37,709	49,757
Nation	41,092	61,784

Regional Average Pay Ranges (Head Nurse RN)

	Average Minimum	Average Maximum
Region 4	48,222	67,280
Region 6	38,788	57,812
Nation	47,754	64,528

Salary Comparison by # of Beds

Not-for-Profit (100 Beds and Over)

	50 th Percentile	75 th Percentile
Region 4	49,068	52,367
Region 6	45,999	48,295
Nation	48,776	55,520

Not-for-Profit (All Bed Sizes)

Salaries were similar to above figures

Salary Comparison by State and City

	Average Salary	Maximum Salary
Minnesota	50,196	64,728
Minneapolis	48,692	57,545

Practical Nurse (LPN)

Current salary range for Mpls. LPN 1: 29,817-40,319

Current salary range for Mpls. LPN 2: 31,529-42,491

Regional Average Pay Ranges (Practical Nurse-LPN)

	Average Minimum	Average Maximum
Region 4	33,011	43,597
Region 6	28,981	37,668
Nation	31,508	46,709

Salary Comparison by # of Beds

Not-for-Profit (100 Beds and Over)

	50 th Percentile	75 th Percentile
Region 4	38,169	42,804
Region 6	33,011	35,934
Nation	37,584	41,864

Not-for-Profit (All Beds Sizes)

Salaries were slighter lower or equal to above figures

Salary Comparison by State and City

	Average Salary	Maximum Salary
Minnesota	35,559	50,634
Minneapolis	38,294	47,878

Certified Nurse Aide

Current salary range for Mpls. Human Service Technician (HST) 23,888-38,127

Regional Average Pay Ranges (Certified Nurse Aide)

	Average Minimum	Average Maximum
Region 4	19,043	27,729
Region 6	18,061	25,515
Nation	18,354	28,355

Salary Comparison by # of Beds

Not-for-Profit (100 Beds and Over)		
	50 th Percentile	75 th Percentile
Region 4	23,323	24,471
Region 6	20,817	22,613
Nation	22,530	24,555

Not-for-Profit (All Bed Sizes)
(Salary were similar to above figures)

Salary Comparison by State and City

	Average Salary	Maximum Salary
Minnesota	23,845	31,487
Minneapolis	24,597	31,487

II. ANALYSIS OF DATA

Salary ranges for all state positions covered in this document have been set within the provisions of MS 43.18 Subd 8. These provisions place a priority on internal equity among related state job classes and among various levels within the same occupation. The provisions also state that compensation for state positions should bear a reasonable relationship to compensation for similar positions outside state service.

Therefore, state salary ranges for Minneapolis Veterans Home nursing positions are the same ranges as those for similar positions in other state departments. This would include the Department of Human Services, the Department of Corrections, the Department of Health, MnSCU, and the Board of Nursing.

In this analysis, salary ranges for nursing staff at the Minneapolis Veterans Home were compared to salary ranges for other profit and not-for-profit facilities engaged in nursing home and long term or continuing care services.

As the figures show, salary ranges (with the exception of LPN positions) at the Minneapolis Veterans Home were significantly higher when compared to similar positions within regions geographically close to Minnesota and also when compared within Minnesota and within Minneapolis.

Salary ranges for Minneapolis Veterans Home LPN positions were similar and in some case slightly lower when making the same comparisons.

In addition, the state benefit package (insurance, leave time, etc.) was equal to or better than those of the comparable facilities.

As stated above, several state agencies utilize nursing positions. These positions are engaged in a variety of job responsibilities. Also, as stated above, we do maintain internal equity among these positions. Therefore, when setting salary ranges, we do compare to nursing salary ranges within a variety of facilities. This includes public health nurses and clinics in addition to nursing homes. Most likely, this is the reason that state nursing salary ranges are higher when compared only to ranges for nursing home or continuing care facilities.

In summary, salaries for nursing staff at the Minneapolis Veterans home compare very favorably to all facilities surveyed as part of the AAHSA Surveys.

Minnesota Veterans Home Salary Comparisons – Executive Director and Home Administrators⁵⁷

Introduction:

The following salary comparisons were taken from two surveys:

AAHSA Nursing Home Survey (2006-2007)

2,522 nursing homes participated in the survey

The survey looked at “For-Profit” and “Not-For-Profit” Categories

AAHSA Continuing Care Retirement Community Salary Survey (CCRC) (2006-2007)

449 CCRC’s nationwide participated

Survey Definitions (both Surveys used the same job definitions):

Executive Director: Responsible for all operations of the community. Hired by the Board of Directors; reports to board regarding strategic planning and policy making activities.

Home Administrator: Responsible for planning and is accountable for all activities and departments of the Nursing Home subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. Administers, directs, and coordinates all activities of Nursing Home to carry out its objectives in providing resident care.

Region Comparisons: Both surveys offered comparisons by Regions. Regions 4 and 6 were used for the purpose of this analysis due to their proximity to Minnesota.

Region 4 = Wisconsin, Illinois, Michigan, Indiana, Ohio (Nursing Home Survey responses 20.30%; CCRC Survey responses 18.26%)

Region 6 = Minnesota, North Dakota, South Dakota, Nebraska, Kansas, Missouri, Minnesota (Nursing Home Survey responses 14.55%; CCRC Survey responses 6.24%)

I. NURSING HOME SURVEY

Executive Director Salary Comparisons:

Current Minnesota position salary range 26M 81,557-116,740

Regional Average Pay Ranges (All Executive Dir. positions covered by the Survey):

	Average Minimum	Average Maximum
Region 4	92,879`	139,537
Region 6	Not Available	
Nation	96,075	143,862

⁵⁷ Minnesota Department of Employee Relations, Veterans Home Salary Comparisons, June 2007.

Salary Comparison by # of Beds:

Not-for-Profit (100 Beds and Over):

	50 th Percentile	75 th Percentile*
Region 4	129,366	171,700
Region 6	115,000	126,800
Nationwide	122,559	155,235

Not-for-Profit (All Bed Sizes):

	50 th Percentile	75 th Percentile
Region 4	122,718	145,000
Region 6	108,779	123,800
Nationwide	119,500	146,791

Note: Salaries for Combined For-Profit and Not-for-Profit were similar

Salary Comparison by State:

	50 th Percentile	75 th Percentile	Maximum
MN	Not Available in Survey		
WI	123,109	143,571	203,507
CO	96,640	112,205	179,213
MI	120,000	130,292	185,400
IL	137,900	143,395	205,000
Nation	115,000	140,000	466,250

National Average: 124,416

Salary Comparison by City:

	50 th Percentile	75 th Percentile	Maximum
Minneapolis	100,000	108,558	122,718
Chicago	121,750	141,425	205,000

Home Administrator Salary Comparisons:

Current Minnesota salary range for Mpls. Administrator 75,961-108,889

Regional Average Pay Ranges (all Home Adm. positions covered by Survey):

	Average Minimum	Average Maximum
Region 4	68,272	103,128
Region 6	53,386	79,728
Nation	71,629	112,573

Salary Comparison by # of Beds:

Not-for-Profit (100 Beds and Over):

	50 th Percentile	75 th Percentile
Region 4	83,658	94,470
Region 6	73,000	79,997
Nationwide	82,330	94,931

Not-for-Profit (All Bed Sizes):

	50 th Percentile	75 th Percentile
Region 4	80,000	90,550
Region 6	62,834	73,000
Nationwide	76,972	90,000

Salary Comparison by State:

	50 th Percentile	75 th Percentile	Maximum
MN	67,883	79,100	97,900
WI	76,627	86,178	144,344
CO	80,007	89,586	101,754
MI	78,000	85,000	105,000
IL	76,000	90,000	169,000
Nation	80,000	90,000	350,000

National Average Salary: 81,259

Salary Comparison by City:

	50 th Percentile	75 th Percentile	Maximum
Minneapolis	72,638	80,489	101,712
Chicago	78,000	88,889	160,000
Des Moines	62,793	73,312	87,000
Milwaukee	83,000	89,440	142,500

II. CCRC SURVEY

Executive Director Salary Comparisons:

Regional Average Pay Ranges:

	Average Minimum	Average Maximum
Region 4	95,249	143,146
Region 6	Not Available	
Nation	96,009	143,710

Salary Comparison by # of Units (300 Units and Over):

	50 th Percentile	75 th Percentile	Maximum
Region 4	128,731	144,048	258,000
Region 6	124,600	133,687	200,000
Nation	125,500	150,345	430,000

National Average: 133,412

Salary Comparison by State:

	50 th Percentile	75 th Percentile	Maximum
MN	Not Available		
WI	123,109	138,196	145,000
CO	95,000	99,143	150,000
MI	114,117	129,000	140,379
IL	137,900	143,395	205,000
Nation	113,000	135,960	430,000

National Average: 121,400

Home Administrator Salary Comparison:

Regional Average Pay Ranges:

	Average Minimum	Average Maximum
Region 4	66,104	94,752
Region 6	Not Available	
Nation	66,559	96,179

Salary Comparison by # of Units (300 total units and over)

	50 th Percentile	75 th Percentile	Maximum
Region 4	79,920	85,265	100,000
Region 6	73,000	83,726	106,000
Nation	80,000	90,000	131,700

National Average: 82,250

Salary Comparison by State:

	50 th Percentile	75 th Percentile	Maximum
MN	Not Available		
WI	84,053	88,900	97,600
CO	71,908	79,976	95,118
MI	76,275	80,292	90,400
IL	74,299	88,150	130,000
Nation	80,000	88,583	135,960

National Average: 81,348

III. ANALYSIS OF DATA

Executive Director: The current maximum salary for the Veterans Homes Executive Director in Minnesota is somewhat lower than the 50th percentile of other states in our comparable region and nationwide. This means that 50% of the positions covered by the surveys are paid less than the maximum rate of the Veteran’s Homes Executive Director position and 50% are paid more.

When compared to the regional average pay ranges for Executive Director positions covered by the surveys, the salary range minimum and maximum for the Veterans Homes Executive Director position was lower than average, however, still well within the range.

When looking at Executive Director positions in Minneapolis covered by the Nursing Home Survey, the Veterans Homes Executive Director position salary is very comparable.

Additional Compensation and Benefits: Some positions in Region 4 are eligible for bonuses in addition to the base salary.

Health Plan benefits and Vacation benefits are considerably better in Minnesota when compared to other organizations and states.

Internal Executive Branch Comparison: When compared with other state positions in terms of job responsibilities and salary, the Executive Director position is paid very well. Since executive branch compensation is based primarily on internal equity, this is an important factor to keep in mind. There are several critical state jobs where the compensation comparisons are similar to, or much worse, than the Veteran’s Homes Executive Director position. The current salary range for the Veteran’s Homes Executive Director has a maximum of \$116,740 which is the highest salary range in the compensation structure for the executive branch. Further it is not subject to the salary cap. This puts the Veteran’s Homes Executive Director position above the highest paid Agency Heads whose current salary is \$108,388.

Summary: This analysis may mean that we would be unable to attract applicants who have been employed at the Executive Director level for a number of years except for those who may want to change jobs for personal reasons such as relocation.

We should be looking at an applicant pool of people with good management experience who may currently be at a lower organizational level but still have years of good experience in long term care organizations.

Home Administrator: The current salary for the Minneapolis Home Administrator compares well with the salaries for positions covered by these surveys.

APPENDIX I MINNESOTA VETERANS HOMES WAITING LIST

Veterans Homes # of Beds and Availability⁵⁸ (Last Updated: 10-18-07)

Facility Type of Bed	Number of Operating Beds	Vacancies		Waiting List	Approximate Wait
		Male	Female		
Fergus Falls					
Skilled Care	85	3	0	65	Veteran: 5 - 7 months Spouse: 12+ months
Hastings					
Domiciliary	199	11	2	0	1 week
Supportive Housing	5	1	0	0	1 week
Luverne					
Skilled Care	85	0	0	69	Veteran: 2 - 4 months Spouse: 2+ years
Minneapolis					
Domiciliary	61	9	0	6	Men: 2 - 4 months Women: 2 - 4 months
Skilled Care	250	4	1	368	Limited assistance care: 8 - 9 months Higher care levels: 8 - 9 months
Skilled Care/Dementia	91	6	0		Limited assistance care: 8 - 10 months Higher care levels: 10 - 12 months
Silver Bay					
Skilled Care	62	2	0	15	Men: 3 - 5 months Women: 3 - 5 months
SCU Alzheimers	25	2	0		Men: 3 - 5 months Women: 3 - 5 months

⁵⁸ MN Veterans Home Board website, <http://www.myh.state.mn.us/bedavail.html>.

APPENDIX J

ORAL TESTIMONY LIST

The following individuals/organizations provided oral testimony to the commission:

- Daughter of a current resident at the Minneapolis Veterans Home.
- Current resident at the Hastings Veterans Home.
- Spouse, speaking on behalf of his wife, who has been on the waiting list for the Minneapolis Home.
- Daughter of veteran receiving care at another facility while on the waiting list for the Minneapolis Home.
- Isanti county veterans service officer.
- Commanders' Task Force.
- United Veterans Legislative Council of Minnesota.
- Veterans of Foreign Wars.
- Minnesota Disabled American Veterans.
- American Legion.
- Minnesota Nurses Association.
- Registered nurse (RN) working at Minneapolis Home.
- Minnesota Association of Professional Employees (MAPE).
- AFSCME, Council #5.
- Health service technician working at Minneapolis Home.
- Licensed practical nurse working at Minneapolis Home.
- Dr. Ratner, internist and geriatrician.
- Jeff Johnson, Veterans Homes Board Chairman

APPENDIX K COMMISSION'S VISION FOR VETERANS LONG- TERM CARE

The commission shared this vision with veterans service organizations on
September 6, 2007:

***“We are all faced with a series of great opportunities –
brilliantly disguised as insoluble problems.”***

- John W. Gardner

An opportunity to serve our veterans

Minnesota has an opportunity to renew its commitment to our veterans. A new commitment would involve taking a new approach to veterans long-term care that would:

- Transform veterans homes into “Centers of Excellence” in providing chronic disease management, nursing care, and supportive housing. The Centers of Excellence could become an opportunity to demonstrate new patterns of housing with services in transformed residential environments.
- Eliminate or dramatically shorten waiting lists by offering veterans a variety of alternatives to institutional nursing home care to meet their needs. These could include community services, home services, local assisted living, respite services, and others—including skilled nursing care at the veterans homes.
- Ask veterans and their families (including the new generation of veterans) what they need and then provide expert care coordinators to help them access the full-spectrum of services available to them.
- In keeping with the provisions of the Millennium Health Care Act, build partnerships among the State Veterans Homes, Veterans Administration Medical Centers, Veterans Integrated Service Networks, and other community organizations to create regional hubs that provide resources and offer a state of the art continuum of quality care for veterans and their families.
- Provide helpful advice on how families could coordinate VA benefits with other insurance and public programs so that veterans got the benefits they are entitled.

***General Douglas MacArthur once said, “Age wrinkles the body.
Quitting wrinkles the soul.”
In Minnesota, it’s time to get to work.***

APPENDIX L COMMISSION MEETING DATES AND TOPICS

DATE:	OBJECTIVES
May 16, 2007 9 a.m. – 3 p.m. Lottery Headquarters	<ol style="list-style-type: none"> 1. Introduce new members. 2. Discuss the commission’s charge. 3. Hear an overview of Minnesota’s veterans homes governance, operations, and history of regulatory problems. 4. Discuss future meetings and summarize next steps.
May 31, 2007 9 a.m. – 3 p.m. Lottery Headquarters	<ol style="list-style-type: none"> 1. Approve revised charge and meeting schedule. 2. Summarize discussion regarding governance, management, and operations of Minnesota’s veterans homes.
June 28, 2007 9 a.m. – 3 p.m. State Office Building Room 200 South	<ol style="list-style-type: none"> 1. Hear the perspectives of veterans and other stakeholders regarding current and future care needs. The commission wishes to hear from veterans from urban and rural areas, requiring a variety of services, and receiving care in a variety of settings.
August 8, 2007 9 a.m. – 3 p.m. Retirement Systems Building	<ol style="list-style-type: none"> 1. Overview of what is currently known about the key components to insuring strong long-term care facility operational performance. 2. Overview of the spectrum of long-term care services commonly available to meet the needs of elderly and chronically ill people.
August 9, 2007 9 a.m. – 3 p.m. UCare	<ol style="list-style-type: none"> 1. Develop a vision and strategic focus areas for the commission’s recommendations.
August 29, 2007 9 a.m. – 3 p.m. Retirement Systems Building	<ol style="list-style-type: none"> 1. Review draft outline of the commission’s report. 2. Develop preliminary list of possible recommendations.
September 26, 2007 9 a.m. – 3 p.m. Lottery Headquarters	<ol style="list-style-type: none"> 1. Review draft report, including preliminary recommendations. 2. Discuss other sections of the draft report
October 30, 2007 9 a.m. – 3 p.m. Retirement Systems Building	<ol style="list-style-type: none"> 1. Review and approve final report and recommendations. 2. Discuss implementation and follow-up steps.
November 19, 2007 9:00 a.m.—10:00 a.m. State Capitol	<ol style="list-style-type: none"> 1. Approve commission’s report to the Governor.

APPENDIX M

MEETING MATERIALS AND RESOURCES

The information below is available online if a website is given; or, Ryan Church can provide an electronic copy upon request (ryan.church@state.mn.us or 651-201-2287). Ryan also has a copy of all meeting agendas and minutes.

Web addresses may have changed since this list was published.

Documents and Reports

Documents and reports, federal government

Center for Medicare and Medicaid, Policy Council Document: Long-Term Care Reform Plan, September 28, 2006.

[documents\commission\LTC_reform_plan_2006.pdf](#)

Department of Veterans Affairs, Federal Benefits for Veterans and Dependents, 2007 Edition.

http://www.admin.state.mn.us/documents/commission/Federal_benefits.pdf

Department of Veterans Affairs, VA Midwest Health Care Network: Veterans Integrated Service Network, VISN 23 Annual Report FY2005, January 2006.

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State Home Inspection Standards – Domiciliary.

http://www.admin.state.mn.us/documents/commission/Inspection_standards_dom_form.pdf

State Home Inspection Standards - Nursing Home Care.

http://www.admin.state.mn.us/documents/commission/New_NH_inspection_form.pdf

Secretary Principi, The Cares Decision: A Special Report, May-June 2004.

http://www.admin.state.mn.us/documents/commission/CARES_report_2004.pdf

United States General Accounting Office, VA and Defense Health Care: Increased Risk of Medication Errors for Shared Patients, Report to Chairman, Subcommittee on Defense, Committee on Appropriations, U.S. Senate, September 2002

<http://www.admin.state.mn.us/documents/commission/Medication.pdf>

United States General Accounting Office, VA Long-Term Care: Changes in Service Delivery Raise Important Questions, Testimony before the Committee on Veterans' Affairs, House of Representatives, January 28, 2004.

http://www.admin.state.mn.us/documents/commission/gao_changes.pdf

United States General Accounting Office, VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services is Uneven, letter to Chairman and Ranking Democratic Member of Committee on Veterans' Affairs, U.S. Senate, March 29, 2002.
http://www.admin.state.mn.us/documents/commission/gao_millennium_act_provisions.pdf

United States General Accounting Office, VA Long-Term Care: More Accurate Measure of Home-Based Primary Care Workload is Needed, Report to the Secretary of Veterans Affairs, September 2004.
http://www.admin.state.mn.us/documents/commission/gao_homebased_care.pdf

United States General Accounting Office, VA Long-Term Care: Oversight of Nursing Home Program Impeded by Data Gaps, Report to the Chairman, Committee on Veterans' Affairs, House of Representatives, November 2004.
http://www.admin.state.mn.us/documents/commission/gao_data_gaps.pdf

United States General Accounting Office, VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care, Report to Congressional Requesters, May 2003.
http://www.admin.state.mn.us/documents/commission/gao_service_gaps.pdf

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http://www.admin.state.mn.us/documents/commission/gao_noninstitutional_services.pdf

United States General Accounting Office, VA Long-Term Care: Trends and Planning Challenges in Providing Nursing Home Care to Veterans, Testimony before the Committee on Veterans' Affairs, U.S. Senate, January 9, 2006.
http://www.admin.state.mn.us/documents/commission/gao_trends_challenges.pdf

United States General Accounting Office, VA Long-Term Care: Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions, Testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives, May 22, 2003.
http://www.admin.state.mn.us/documents/commission/gao_access.pdf

Documents and reports, other

Additional reports are included in the meeting materials listed below.

Kane, Robert L; Flood, Shannon; Bershadsky, Boris; Kechhafer, Gail; Effect of an Innovative Medicare Managed Care Program on the Quality of Care for Nursing Home Residents, *The Gerontologist*, Vol. 44, No. 1, 95–103.
http://www.admin.state.mn.us/documents/commission/Kane_article.pdf

My InnerView Inc., 2006 National Survey of Nursing Home Workforce Satisfaction, June 2007.

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Comprehensive Review, January 2006.

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Management Analysis & Development, Management Audit Minnesota Veterans Homes Department of Veterans Affairs, November 1980.

http://www.admin.state.mn.us/documents/commission/Management_audit_1980.pdf

Office of the Legislative Auditor State of Minnesota, Department of Veterans Affairs, Minneapolis Veterans Home, Hastings Veterans Home, Follow-Up Audit for the Period October 1, 1984—May 10, 1985; August, 1985.

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Meeting handouts

May 16, 2007

Abbott, Craig W.; Health Dimensions Group; letter to Bob Schroeder, Office of Governor Pawlenty, and Jeff Johnson, Minnesota Veterans Homes Board; including *Status Report of Minneapolis Veterans Home*, April 18, 2007.

Letter:

http://www.admin.state.mn.us/documents/commission/Meeting_051607_HDG_letter.pdf

Status report:

http://www.admin.state.mn.us/documents/commission/Status_Report_041807.pdf

Department of Administration Management Analysis & Development, *Management Study of the Minnesota Veterans Homes*, February, 1987.

http://www/admin.state.mn.us/documents/commission/Management_Analysis_Vets_Homes.pdf

Department of Health, PowerPoint presentation handouts prepared by Darcy Miner, Division Director, Compliance Monitoring Division, Minnesota Department of Health.

http://www.admin.state.mn.us/documents/commission/DOH_Darcy_Mike_2007.ppt

Governor's Blue Ribbon Commission, *The Governor's Blue Ribbon Commission on the Minnesota Veterans Homes Final Report*, February 12, 1988.

http://www.admin.state.mn.us/documents/commission/Governor_Report_Vets_Homes.pdf

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<http://www.governor.state.mn.us/priorities/governorsorders/executiveorders/PROD007996.html>

Governor's Veterans Long-Term Care Commission draft Charge/Charter prepared by Chairman, Dale Thompson and Management Analysis & Development, May 2007.
http://www.admin.state.mn.us/documents/commission/Commission_Charge.pdf

Governor's Veterans Long-Term Care Commission Member List with Biographies, Meeting Schedule, and Contact List prepared by Management Analysis & Development.
Members: http://www.admin.state.mn.us/documents/commission/member_list.pdf
Contacts: http://www.admin.state.mn.us/documents/commission/contact_list.pdf
Biographies: http://www.admin.state.mn.us/documents/commission/member_bios.pdf
Meetings: <http://www.admin.state.mn.us/documents/commission/schedule.pdf>

Health Dimensions Group, PowerPoint presentation handouts prepared by Craig Abbott, Chief Operating Officer, Health Dimensions Group.
http://www.admin.state.mn.us/documents/commission/Health_Dimensions_Group.ppt

Health Dimensions Group, handout entitled, *Health Dimensions Group VA State Home Experience and Expertise* and folder of organization materials and brochures.

Management Analysis & Development, *Group Consensus Decision-Making* handout prepared by Ryan Church, Senior Management Consultant.
http://www.admin.state.mn.us/documents/commission/Consensus_decisionmaking.pdf

Management Analysis & Development, *Timeline of Key Events at Minneapolis Veterans Home: 1887-2007* handout prepared by Renee Raduenz, Management Consultant.
http://www.admin.state.mn.us/documents/commission/Key_events.pdf

Minnesota Office of the Revisor of Statutes, Minnesota State Statutes, Ch. 198, Veterans Homes.
http://www.revisor.leg.state.mn.us/bin/getpub.phppubtype=STAT_CHAP&year=current&chapter=198

Minnesota Rules Table of Chapters for Minnesota Veterans Homes Board of Directors and Veterans Homes, Chapter 9050.
<http://www.revisor.leg.state.mn.us/arule/9050/>

Minnesota Veterans Homes, PowerPoint presentation handouts prepared by Charles (Chip) Cox, Interim Executive Director, Minnesota Veterans Homes Board.
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Minnesota Veterans Homes Board of Directors, folder including brochures on Minnesota Veterans Homes and programs.

Sister Mary Madonna Ashton, Commissioner of Health, [*Report on the Minnesota Veterans Home in Minneapolis*](#), August 27, 1987

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Governor's Long-Term Care Advisory Commission revised Charge/Charter prepared by Chairman Dale Thompson and Management Analysis & Development, May 2007.

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Meeting Minutes (draft) from May 16, 2007 Governor's Long-Term Care Advisory Commission meeting.

http://www.admin.state.mn.us/documents/commission/Minutes_051607.pdf

Minnesota Statutes, Minnesota Statute Index 2006, Veterans Homes and Veterans Homes Board.

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Minnesota Veterans Homes, PowerPoint presentation prepared by Charles (Chip) Cox, Interim Executive Director, Minnesota Veterans Homes Board (revised version presented at May 16 meeting).

http://www.admin.state.mn.us/documents/commission/MVH_CC_update.ppt

Minnesota Veterans Homes, PowerPoint presentation handouts prepared by Dan Williams, Vice Chairman of Veterans Home Board, May 31, 2007.

http://www.admin.state.mn.us/documents/commission/MVH_presentation.ppt

Minnesota Veterans Homes, Veterans Homes Board Policies, 2004.

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Windham, Diane M.; letters to Senator Linda Berglin, September 25, 2006; and Governor Pawlenty re: A suggestion concerning the Minnesota Veterans Home; February 10, 2007. Letter to Sen. Berglin:

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Letter to Gov. Pawlenty:

http://www.admin.state.mn.us/documents/commission/Windham_email.pdf

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<http://www.caringbridge.org/>, May 31, 2007.

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http://www.admin.state.mn.us/documents/commission/062807_afscme_council_5.pdf

Cox, John, Commander; Commanders' Task Force, testimony to Governor's Veterans Long-Term Care Advisory Commission, June 28, 2007.

http://www.admin.state.mn.us/documents/commission/062807_commanders_task_force_cox.pdf

Kyser, Jerry; United Veterans Legislative Council of Minnesota; testimony to Governor's Veterans Long-Term Care Advisory Commission, June 28, 2007.

http://www.admin.state.mn.us/documents/commission/062807_uvlc.pdf

Berry, Shawn, HST; American Federation of State, County and Municipal Employees (AFSCME) Council 5, testimony to Governor's Veterans Long-Term Care Advisory Commission, June 28, 2007.

http://www.admin.state.mn.us/documents/commission/062807_afscme_council_5_berry.pdf

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http://www.admin.state.mn.us/documents/commission/062807_vfw.pdf

Lange, Linda, RN, JD; Minnesota Nurses Association, testimony to Governor's Veteran's Long-Term Care Advisory Commission, June 28, 2007.

http://www.admin.state.mn.us/documents/commission/062807_mn_nurses_assoc_lange.pdf

New York Times, Most nursing homes have too few workers, study says, article handed out by Minnesota Nurses Association, unknown date.

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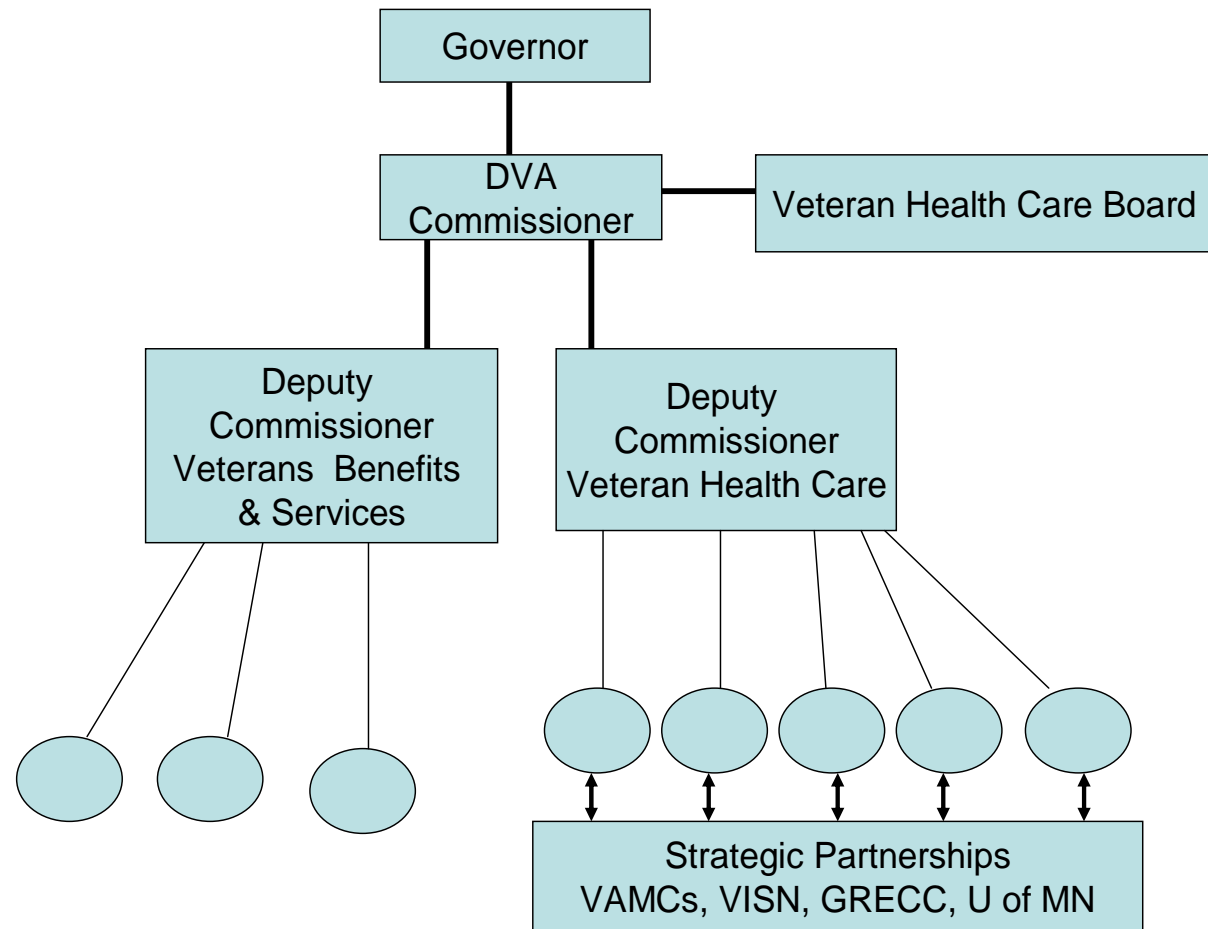
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Appendix N Governance Structure



Appendix O Press Release



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“Serving Veterans and their spouses since 1888”

Media Advisory

Contact: Sandra Larson
Phone: 651-297-5251

FOR IMMEDIATE RELEASE
Date: October 18, 2007

MINNESOTA VETERANS HOMES BOARD ANNOUNCES NEW EXECUTIVE DIRECTOR

Jeff Johnson, Chair of the Minnesota Veterans Homes Board announced today that Mr. Gilbert Acevedo has accepted the position of Executive Director for the State Veterans Homes.

Mr. Acevedo will be moving from Poway, California where he has been serving as the administrator of the California Veterans Home - Chula Vista - a 400 bed Continuum Care Retirement Community which provides three levels of care (independent, assisted and skilled nursing) and an ambulatory care clinic. Acevedo has been employed by the Veterans Home - California for five and a half years also serving as the Assistant Deputy Secretary, California Department of Veterans Affairs; Assistant Administrator; Chief, Medical Administrative Services; and Residential Care for the Elderly Administrator, California Department of Veterans Affairs.

Currently, Mr. Acevedo is a member of the American College of Health Care Executives, American College of Health Care Administrators, California Association of Health Care Facilities, San Diego Organization of Healthcare Leaders, American Legion, American Veterans, Military Order of the Cooties, Veterans of Foreign Wars, Disabled American Veterans, Marine Corps League and United States Submarine Veterans.

Prior to joining the California Veterans Home - Chula Vista, Acevedo served in the U.S. Navy from 1978 to 2001, retiring with the rank of Command Master Chief. As Command Master Chief, he held the title of executive manager and operated a medium sized hospital and 14 ambulatory clinics throughout the state of California. He traveled to the locations to meet with staff and troubleshoot operational issues.

"The Board in its unanimous decision is very pleased to have Mr. Acevedo join and lead the agency, his background and experience is exactly what the Board has been looking for to lead the agency into the future, said Chairman Johnson."