MINNESOTA

Department of Administration

MANAGEMENT ANALYSIS DIVISION

An analysis of

THE NEED FOR ADDITIONAL VETERANS NURSING HOMES IN MINNESOTA

1989

Pursuant to 1989 Laws, Chap 332, Section 2

An analysis of

The Need for Additional Veterans Nursing Homes in Minnesota

Minnesota Department of Administration

Management Analysis Division

December 1989

203 Administration Building, 50 Sherburne Avenue, St. Paul, Minnesota 55155

STATE OF MINNESOTA

Department of Administration

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February 1, 1990

The Honorable Rudy Perpich
Governor
130 State Capitol Building

Patrick E. Flahaven
Secretary of the Senate
231 State Capitol Building

Edward A. Burdick
Chief Clerk, House of Representatives
211 State Capitol Building

Dear Gentlemen:

Pursuant to Laws of Minnesota 1989, Chapter 332, Section 2, Subd. 1, the Department of Administration has completed a study in cooperation with the Veterans Home Board of Directors and the Interagency Board for Quality Assurance to assist the legislature to determine if additional veterans homes should be established in any health systems agencies regions of the state not currently served by a veterans home.

The results and recommendations of the study are contained in the enclosed report.

Sincerely,

Sandra J. Hale
Commissioner
Department of Administration

SJH/TLB

200 Administration Building
50 Sherburne Avenue
Saint Paul, Minnesota 55155
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An analysis of

The Need for Additional Veterans Nursing Homes in Minnesota

Executive Summary

EXECUTIVE SUMMARY

The 1989 Legislature directed the commissioner of administration to study the need for additional veterans nursing homes in regions of the state not currently served by state veterans nursing homes. If need for additional homes was documented, the legislation directed the commissioner to identify potential sites for additional homes.

Veterans demographics

About 485,000 veterans lived in Minnesota in 1989. By the year 2000, the veterans population is projected to decrease by 15 percent. Between 1989 and 2020, it is expected to decrease by 41 percent.

While the veterans population decreases, it will also age. Currently, the population is concentrated between the ages of 35 and 64, with a median age of 52. By 2020, nearly half the state's veterans will be over 65 years of age, the time of life when nursing home or other long-term care is most needed.

Long-term-care options for veterans

Long-term care, often equated with nursing home care, also includes home- and community-based services. Most people who need long-term care receive it informally in their homes from relatives or friends.

In 1989, an estimated 4,120 Minnesota veterans resided in nursing homes. That number is expected to rise to 6,709 in the year 2000, and to peak at 9,082 in 2010 before gradually declining. Approximately 78 percent of Minnesota veterans who need nursing home care receive it in community nursing homes (funded independently of any veterans program), while 14 percent receive it in community nursing homes under contract to the U.S. Department of Veterans Affairs (VA) or in VA Medical Centers, and 8.4 percent in the Minnesota Veterans Home in Minneapolis.

Home- and community-based services for all older Minnesotans are supported by the state's Alternative Care Grant Program. The state does not provide alternative care specifically for veterans.

Evaluating the need for additional veterans nursing homes

Determining the need for another state nursing home requires looking at veterans' population growth and nursing home use estimates, costs of building and operating the facility, the appropriateness of the care offered by such a facility, management of

the current veterans nursing home system, and current fiscal problems within the VA.

Population growth and nursing home utilization estimates do not indicate a need for additional nursing home beds in the next four to six years.

Current occupancy rates leave more than enough empty beds to accommodate those veterans within the existing system.

Too many beds are currently used by Minnesotans who could better be served outside of a nursing home. The state pursues the use of alternative care services by requiring all potential nursing home residents to be screened before admittance. The screening diverts individuals who do not need the range of care offered in a nursing home into settings more appropriate to their needs. The effect of the screening process can be seen in declining nursing home utilization rates. Continued diversion of individuals into other care settings will slow the growing need for nursing home beds in the future, while providing more appropriate care for state citizens.

With the addition of 89 beds at the Silver Bay home, the state will not need more veterans home beds until sometime between the years 1995 and 2000 in order to maintain the level of service it currently provides. If the state-approved Luverne facility, providing an additional 83 beds, receives federal funding, the state will not need to add capacity to the system until after the year 2000.

A state veterans home will cost more than using existing nursing homes or alternative care services.

The total per-day cost of community nursing home care averages $73.19 for each resident. The per-day cost of a new veterans home would be $114.76 per resident (in a 60-resident home).

On average, it will cost the state $883,773 per year more to operate a new 60-resident veterans home than it would to care for the same number of veterans in an existing community nursing home.

The average annual cost to the state of an alternative care grant is $2,823 per recipient. The average annual cost to the state of providing nursing home care in a new veterans home is $20,332 per resident in a 60-resident home and $16,836 per resident in a 120-resident home.

A state veterans home may not provide care appropriate to the needs and desires of Minnesota's veterans or be the best use of the limited state resources allocated for veterans' programs.

The state should ensure that the care offered to its veterans is appropriate to their needs. A nursing home bed should be viewed as the last resort: Only in the absence

of other alternatives should an individual be placed in a nursing home. People who are capable of living on their own with some aid from family or the state should not have to face confinement in a nursing home and the loss of independence that can result in a decreased quality of life.

According to polls, 92 percent of veterans want to stay out of nursing homes as long as possible. Polls also indicate that veterans want to remain close to friends and family if they must live in a nursing home. Placing veterans in local homes would keep them near friends and family, in contrast to a state veterans home, which may be hundreds of miles away from home.

Additional veterans homes may place difficult burdens on system management.

The Veterans Homes Board of Directors is in the process of correcting management problems at the current homes. To this job has been added establishment and operation of the Silver Bay facility, a 26 percent expansion of the veterans home system. The board faces a challenging task ahead.

Existing nursing home bed capacity could absorb some of the demand for nursing home care before additional homes are needed.

The Minneapolis VA Medical Center currently operates 40 extended-care beds, but has the capacity for a total of 120 beds. Eighty beds are not being used because the funding for their operation is not available. The state also has a surplus of community nursing home beds that the VA could make use of through its community nursing home contract program. The advantage of this approach is that it would bring federal funds into the state and make use of excess capacity with little or no cost to the state.

The current fiscal crisis facing the U.S. Department of Veterans Affairs may affect future federal payments to the state.

Future funding for the VA is uncertain. Recent budget problems have forced the department to cut back on the health care services it offers to veterans. It is possible that state veterans health care commitments made today may greatly exceed cost estimates that are based on historical analysis, and the more expensive the state program, the more severe the impact may be.

Funding selected alternative care services would de-emphasize institutionalization.

State-administered alternative services for veterans could build on the existing capacity of the VA Medical Centers and the state's Alternative Care Grant Program in delivering alternative long-term-care services.

Offering case management to veterans would help them find and choose appropriate long-term-care services.

Recommendations

Based on the findings of this study, three recommendations are offered.

Recommendation 1.

The State of Minnesota should not, at this time, construct and operate additional veterans nursing homes. With the completion of Silver Bay, the state will not need additional veterans nursing homes until the late 1990s. The state should make use of the nursing home capacity that is already in place before building additional veterans nursing homes. The legislature has several options regarding the Luverne veterans home.

Recommendation 2.

The State of Minnesota should expand the array of long-term-care services offered to veterans. The state should develop alternative care services, such as home supportive care, in cooperation with the VA, and establish a demonstration project to provide case management to a limited number of veterans.

Recommendation 3.

As the Veterans Homes Board develops its long-range plans, it should consider questions about whom it is going to serve and how it will best serve them. To assist in answering these questions, a comprehensive survey of veterans' needs and desires should be conducted. Identification of veterans' status on statewide preadmission screening forms would provide useful data.

An analysis of

The Need for Additional Veterans Nursing Homes in Minnesota

Introduction

INTRODUCTION:

Background

The 1989 Legislature directed the Department of Administration to study the need for additional veterans nursing homes in regions of the state without a veterans home and to recommend locations if the study found a need for more homes.

Specifically, Chapter 332, 1989 Minnesota Laws, requires that the commissioner will:

> . . . in cooperation with the veterans home board of directors and the interagency board for quality assurance, . . . complete a study that will assist the legislature to determine:
>
> (1) if additional veterans homes should be established in any health systems agencies regions of the state not currently served by a veterans home; and
>
> (2) in which communities homes should be sited if the study determines additional homes are necessary.

The Department of Administration's Management Analysis Division was responsible for conducting the study.

The project team members were Gail Dekker, Laura Himes Iversen, John Mikes and Paul Schweizer, led by William Clausen. Assistance was provided by Charlie Ball, Barbara Deming, Nancy Hoglund, M. Jill Lafave, Karen Patterson, Jeff Rathermel, Mark Scipioni and Mary Williams.

Methodology

The study was divided into two phases. Phase 1 was designed to evaluate the need for additional veterans nursing homes. Minnesota currently serves veterans needing long-term care in the Minnesota Veterans Homes in Minneapolis and Hastings. The Minneapolis home provides 346 licensed skilled nursing home beds and 194 domiciliary beds; the Hastings home has 200 domiciliary beds. In addition, the legislature and the U.S. Department of Veterans Affairs (VA) have authorized the construction of an 89-bed veterans nursing home in Silver Bay.

The legislature has also approved the establishment of a veterans home in Luverne. Application to the VA for construction funds for an 83-bed facility was submitted in the summer of 1989. The legislation for this study contemplates the reconsideration of the Luverne home authorization under certain conditions. Specifically, the legislation states:

> LACK OF FEDERAL FUNDING: If the funds to be provided by the federal government are not approved by December 1, 1989, the future authorization of the siting of a veterans nursing care facility in Luverne must be considered in the study provided by section 3. If the need for a veterans home is found to exist in southwest Minnesota, the site of the home must be in Luverne (M.S. 256B.056).

The Luverne application for construction funds has been approved by the VA, but the funds had not been appropriated as of Dec. 1, 1989. In accordance with the legislation, this study considers the need for additional veterans homes in Health Systems Agencies Region 6 as well as the health systems agencies regions that do not have a veterans home operating or authorized within their boundaries.

Phase 2 of the study was designed to locate sites for additional homes in the event that Phase 1 led to a determination that additional homes are needed.

The information for Phase 1 was obtained through data collected from a variety of sources, including the U.S. Department of Veterans Affairs; the Minnesota departments of Employee Relations, Health, Human Services, Jobs and Training, and Veterans Affairs; the state demographer, the Veterans Homes Board of Directors, the Minneapolis and Hastings veterans homes and the Interagency Board for Quality Assurance; nursing home associations; and long-term-care experts. The study team reviewed background documents, including studies of veterans' long-term-care needs in Minnesota, other states and the nation, and interviewed officials of the VA, the Minnesota Department of Veterans Affairs, the Veterans Homes Board of Directors, the Minneapolis and Hastings veterans homes, nursing home associations and congressional staff.

Scope

This study evaluates the need for veterans homes in Minnesota regions that have none. As mandated in Chapter 332, Sec. 2, Subd. 2, of 1989 Minnesota Laws, the study considers the following factors:

(1) the projected number of veterans needing nursing home care in the state and in each health systems agencies region of the state;

(2) the availability and feasibility of other long-term-care alternatives for veterans;

(3) the impact that additional veterans homes would have on existing community nursing homes;

(4) the availability of federal funding for construction and operation of additional veterans homes and the impact of other federal regulations;

(5) the overall cost to the state of a veterans home in each studied health systems agencies region of the state; and

(6) the Veterans Homes Board of Directors' long-term plan for veterans' health care.

This report documents the results of the study. Part 1 of the report describes Minnesota's veterans population, with particular attention to aging veterans, the primary clientele for a new veterans nursing home.

Part 2 identifies the choices available to a veteran in need of long-term care. It also discusses federal and state long-term-care policies as they affect the availability of each alternative.

Once the report has described the numbers and locations of aging veterans and the long-term-care choices available to them, it then projects veterans' demand for one source of long-term care: nursing homes. Part 3 discusses the assumptions required in projecting demand for nursing home care, and presents the number of veterans who are likely to require nursing home services in the future.

Part 4 then analyzes the key considerations necessary in determining how Minnesota should serve the veterans identified as needing nursing home care. These factors include the percentage of all veterans in nursing homes that should be served in state veterans homes, the appropriateness of nursing home care, the cost of veterans home care compared with the cost of alternatives, the impact that additional veterans homes would have on community nursing homes, and the availability of federal funding for veterans homes and alternative long-term care.

Based on the analysis in Part 4, Part 5 discusses the recommendations of the project team.

Assumptions

The following assumptions were used in analyzing the need for new veterans nursing homes:

A new veterans home would be a skilled nursing facility.

The demographics of the aging veterans population suggest that future need for skilled nursing care will increase. It is therefore assumed that a skilled nursing facility would be an appropriate starting point for expansion of state veterans home services to the geographic areas of this study. As defined by the Minnesota Department of Health, a nursing home "provides for the accommodation of persons who are not acutely ill and not in need of hospital care, but who do require nursing care and related medical services. Examples of nursing care include: bedside care and rehabilitative nursing techniques, administration of medicines, irrigations and catheterizations, a modified diet regime, application of dressings or bandages and other treatments prescribed by a physician. In addition, the social, religious, education and recreational need of these patients must be fulfilled" [1].

A preliminary estimate of preferred size for a new state veterans home would be in the range of 60 to 120 beds.

Regulations of the VA (38 CFR, Chapter 1, Section 17.177) indicate that staffing economies occur at the level of a 50-bed nursing home care facility, with a normal range of 40 to 60 beds per unit. Discussions with VA state nursing home program staff indicate that a range of 60 to 120 beds is appropriate for analysis of a new state veterans nursing home. For purposes of this study, it was assumed that a minimum size of one 60-bed unit and a maximum size of two such units would be appropriate.

A new facility would provide general long-term care for veterans, similar to that provided to male residents of community nursing homes, rather than a specialized service such as treatment for chemical dependency, mental illness or Alzheimer's disease.

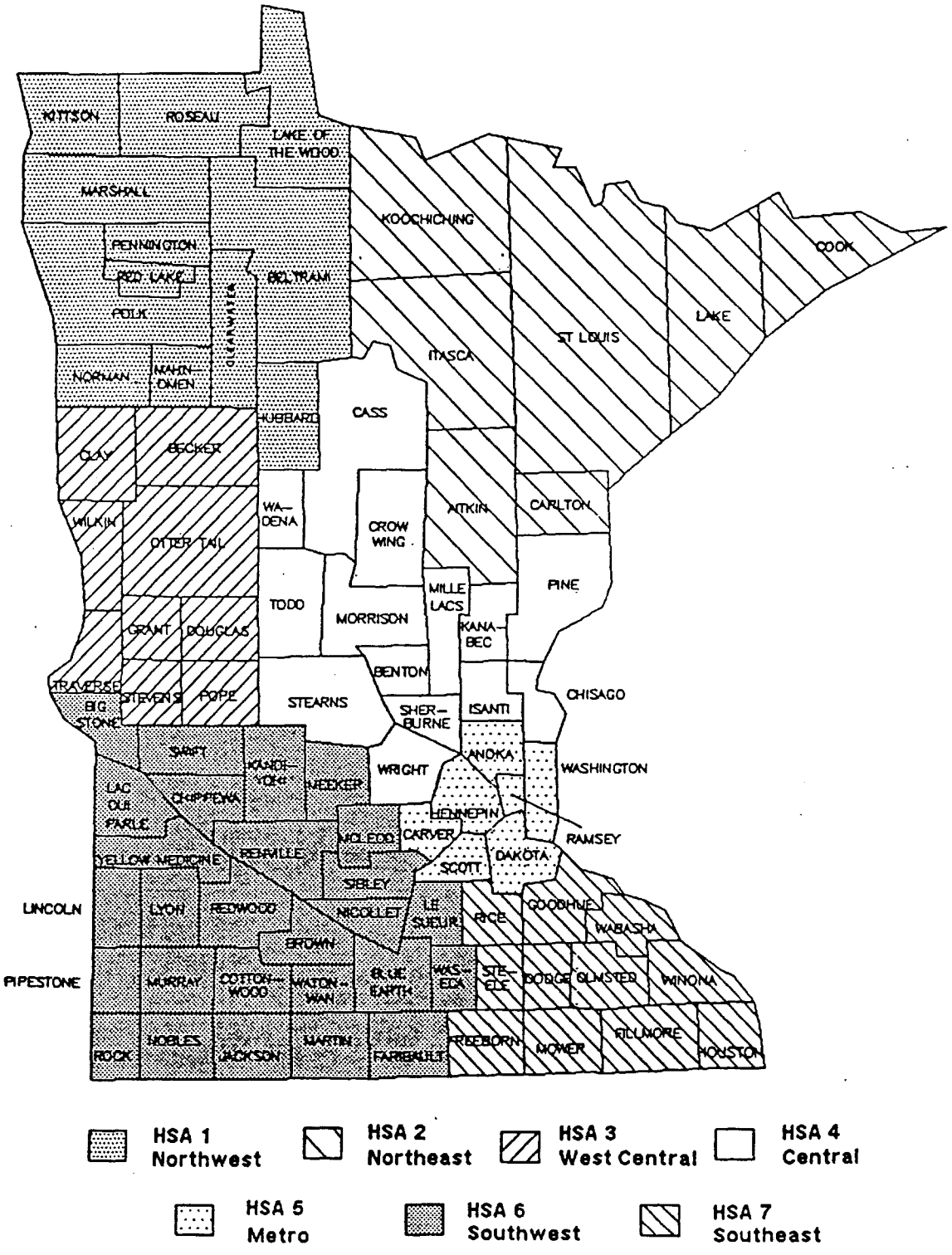
These assumptions are the same as those applied in the report, "Potential Sites for a State Veterans Home: Southwest Minnesota and Fergus Falls," prepared by the Minnesota Department of Administration, Management Analysis Division, in February 1989.

Enabling legislation for this report envisions a regional analysis and comparison of the need for veterans homes. The legislation requires that health systems agencies regions be used for this analysis. HSA regions are shown in Figure 1. Since HSA Regions 2 and 5 are already served by existing or planned veterans homes (Silver Bay and Minneapolis, respectively), the legislature limited the study to HSA regions not served by veterans homes. This study focuses on Regions 1, 3, 4, 6 and 7.

Reference

1. Minnesota Department of Health, *Directory of Licensed and Certified Facilities,* Minneapolis, 1988.

Figure 1. Health systems agencies regions



An analysis of

The Need for Additional Veterans Nursing Homes in Minnesota

Part 1.

Minnesota's Veterans Population

MINNESOTA'S VETERANS POPULATION:

Introduction

Slightly fewer than a half-million veterans live in Minnesota today [1]. By the year 2000, the veterans population is projected to decrease by 15 percent. Between now and 2020, it is expected to decrease by 41 percent.

While the veterans population decreases, it will also age. Currently, the population is concentrated between the ages of 35 and 64, with a median age of 52. By 2020, nearly half the state's veterans will be over 65, the time of life when nursing home care is most likely needed.

MINNESOTA'S VETERANS POPULATION:

A statistical snapshot

According to U.S. Department of Veterans Affairs estimates, 485,362 veterans live in Minnesota and make up about 11 percent of the state's population. Ninety-six percent are male.

Most veterans served during the Vietnam era (155,900) or World War II (151,900). More than 85,000 served during the Korean Conflict and 3,100 during World War I. Nearly 110,000 served during periods of peace between wars (Table 1).

More than half the state's veterans live in the seven-county Twin Cities metropolitan area (HSA Region 5). The next largest concentrations are in central (HSA Region 4) and southwest (HSA Region 6) Minnesota, where about 10 percent live in each region. Other populations are 3 percent in HSA Region 1, 8 percent in HSA Region 2, 4 percent in HSA Region 3 and 9 percent in HSA Region 7 (Figure 2).

Veterans aged 65 and over comprise about a fifth of all veterans and 19 percent of Minnesota's elderly population. About 48 percent of all Minnesota men 65 and over are veterans.

Table 1. 1989 Minnesota veterans population by time of service*

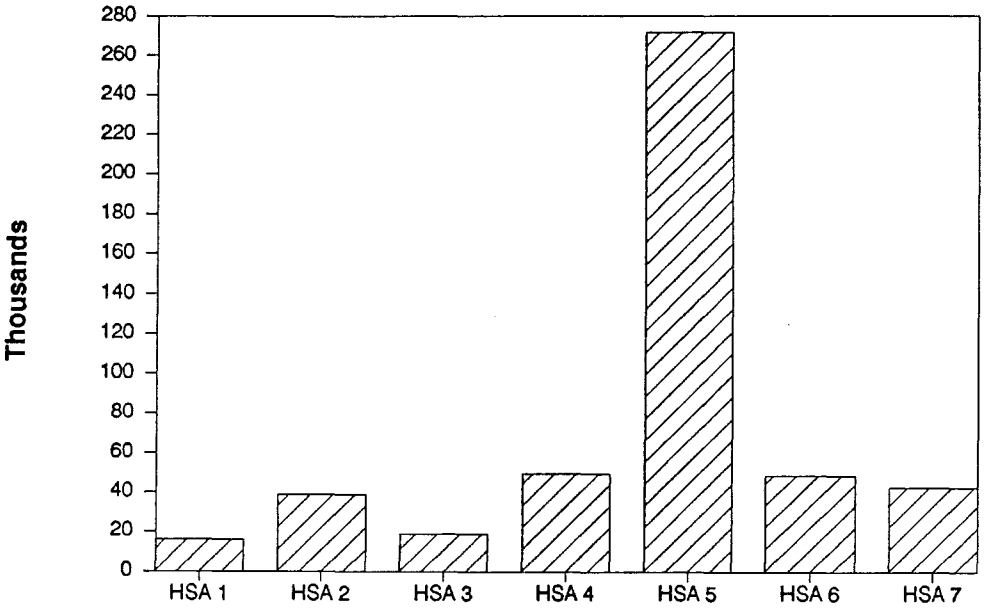
Vietnam era	Korean era	WW II era	WWI era	Peacetime	Total**
155,900	85,300	151,900	3,100	109,800	485,362

*Represents veterans who served during certain time periods, *not* the number of war or combat veterans.

**Because of overlapping periods of service (some veterans served during the Vietnam War and during peacetime, for example), the sum of the eras does not equal the number of veterans.

Source: "Minnesota Veteran Population by County and Period of Service," U.S. Department of Veterans Affairs, Statistical Policy and Research Service, 1989.

Figure 2. Veterans population by HSA region, 1989



Source: "Minnesota Veteran Population by County and Period of Service," U.S. Department of Veterans Affairs, Statistical Policy and Research Service, 1989.

MINNESOTA'S VETERANS POPULATION:

Population projections

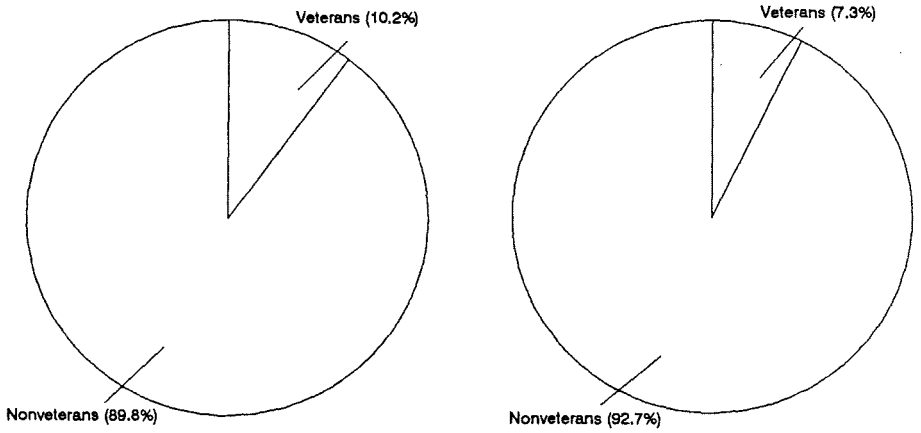
In contrast with state population as a whole, the population of veterans is expected to decrease.

Minnesota's population is projected to increase by 11 percent to 4,756,000 in 2010, according to the state demographer. The number of veterans will drop to fewer than 350,000 by 2010 and to fewer than 286,000 by 2020.

In 1995, veterans will total approximately 10 percent of the state's population; by 2010, the figure will be slightly more than 7 percent (Figure 3).

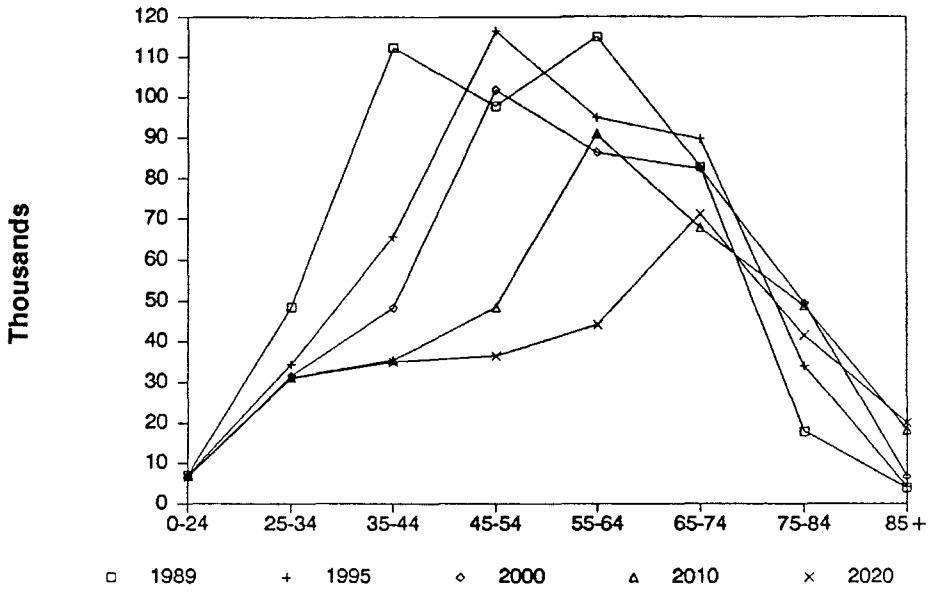
As the years pass, an increasing proportion of the state's population will be elderly. The number of Minnesotans over age 65 is projected to increase by 28 percent, the number of Minnesotans 85 and older by 77 percent.

Figure 3. Veterans as a percent of population, 1995 and 2010



Source: "Minnesota Veteran Population by County and Period of Service," U.S. Department of Veterans Affairs, Statistical Policy and Research Service, 1989.

Figure 4. Veterans by age group, 1989-2020

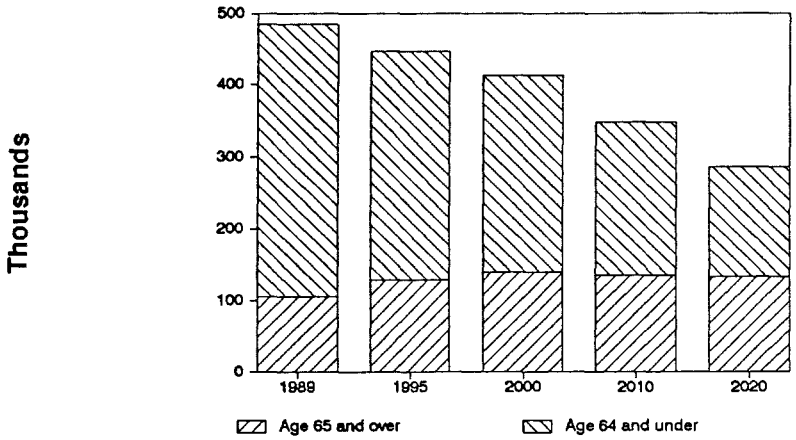


Source: "Minnesota Veteran Population by County and Period of Service," U.S. Department of Veterans Affairs, Statistical Policy and Research Service, 1989.

The veterans population will also get older (Figure 4). In 2000, veterans will be concentrated in the 45-to-74 age group. By 2010, they will be concentrated in the 55-to-84 age group.

Veterans 65 and over will comprise an increasing share of all veterans into the next century (Figure 5). However, the number of elderly veterans as a proportion of Minnesota's total elderly population will decrease after 2000. The number of veterans 65 or older is expected to grow to about 138,000 by the turn of the century and then to slowly decrease to about 133,000 by 2020 (Table 2).

Figure 5. Veterans 65 and over, 1989-2020



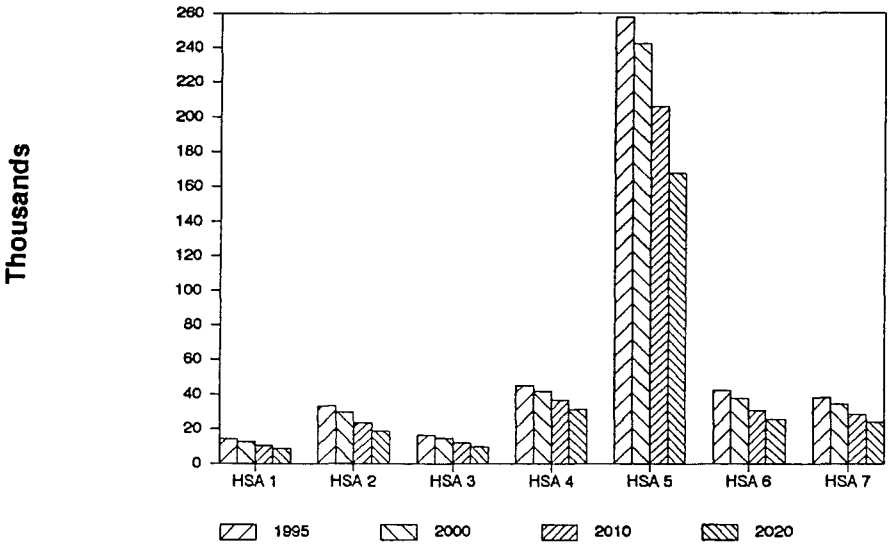
Source: "Minnesota Veteran Population by County and Period of Service," U.S. Department of Veterans Affairs, Statistical Policy and Research Service, 1989.

Table 2. Veterans population aged 65 and over by HSA region, 1989-2020

Region	1989	1995	2000	2010	2020
HSA 1	3,656	4,040	4,144	3,782	3,439
HSA 2	9,663	10,943	10,953	9,205	8,338
HSA 3	4,410	4,902	5,049	4,362	3,821
HSA 4	10,430	12,034	12,926	12,744	11,864
HSA 5	56,819	73,448	81,692	82,713	84,903
HSA 6	10,634	11,999	12,334	10,920	9,882
HSA 7	8,994	10,570	11,229	10,944	10,414
Totals	**104,606**	**127,936**	**138,327**	**134,670**	**132,661**

Source: "Minnesota Veteran Population by County," U.S. Department of Veterans Affairs, Statistical and Policy Research Service, 1989.

Figure 6. Veterans population by HSA region, 1995-2020



Source: "Minnesota Veteran Population by County and Period of Service," U.S. Department of Veterans Affairs, Statistical Policy and Research Service, 1989.

Table 3. Veterans population by HSA region, 1989-2020

Region	1989	1995	2000	2010	2020
HSA 1	15,912	13,956	12,503	10,347	8,714
HSA 2	38,769	33,381	29,859	23,481	18,672
HSA 3	19,012	16,332	14,630	11,785	9,678
HSA 4	49,424	45,127	41,783	36,552	31,285
HSA 5	271,577	257,588	242,435	205,877	167,731
HSA 6	48,334	42,140	37,740	30,764	25,723
HSA 7	42,334	37,940	34,471	28,634	24,056
Totals*	**485,362**	**446,464**	**413,421**	**347,440**	**285,859**

*Sum of columns may not equal totals because of rounding.

Source: "Minnesota Veteran Population by County," U.S. Department of Veterans Affairs, Statistical and Policy Research Service, 1989.

Projections of the veterans population by HSA region for 1995 to 2020 show that current geographic concentrations will continue, with the highest proportion living in the seven-county Twin Cities metropolitan area. Central Minnesota will continue to have the largest veterans population in Greater Minnesota, with southwest Minnesota second (Table 3 and Figure 6).

Appendix A shows veterans population projections by county.

Reference

1. All data in Part 1 is from "Minnesota Veteran Population by County and Period of Service," U.S. Department of Veterans Affairs, Statistical Policy and Research Service, 1989.

An analysis of

The Need for Additional Veterans Nursing Homes in Minnesota

Part 2.

Long-term-care Services for Minnesota Veterans

LONG-TERM-CARE SERVICES:

Introduction

In order to evaluate the need for additional veterans homes, it is important to know what long-term-care options are currently available to veterans in Minnesota. Long-term care, often equated with nursing home care, also includes a variety of home- and community-based services. In general, long-term care is "the provision of diagnostic, preventive, therapeutic and supportive services to patients of all ages with severe chronic disease or disability involving substantial functional impairment. The care, frequently of long duration, may be provided by a variety of health care professionals and other caregivers, formal and informal, in a variety of settings . . . ." [1].

Most people who need long-term care, including veterans, receive it informally in their homes from relatives or friends. It is estimated that 80 to 90 percent of all long-term care delivered to older persons is provided by informal (unpaid) caregivers [2].

In 1989, an estimated 4,120 Minnesota veterans, less than 1 percent of the state's veterans population, resided in nursing homes. Veterans who need nursing home care receive it in community nursing homes (funded independently of any veterans program), community nursing homes under contract to the VA, VA Medical Centers or the state veterans home in Minneapolis. Approximately 78 percent receive nursing home care in community nursing homes independent of the VA, while 14 percent receive it through the VA (in both VA Medical Centers and community nursing homes under contract to the VA) and 8.4 percent through the state veterans home.

In 1989, Medicaid and out-of-pocket payments funded more than 90 percent of all nursing home patient days.

Almost all state and federal programs that provide long-term care are structured to emphasize nursing home care. Home- and community-based services are not funded by the Minnesota Department of Veterans Affairs and only to a very limited extent by the VA. For the general population, Minnesota's largest source of funding for home- and community-based care is the state's Alternative Care Grant Program. This program, a part of Medicaid, serves approximately 1 percent of all older Minnesotans.

LONG-TERM-CARE SERVICES:

Institutional care

In Minnesota, more than 21 percent of veterans in nursing homes receive care that is paid for in part or in whole by the VA. Community nursing homes under contract to the VA, VA Medical Center extended-care beds, and the Minneapolis veterans home each provide about a third of VA-supported nursing home care.

State veterans' services

State-funded nursing home care for veterans is provided in the Minnesota Veterans Home in Minneapolis. In 1989, 8.4 percent of veterans in nursing homes received care in the Minneapolis home. This facility has 346 licensed nursing home beds. As of Aug. 16, 1989, 65 (19 percent) of the Minneapolis home's 341 residents were from HSA Regions 1, 3, 4, 6 and 7. The average length of stay for veterans in the Minneapolis home is 690 days [3]. The nursing home occupancy rate is 99 percent. Ninety-three percent of its residents are male. The average age is 74.

An 89-bed veterans nursing home in Silver Bay is expected to open in the summer of 1990, and the construction of a veterans home in Luverne would add 83 skilled nursing home beds to the system.

The Minneapolis home has a waiting list for admission. Admission is based primarily on an individual's place on the waiting list and on the home's ability to meet the individual's needs [4, 5]. The list may include persons who currently need long-term-care services as well as persons who expect to need such care in the near future. As of August 1989, 121 persons were on the waiting list; approximately 17 percent were from Regions 1, 3, 4, 6 and 7 [6].

The overwhelming number of residents in the Minneapolis home are veterans. Ten to 20 residents are spouses. The VA does not pay for the care of spouses at the veterans home.

The VA pays 65 percent of state veterans homes' construction costs. The VA also pays a per diem for each veteran in a state veterans home. The per diem for federal Fiscal Year 1990 is $21.83, about 30 percent of the home's maintenance charge to residents. The current charge for the nursing facility is $67.72 per day, or $2,029.40 a month [7].

Residents at the home contribute both their assets and income to the cost of care, but are not turned away because of inability to pay. The state carries the final responsibility for costs.

Table 4. Selected characteristics of VA Medical Centers, October 1988 through March 1989

VAMC	Region	Operating beds	Average daily census	Occupancy rate	Patients served
Minneapolis	5, near 4 and 7	40*	36	90%	121
Fargo	near 3 and 1	50	46	92%	189
Sioux Falls	near 6	75	73	97%	137
St. Cloud	4, near 3 and 1	130	151	116%**	262
Total		**295**	**306*** **		**709**

*This facility has the capacity for 120, but only 40 are currently operating because of VA funding cuts.

**The St. Cloud VA Medical Center is adding 96 nursing home beds.

***Approximately 246 were Minnesota veterans.

Source: U.S. Department of Veterans Affairs, *Summary of Medical Programs*, Washington, D.C., 1989.

The Veterans Homes Board operates two domiciliary care facilities that provide a level of care similar to that provided in boarding care homes. Both provide personal or custodial care exclusively, and residents are expected to have minimal medical needs. Domiciliary facilities are located in Minneapolis (194 beds) and Hastings (200 beds). Occupancy rates are 72 and 63 percent, respectively [6].

The Fiscal Year 1990 budget for the Minneapolis nursing and domiciliary facilities is $13.9 million. The budget for the Hastings home is $2.5 million [8].

VA services

Medical centers

VA Medical Centers serving Minnesotans are located in Minneapolis, St. Cloud, Fargo, N.D., and Sioux Falls, S.D. These facilities report an average daily census of 306, serving 709 veterans in the first half of federal Fiscal Year 1989 (Table 4) [9].

Table 5. Number of VA nursing home contracts and one-day census of veterans served by HSA region, quarter ending Sept. 30, 1988

Region	Number of contracts	Number of veterans served
HSA 1	4	6
HSA 2	6	19
HSA 3	9	12
HSA 4	24	42
HSA 5	49	192
HSA 6	23	17
HSA 7	12	20
Total	**127**	**308**

Source: U.S. Department of Veterans Affairs, Medical District 18, Minneapolis.

The VA provides for relatively short lengths of stay compared with the state veterans home or community nursing homes. The average length of stay in the Minneapolis VA Medical Center extended-care beds, for instance, is 56 days, while the average community nursing home stay is 461 days [10, 11]. Other VA Medical Centers may allow longer stays [9].

Contracts with community nursing homes

In addition to serving veterans in its medical centers, the VA also contracts with community nursing homes to provide care to eligible veterans. As of Sept. 30, 1988, the VA had 127 contracts with community nursing homes to serve 308 veterans (Table 5).

Unless the veteran has a service-connected disability, these contracts are limited to three months. After that, veterans would typically rely on their own out-of-pocket funds or Medicaid to pay the costs of care.

When determining their eligibility and priority for receiving VA hospital and extended-care services, the VA divides veterans into three categories: A, B and C. These categories are based on whether a disability is service-connected, the patient's income level and other factors.

Recently, VA budget cutbacks have limited its acute-care and extended-care services:

- It is anticipated that the Minneapolis VA Medical Center's Fiscal Year 1990 budget will stay at the Fiscal Year 1989 level [12].
- Forty of the 120 extended-care beds at the new Minneapolis VA Medical Center are open.
- Budget reductions have led the VA to limit VA Medical Center care to Category A veterans. About 98 percent of all persons treated for inpatient care at the VA Medical Centers in District 18 are Category A veterans, although an estimated 48 percent of Minnesota veterans fall into Category A [10, 13]. Category A includes veterans with service-connected disabilities, veterans with a VA pension, veterans exposed to Agent Orange or ionizing radiation, WWI and Mexican Border period veterans, veterans eligible for Medicaid, former prisoners of war, and veterans who meet a low-income test [9, 14].
- The contracts of veterans without service-connected disabilities who receive care in contract community nursing homes have been shortened from six months to three months by Minneapolis and St. Cloud VA Medical Centers in order to serve as many patients as possible [15].

The VA has one site for domiciliary care, a 60-bed facility at St. Cloud.

Community nursing homes

Approximately 78 percent of veterans who need nursing home care receive it in community nursing homes independent of state or federal veterans funding.

In 1987, there were 42,392 nursing home residents in Minnesota. Of these, 29,783 (70 percent) were women, 12,609 (30 percent) men [16].

Table 6. Estimated sources of payment for Minnesota community nursing home residents, 1989

Source	Share
Private pay	44 percent*
Medical Assistance	46 percent
Medicare	10 percent

*Includes all sources of private pay, such as out-of-pocket expenses, VA payments and private insurance through HMOs. It is estimated that the VA and HMOs together pay for less than 1 percent of all nursing home patient days.

Sources: Pam Parker, director, Long-term Care Management Division, and George Hoffman, director, Reports and Statistics Division, Minnesota Department of Human Services.

Cost of nursing home care

In July 1989, the average annual cost of a community nursing home stay in Minnesota was $24,382 ($66.80 per day) for Skilled Nursing and Intermediate Care 2 facilities [17]. Medicaid and private payments are the primary funders of nursing home care. In 1989, Medicaid paid approximately 46 percent of all nursing home care, private payments covered approximately 44 percent and Medicare paid 10 percent (Table 6).

Medicare is a federal program providing selected health care benefits to people 65 and older regardless of their income and assets. Long-term-care benefits covered under Medicare are limited. The program provides skilled nursing home care for a maximum of 150 days per year, but in practice the average length of stay is 12 days [18]. The average nursing home stay in Minnesota, in contrast, is 461 days. Medicare provides coverage only if beneficiaries require daily skilled nursing or rehabilitation that cannot reasonably be provided in any setting except a skilled nursing facility.

Because of Medicare's limited coverage, and because private insurance to cover long-term care is largely unavailable, inadequate or unaffordable, people frequently use their own resources first when paying for nursing home care, depleting them until eligible for Medicaid. Medicaid is a joint state and federal program providing selected health care benefits to people with low incomes. More than 90 percent of people living alone deplete their assets within a year of entering a nursing home, and

more than half of all married couples become impoverished within six months after one spouse enters a nursing home.

Consequently, Medicaid is a significant funder of nursing home care, paying approximately 46 percent of all nursing home costs. Medicaid does not allocate a significant portion of its budget to alternative care.

Of the state's $1.2 billion Medicaid budget in Fiscal Year 1988, approximately $441 million was spent on nursing home care, while less than 2 percent was spent on home health services. The total cost of Preadmission Screening and Alternative Care Grant programs was less than 1 percent of the Medical Assistance budget [20].

Nursing home occupancy

Compared with other states, Minnesota's elderly are heavy users of institutional long-term care. In 1987, Minnesota had 49,673 institutional long-term-care beds, or 94.2 licensed beds per 1,000 older persons. This compares with a national average of 60.7 beds per 1,000 [11].

Minnesota spends a relatively high proportion of state money on institutional care. Overall, approximately 91 percent of the state's long-term-care expenditures are for institutional care. This compares with a national average of 81 percent [11].

As Table 7 shows, nursing home occupancy rates range from 92 percent in Region 5 to 97 percent in Region 6. Data on nursing home beds and occupancy rates is presented by county in Appendix B.

In a 1989 report by the Interagency Board for Quality Assurance, long-term-care occupancy rates are used in conjunction with other factors to identify counties where additional nursing home beds may be needed [11]. Specific criteria used to identify these counties included whether the county had:

- a high occupancy rate (more than 97.5 percent);
- a low utilization rate (at the median or lower);
- a high case mix (above the mean); and
- a high number of persons (that is, above the mean) served by the state's Alternative Care Grant Program.

Table 7. Nursing home beds and occupancy rates by HSA region, 1987

Region	Licensed nursing home beds	Nursing home bed occupancy
HSA 1	2,196	94%
HSA 2	3,421	96%
HSA 3	2,972	96%
HSA 4	5,084	95%
HSA 5	19,140	92%
HSA 6	6,924	97%
HSA 7	5,252	95%
Total	**44,989**	**94%**

Source: Sharon Mitchell, Minnesota Department of Health, 1989.

"Occupancy rate" refers to the percentage of available nursing home beds filled at a given point in time. "Utilization rate" refers to the percentage of the elderly population that uses nursing home beds. "Case mix" is a scale that reflects the level of care a nursing home patient needs and determines the level at which the state reimburses nursing homes for caring for Medicaid residents.

Four counties in Minnesota meet all these criteria; two, Nobles and Stearns, are in regions pertinent to this study — 6 and 4, respectively.

State long-term-care policy

In the early 1980s, the state's rising nursing home expenditures (that is, Medicaid payments to nursing homes for low-income elderly) and concerns about the quality of life for older persons led the legislature to take steps to discourage reliance on institutional care and to encourage the use of alternative services. Two major pieces of this policy include a nursing home moratorium and the Preadmission Screening/Alternative Care Grants Program.

THE NURSING HOME MORATORIUM

The legislature enacted a moratorium on the certification of new Medicaid nursing home beds in 1983. The moratorium was extended to the licensure of nearly all nursing home beds in 1985. The legislature cited the reasons for imposing the moratorium (M.S. 144A.31):

- Medical Assistance expenditures were increasing at a much faster rate than the state's ability to pay for them.
- Nursing home and related costs amounted to more than half of all Medical Assistance costs, so controlling them was "essential to prudent management of the state's budget."
- Construction of new nursing homes and the addition of new nursing home beds inhibited "the state's ability to control expenditures."
- Minnesota led the nation in nursing home expenditures per capita and had the fifth highest number of nursing home beds per capita in the country.
- Private-pay patients and Medical Assistance recipients had "equivalent access to nursing home care."
- The state's dependence on institutions to care for the elderly was "due in part to the dearth of alternative services in the home and community."
- "[I]n the absence of a moratorium, the increased numbers of nursing homes and nursing home beds will consume resources that would otherwise be available to develop a comprehensive long-term-care system that includes a continuum of care."

The only facilities currently exempt from the moratorium are exempted in statute: the two state nursing homes — Ah-Gwah-Ching and Oak Terrace, a new nursing home on the Red Lake Indian Reservation, and the Minnesota Veterans Homes.

The moratorium legislation permits new certified or new licensed nursing home beds "... to address an extreme hardship situation in a particular county" (M.S. 144A.073, Subd. 3(a)). To qualify for the hardship exception, a county must have fewer nursing home beds per 1,000 elderly than the national average, plus 10 percent.

According to the 1989 Interagency Board for Quality Assurance report, "There is currently no county or county-region in the state that qualifies as an 'extreme hardship' case in terms of bed supply. . . . [T]he bed supply in Minnesota is so generous that *every* county-region has a bed supply at least 20 percent larger than the national average" [11].

The Minnesota Health Department has not permitted any increase in the number of nursing home beds since the moratorium became law [21].

Table 8. Veterans' use of nursing home care in Minnesota, 1989

Community homes	3,220	(78.2%)
Community homes with VA contracts	308	(7.5%)
State veterans home	346	(8.4%)
VA Medical Center extended-care units	246	(6.0%)
Total	**4,120**	

Sources: U.S. Department of Veterans Affairs, Medical District 18, Minneapolis, 1989; Minnesota Department of Administration, 1989.

PREADMISSION SCREENING/ALTERNATIVE CARE GRANTS

Minnesota has required preadmission screening of nursing home applicants since 1983. Under this program, all persons seeking nursing home admission are evaluated to determine if nursing home care is appropriate and to arrange alternative community-based care if possible.

The purpose of preadmission screening, according to the Minnesota statute, is to prevent inappropriate nursing home placement for all persons seeking admission to Medical Assistance-certified, licensed nursing homes. In Fiscal Year 1989, 22 percent of men and 31 percent of women participating in preadmission screening were diverted from long-term nursing home stays and were served in the community or in short-term placements [22]. The program is operated in conjunction with the state's Alternative Care Grant Program, which provides alternative care services to persons who are at risk of institutionalization and who meet Medicaid requirements or who would be eligible for Medicaid after 180 days of nursing home care.

Veterans' nursing home use

Table 8 provides estimates of the number of veterans receiving nursing home care through the state veterans home (assuming 100 percent occupancy), through the VA system (either in VA Medical Center facilities or in community nursing homes with VA contracts) and in community nursing homes.

Table 9. Boarding care home beds and occupancy rates by HSA region, 1987

Region	Licensed boarding care home beds	Boarding care home bed occupancy
HSA 1	410	77%
HSA 2	228	78%
HSA 3	111	94%
HSA 4	197	97%
HSA 5	2,970	86%
HSA 6	505	84%
HSA 7	302	83%
Total	**4,723**	

Source: Interagency Board for Quality Assurance, 1989.

Boarding care homes

A boarding care home provides personal or custodial care exclusively. Boarding care homes provide care at a level comparable to that provided in a domiciliary home. In 1987, there were 107 licensed boarding care homes in Minnesota, providing 4,723 beds. Most boarding care homes are certified to participate in Medicaid. Table 9 shows the number of licensed boarding care beds and occupancy rates by HSA region.

As with nursing homes, boarding care homes are primarily funded by Medicaid and out-of-pocket payments [19].

LONG-TERM-CARE SERVICES:

Alternatives to nursing home care

Options are limited for veterans seeking alternatives to nursing home care. The Minnesota Veterans Homes Board does not provide any home- or community-based care for veterans.

VA Medical Center

VA alternative long-term-care benefits are currently available only to Category A veterans. Home care is provided through the VA's Hospital Based Home Care Program and through payment to public health nursing services. Such benefits are available only through the VA Medical Center in Minneapolis.

Other long-term-care options available through at least one VA Medical Center serving Minnesotans include adult day health care, respite care, rural case management, geriatric evaluation units, Alzheimer's units and community residential care (Table 10).

A detailed description of these services is provided in Appendix B. The number of sites for these programs and the number of persons served by them are low. Adult day health care, for instance, is offered at six sites in Minnesota, with an average daily census of less than 10 in the nonmetropolitan area. The total number of respite care beds available at all four VA Medical Centers is approximately seven. Furthermore, rural case management is available only through the Minneapolis VA Medical Center, and St. Cloud is the only VA Medical Center with an Alzheimer's unit.

The general long-term-care system

Alternatives to nursing home care are more accessible in the general long-term-care system than in the VA system, although the general system is still heavily biased toward institutionalization. An estimated 80 percent of long-term care is provided on an informal, unpaid basis by wives, daughters and other family members [2].

Very limited funding for home- and community-based care is available through Medicaid and Medicare. Generally, funding under these programs is for skilled nursing care and does not include supportive or custodial care (as would be provided by home health aides, for example). Overall, an estimated 51 percent of all home care is paid from out-of-pocket funds [23].

A primary source of alternative care funding is Minnesota's Alternative Care Grant Program. The same Minnesota statute that established preadmission screening also

Table 10. Community-based services available to Minnesota veterans through VA Medical Centers

Service	Minneapolis	St. Cloud	Sioux Falls	Fargo
Adult day health care	x			
Alzheimer's unit or beds		x		
Community residential care		x	x	
Geriatric evaluation unit	x	x	x	x*
Geriatric research, educational and clinical center	x			
Respite care	x	x	x	x
Rural case management	x			

*Inactive for the past two years due to VA funding cuts. Current plans are to resume services in the near future [23].

Sources: Kevin Gallagher, M.D., chief of geriatrics, Fargo, N.D., VA Medical Center, Oct. 10, 1989; Karen Weidner, planner, U.S. Department of Veterans Affairs, Medical District 18, Minneapolis.

established alternative care grants. Participation in this program became mandatory for all Minnesota counties in July 1983. Alternative care grants are used to fund services that allow prospective nursing home residents to stay in their own homes, including adult day care, home health aide or personal aide assistance, respite care, adult foster care, supplies and equipment and case management. Persons are eligible for alternative care grants if they are 65 or older, are at risk for nursing home placement and meet income eligibility requirements. Alternative care grants cannot exceed 100 percent of the cost of nursing home care.

Minnesota operates this program through waivers of certain federal Medicaid requirements. In 1989, 7,434 clients received alternative care grant services [22], less than 1 percent of all older Minnesotans. In 1989, approximately 0.02 percent of the state Medicaid budget was allocated to preadmission screening and alternative care grant services [20].

Table 11. Alternative care grant clients receiving home- and community-based services, Fiscal Years 1986-89

	Fiscal year			
Service	1986	1987	1988	1989
Homemaker	2,454	2,238	2,778	3,487
Home health aide	3,355	3,287	3,997	4,780
Personal care	604	644	464	371
Adult day care	708	741	859	969
Respite care	567	496	258	312
Case management	4,702	4,531	5,528	6,574
Total	**12,390**	**11,937**	**13,884**	**16,493**
Unduplicated total*	**6,042**	**5,251**	**6,087**	**7,434**

*Total number of individual clients receiving services. Clients receiving more than one service are counted once.

Source: Barbara Colliander, supervisor, Home and Community Care Services, Long-term Care Management Division, Minnesota Department of Human Services.

The average length of time a person receives alternative care grant services is eight to nine months. The average annual cost of a grant to the state is $2,823.

Table 11 shows that the total number of Minnesotans receiving alternative care grant services rose substantially between 1986 and 1989, from 6,042 to 7,434, a 23 percent increase. Nevertheless, only about 1 percent of all older persons participated in the Alternative Care Grant Program in 1987 [11].

The number of Minnesotans receiving community-based services through alternative care grants increased by 49 percent between 1985 and 1988.

Veterans' use of these services is not known because veterans' status data is not collected on participants.

References

1. Somers, Anne, "Insurance of Long-term Care: Some Definitions, Problems, and Guidelines for Action," *The New England Journal of Medicine,* Vol. 317, No. 1, 1987, Pp. 23-29.
2. U.S. House of Representatives, Select Committee on Aging, *Exploding the Myths: Caregiving in America*, 100th Congress, First Session, January 1987.
3. Smith, Jeffrey, "Administrator's Report: Minnesota Veterans Homes at Minneapolis," July 1989.
4. Minnesota Veterans Homes, "Operating Policies and Procedures," Nov. 18, 1989.
5. Smith, Jeffrey, administrator, Minnesota Veterans Home - Minneapolis, Aug. 15, 1989, interview.
6. Minnesota Veterans Home - Minneapolis, unpublished data from Jeffrey Smith, administrator, regarding number of residents, average age of residents, county origin of residents and persons on the waiting list, July 1989.
7. Inwood, Jay, director of social services, Minnesota Veterans Home - Minneapolis, Aug. 15, 1989, interview, and Oct. 10, 1989, telephone interview.
8. 1990-91 Proposed Biennial Budget, State of Minnesota, St. Paul.
9. U.S. Department of Veterans Affairs, *Federal Benefits for Veterans and Dependents,* Washington, D.C., 1989.
10. Weidner, Karen, planner, U.S. Department of Veterans Affairs, Medical District 18, Minneapolis, Aug. 28, 1989, telephone interview.
11. Interagency Board for Quality Assurance, *An Analysis of the 1987 Distribution of Nursing Home Beds in Minnesota,* January 1989.
12. Ingber, Gary, chief fiscal officer, VA Medical Center, Minneapolis, Sept. 14, 1989, telephone interview.
13. Stockford, Dan, Department of Veterans Affairs, VA Statistical Research Service, Aug. 28, 1989, telephone interview.
14. Lindsey, Joseph, chief, Medical Administration Section, VA Medical Center, Minneapolis, Oct. 10, 1989, telephone interview.
15. Buran, Gretchen, director of social work, VA Medical Center, Minneapolis, Aug. 1, 1989, interview, and Aug. 28, 1989, telephone interview.
16. Mitchell, Sharon, Minnesota Department of Health, Health Resources Division, Survey and Compliance Section, August and September 1989 telephone interviews and unpublished data.
17. Carlton, Gordon, management analyst, Rule Administration and Policy Development Division, Department of Human Services, Oct. 25, 1989, telephone interview.
18. Prospective Payment Assessment Commission (ProPAC), "Medicare Prospective Payment and the American Health Care System: Report to the Congress," Washington, D.C., June 1989.
19. Parker, Pam, director, Long-term Care Management Division, Minnesota Department of Human Services, July 31 and Sept. 15, 1989, telephone interviews.
20. Richardson, Donald, Reports and Statistics Division, Minnesota Department of Human Services, unpublished Medicaid data, August 1989.
21. Kane, Anne, director, Interagency Board for Quality Assurance, Oct. 5, 1989, telephone interview.
22. Colliander, Barbara, supervisor, Home and Community Care Services, Long-term Care Management Division, Minnesota Department of Human Services, unpublished data, August and November 1989.
23. Gordon, Nancy, Congressional Budget Office, preliminary calculations based on estimates from the Actuarial Research Corporation, used in the report *InterStudy's Long-term Care Expansion Program: A Proposal for Reform*, InterStudy, Excelsior, Minn., 1988.

An analysis of

The Need for Additional Veterans Nursing Homes in Minnesota

Part 3.

Projecting Veterans' Demand for Nursing Home Care

PROJECTING VETERANS' DEMAND:

Introduction

In this part, the number of veterans in nursing homes is estimated and veterans' demand for nursing home care is projected.

Estimating current use of nursing home beds by veterans is a complex task. Projecting future demand is even more difficult. A wide range of variables affects the availability and appropriateness of the options that make up the overall long-term-care system. Data on these variables that would assist in projecting need is often not available. An absolute determination of need for nursing home beds in any future year, therefore, cannot be made. In order to develop reasonable projections of the potential demand for additional nursing home beds, analysts must rely on simplifying assumptions.

This study estimates that 4,120 veterans received nursing home care in 1989. That figure will rise to 6,709 in 2000 and peak at 9,082 in 2020.

PROJECTING VETERANS' DEMAND:

The VA formula

The VA uses a formula derived from 1985 population estimates to project veterans' demand for nursing home care. The formula uses utilization rates that estimate the number of men per 1,000 who need nursing home care in the population as a whole. The utilization rates are based on two assumptions: that veterans will need nursing home care at the same rate as all men, and that, in the future, men will use nursing homes at the current rate. The rates do not take into account the 4 percent of veterans who are women (separate rates for female veterans are not calculated by the VA), nor do they account for possible differences between the general male population and the veterans population. The rates also do not anticipate changes in health status, social supports and income that could affect long-term-care demand.

Utilization rates are developed for each VA Medical District and for different age groups (Table 12).

Using the VA utilization rates to estimate future Minnesota demand presents two problems:

- The VA rates take into account nursing home use in the Midwest census region, based on the 1985 National Nursing Home Survey. The states in the region have different nursing home utilization rates among men. The states include Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin.

- Because they were developed in 1985, the rates do not reflect more recent developments in long-term care.

Table 12. VA-estimated nursing home utilization rates for Medical District 18

Age	No. males in nursing homes per 1,000 males in general population
0-24	0.000
25-34	0.373
35-44	0.841
45-54	2.059
55-64	5.427
65-74	10.764
75-84	59.066
85+	201.701

Source: U.S. Department of Veterans Affairs, Medical District 18, Minneapolis, 1989.

PROJECTING VETERANS' DEMAND:

Minnesota-specific rates

For greater accuracy, it is possible to use Minnesota-specific utilization rates among males from more recent years that better reflect long-term-care trends in Minnesota.

Two sets of rates were developed for Minnesota based on data for 1985 and 1987 (the most recent year for which data was available). The assumptions are the same as the VA's assumptions in developing utilization rates. Veterans are assumed to use nursing home care at the same rate as males in the general population. Utilization of nursing homes equals the number of men in nursing homes divided by the number of men in the general population. It is assumed that the proportion of men using nursing homes now will be the same proportion using nursing homes in the future. Table 13 presents Minnesota-specific utilization rates.

Appendix C shows a breakdown by county and HSA region that displays veterans population estimates and nursing home demand estimates using the VA utilization rates and Minnesota-specific rates from 1985 and 1987.

The appendix shows the general trend toward a lower veterans population and an increased demand for nursing home care. The Minnesota-only rates reflect the recent trend toward diverting individuals away from nursing home care.

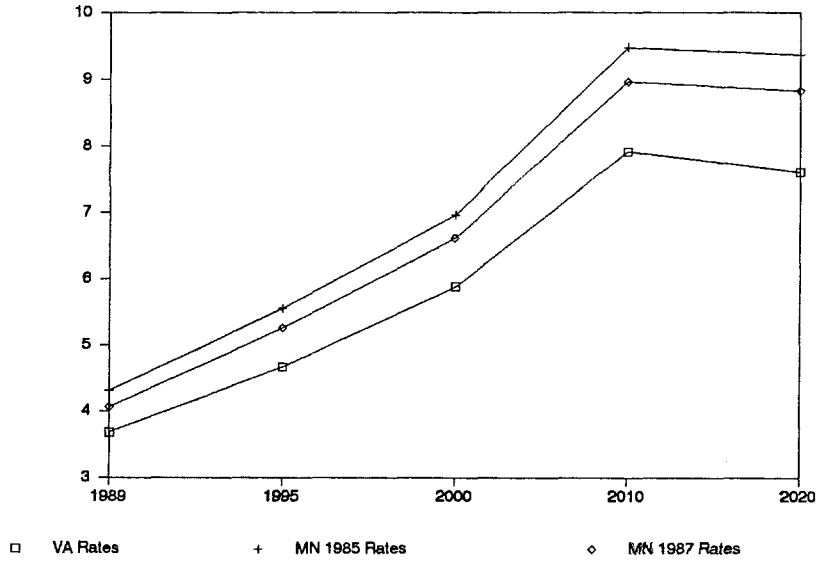
In both Minnesota-specific years, the utilization rates are higher than those for Medical District 18 as a whole. Projections based on the 1987 Minnesota rate are lower than the projections based on 1985 data but still higher than the VA projections (Figure 7, Table 14).

Table 13. Minnesota-specific nursing home utilization rates

	No. males in nursing homes per 1,000 males in general population	
Age	1985	1987
0-44	0.307	0.306
45-64	3.022	2.864
65-74	17.682	16.316
75-84	66.077	64.299
85+	261.056	243.105

Sources: Minnesota Department of Human Services, 1989; Minnesota State Demographer, 1983.

Figure 7. Veterans needing nursing home care, 1989-2020



Sources: U.S. Department of Veterans Affairs, Medical District 18, Minneapolis, 1989; Minnesota Department of Human Services, 1989; Minnesota State Demographer, 1983.

Table 14. Comparison of projections using Veterans Affairs and Minnesota-specific nursing home utilization rates for veterans*

	Regional VA util. rates	MN 1985 rates	Percent difference from VA	MN 1987 rates	Percent difference from VA	Percent difference from MN/85
1989	3,680	4,369	+18.7	4,120	+11.9	-5.7
1995	4,666	5,630	+20.7	5,336	+12.5	-5.2
2000	5,881	7,060	+20.1	6,709	+14.1	-5.0
2010	7,911	9,610	+21.5	9,082	+14.8	-5.5
2020	7,604	9,484	+24.7	8,941	+17.6	-5.7

*Based on the number of men in nursing homes. Assumes that male veterans will need nursing home care at the same rate as men in the general population.

Applying the VA utilization rates to 1989 population estimates indicates that about 3,680 veterans required nursing home care in 1989. The Minnesota rates from 1985 estimate that 4,369 veterans needed such care, a difference of 19 percent. The Minnesota rates from 1987 estimate that 4,120 veterans needed nursing home care. This is 12 percent higher than the VA estimate and 6 percent lower than the 1985 Minnesota-specific rates.

Applying any of the utilization rates to predicted populations indicates that nursing home care demand will increase due to the aging of the veterans population, despite decreases in the overall number of veterans. According to the Minnesota-specific 1987 rates, demand will peak around 2010, when 9,086 veterans will require nursing care services, an increase from 1989 of 117 percent.

After 2010, the demand for nursing home care will slowly begin to decrease; between 2010 and 2020, the Minnesota-specific 1987 utilization rates predict a drop of 1.6 percent.

This study relies on Minnesota-specific rates for 1987, since these are derived from the most recent available data and most accurately reflect Minnesota's rate of nursing home use. Table 15 shows the number of veterans needing nursing home care by HSA region as predicted by the Minnesota-specific 1987 rates.

Table 15. Estimates of veterans requiring nursing home care by HSA region, 1989-2020

	1989			1995			2000			2010			2020		
Region	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87
HSA 1	137	165	155	160	194	183	191	232	220	251	309	291	227	285	268
HSA 2	326	386	365	404	484	461	476	569	542	552	666	630	475	588	555
HSA 3	175	209	197	205	246	233	245	295	280	306	374	353	270	336	316
HSA 4	398	475	448	489	587	557	600	721	684	778	949	896	753	936	882
HSA 5	1869	2212	2084	2483	3004	2845	3240	3882	3692	4510	5456	5161	4481	5589	5274
HSA 6	422	502	474	500	601	570	604	725	689	774	944	891	691	861	811
HSA 7	352	421	396	424	513	486	525	635	602	741	913	860	708	889	836
Totals*	**3680**	**4369**	**4120**	**4666**	**5630**	**5336**	**5881**	**7060**	**6709**	**7911**	**9610**	**9082**	**7604**	**9484**	**8941**

*Sum of columns may not equal totals because of rounding.

An analysis of

The Need for Additional Veterans Nursing Homes in Minnesota

Part 4.

Evaluating the Need for New Veterans Nursing Homes

EVALUATING THE NEED:

Introduction

The use of projected numbers of veterans needing nursing home care is not sufficient to determine whether the state should build additional veterans nursing homes. Determining a need requires looking not only at the general demand for care, but also at several other factors:

- The proportion of all veterans in nursing homes that should be served in state veterans homes.
- The appropriateness of nursing home care.
- The cost of veterans home care compared with the cost of alternatives.
- The impact that additional veterans homes would have on community nursing homes.
- The availability of federal funding for veterans homes and alternative long-term care.

EVALUATING THE NEED:

Determining the proportion of veterans to be served in the state veterans home system

The first step in this analysis is to determine whether the impending increase in the number of veterans needing nursing home care translates into a need for additional state veterans homes.

Data presented in Table 15 of Part 3 indicates that 5,336 Minnesota veterans will need some form of nursing home care in 1995. That number rises to 6,709 in 2000 and 9,082 in 2010. If utilization rates do not drop significantly and if nursing homes prove the most appropriate option for older veterans, then the potential need for additional nursing home beds is strongly implied by the data. However, before the need for additional state veterans nursing home beds is determined, the proportion of veterans that state veterans homes should serve must be considered. In this section, the term "proportion of service" or "level of service" refers to the proportion of all veterans who need nursing home care that will be served by state veterans homes.

The social contract

Accurately projecting need for additional veterans nursing homes in Minnesota is affected by both the accuracy of future demand estimates and by factors unique to veterans, one of which is the social contract.

The obligation of government to provide health care to veterans is part of a social contract between society and veterans in recognition of service to the country. The social contract exists with veterans to provide them with a health care system not available to nonveterans. As part of the social contract, veterans also receive housing, education and job preference benefits.

The VA and its programs are evidence of the contract at the federal level, while the state Department of Veterans Affairs and existing and planned veterans nursing homes provide evidence of the state's commitment to provide for some portion of veterans' long-term care.

The limits of the social contract have not been well defined at either the federal or state level. For example, although the social contract places certain responsibilities on society, the specific requirements on state government are not clear. There is no federal mandate to provide long-term care and there is no state policy that specifies the number of veterans or the share of the veterans population that should be served in state veterans nursing homes, nor the type of service that should be provided. Neither the maximum number of nursing home beds to be provided to veterans nor

the percentage of veterans who will be served in state-operated nursing homes has ever been determined.

Despite the absence of policy on the level of service, there are many ways of estimating the share of veterans to be served by state veterans homes.

Minnesota will continue to serve some but not all veterans needing nursing home care in state veterans homes. Thirty-two states currently operate veterans homes; none serves all of the veterans needing nursing home care. Neither the state nor the federal government serves 100 percent of its veterans populations. The VA Medical Centers have historically served many veterans who do not have service-connected disabilities, but have recently been forced by budget problems to limit the categories of veterans they serve. VA Medical District 18 has historically served 16 percent of the district's veterans who need nursing home care.

In Minnesota, approximately 78 percent of nursing home residents who are veterans reside in community nursing homes without receiving a VA nursing home care benefit. It is assumed, therefore, that in the future, veterans homes will continue to serve less than 100 percent of all veterans needing nursing home care, relying on the VA and community nursing homes to serve the remainder.

At the same time, Minnesota will likely continue to provide veterans home care to some part of the population. Minnesota currently has space for 346 residents at the Minneapolis veterans home. This capacity enables the home to serve 8.4 percent of all veterans receiving nursing home care. With the planned expansion of the veterans home system to include the new home in Silver Bay, veterans homes will continue to play a role in the veterans' long-term-care picture for at least the next 20 years (the minimum amount of time for which states must operate veterans homes funded by the VA without repaying construction costs).

Indicators of need

There are a number of potential indicators of need. These include the number of names on the waiting list at the Minneapolis home, VA limits on the number of nursing home beds it will fund in each state, and the current level of service provided by the veterans home.

The Minneapolis home waiting list

One simple indicator of need is the number of names on the Minneapolis home waiting list. In August 1989, the number was 121. The presence of the waiting list was cited in interviews as demonstrating a need for additional veterans homes.

However, there are several reasons why the waiting list is not a sound measure of need for additional homes. First, applicants often reach the top of the list before they are ready for admission. They are then offered the options of having their names removed or moved to the bottom of the list. In the past six months, 74 applicants

moved their names to the bottom of the list when offered admission [1]. The number of applicants that would actually accept admission if new beds were available would, therefore, be less than 121. Second, even if all 124 individuals were admitted at the same time, most could be accommodated by the 89 new beds planned for Silver Bay. Federal funding of the Luverne home would add another 83 beds.

VA policy on need for veterans' nursing home beds

The VA has a number of indicators that could be used to estimate need for veterans homes. One measure is the policy that state veterans homes should provide service that does not exceed four beds per 1,000 veterans in the state. Using its 1983 veterans population estimate for Minnesota, the VA states that 2,100 veterans nursing home beds are needed.

For several reasons, the VA limit is not a reliable indicator of need. First, the purpose of the calculation is to limit the number of state nursing home beds the VA will fund, not to estimate the need for nursing home care. Second, the source of and rationale for using the VA calculation are not explained or justified by the VA, and may overstate or understate need in any given state. Third, the estimated need is based on a simple calculation that does not recognize the differences between states. For example, older Minnesotans are among the highest users of nursing home care in the country, and are unlikely to be denied nursing home care if they need it. Also, the availability of other long-term-care options for veterans, which varies greatly by state, should figure strongly in a calculation of need, but is not included in the VA limits. Similarly, the VA calculation does not consider the age distribution and health status of veterans within each state. Any state with a relatively young and healthy veterans population would have its nursing home bed needs overstated relative to other states.

Current proportion of veterans served by the Minnesota Veterans Home

To determine the overall need for nursing home beds among veterans, Part 3 of this report assumed, as the VA does, that the best estimate available for the proportion of veterans that will need nursing home care in the future is the proportion receiving nursing home care now. Lacking a state policy specifying this proportion, the same approach can be applied in projecting need for state veterans nursing home beds.

Table 16 projects the need for additional veterans nursing home beds under the assumption that future need will equal the current level of service. Table 16 was constructed by multiplying the projected number of veterans needing nursing home care developed in Part 3 by the proportion of all veterans receiving nursing home care who receive that care in the Minnesota Veterans Home system (8.4 percent). The resulting numbers indicate the total demand for veterans nursing home beds without considering the available supply. Then the number of nursing home beds either currently in the system or planned (346 beds in Minneapolis and 89 beds in

Table 16. Projected number of veterans needing state nursing home beds by HSA region

Region	1989 Beds needed	1989 8.4% share	1995 Beds needed	1995 8.4% share	2000 Beds needed	2000 8.4% share	2010 Beds needed	2010 8.4% share	2020 Beds needed	2020 8.4% share
HSA 1	155	13	184	15	220	18	291	24	268	23
HSA 2	365	31	461	39	542	46	630	53	555	47
HSA 3	197	17	234	20	280	24	353	30	316	27
HSA 4	448	38	557	47	684	57	896	75	882	74
HSA 5	2084	175	2845	239	3692	310	5161	434	5274	443
HSA 6	474	40	570	48	689	58	891	75	811	68
HSA 7	396	33	486	41	602	51	860	72	836	70
Total	**4120**	**346**	**5336**	**448**	**6709**	**564**	**9082**	**763**	**8941**	**751**
Capacity		346		435*		435		435		435
Needed beds		0		13		129		328		316

*The increase in capacity reflects the addition of 89 beds in Silver Bay.

Silver Bay) was subtracted from the number of beds needed. The result is the net additional beds required to maintain the same proportion of service.

Two initial conclusions can be drawn from an analysis of Table 16. First, to maintain its proportion of veterans served in the state veterans home system, the state will have to add 328 veterans home beds by 2010, the year nursing home demand by veterans peaks. Despite the growth in the older veterans population, the need for additional beds will not be sufficient to fill an additional 60-bed nursing home unit until some time between 1995 and 2000. The reason for this is that the system is about to expand by 26 percent. The approved addition of 89 nursing home beds in Silver Bay will result in a total of 435 state veterans home beds. The planned increase in capacity will more than compensate for the increase in veterans needing state nursing home care until the late 1990s.

Table 17. Current level of service compared with VA guidelines

Location	Number of veteran residents	Share	Share of VA-funded care	Preferred share: VA 30-40-30 guidelines
Community nursing homes	3,220	78.2%		
VA nursing homes	246	6.0%	27.3%	6.6%
VA contract nursing homes	308	7.5%	34.2%	8.7%
State veterans nursing homes	346	8.4%	38.4%	6.6%
Total	**4,120**	**100.0%**	**100.0%**	

Minnesota's level of service compared with VA guidelines

To determine whether this proportional, or "market share," approach is reasonable, it is helpful to compare Minnesota's level of service with the VA's guidelines and with the performance of other states.

The VA prefers that, of all veterans receiving nursing home care funded in part or whole by the VA, 30 percent should receive care in VA Medical Center nursing care facilities, 40 percent in VA contract community nursing homes, and 30 percent in state veterans homes. Thirty-eight percent of Minnesota veterans that receive VA-funded care reside in the state veterans home (Table 17). If Minnesota lowered its level of service to the VA guidelines, state veterans homes would serve 6.6 percent of veterans needing nursing home care instead of 8.4 percent. To the extent that the VA policy provides a guideline to states, Minnesota serves more than the preferred percentage of veterans. This comparison indicates that serving 8.4 percent of all veterans receiving nursing home care in the state veterans home system is a reasonable level of service.

Minnesota's level of service compared with other states' veterans home capacities

Another test of the proportional approach is to compare Minnesota's level of service with that of other states. The VA calculation used to prioritize new nursing home construction applications can be used to make this comparison. In Table 18, the number of VA-authorized state nursing home beds in each state is divided by the VA limit on veterans home beds (a function of veterans population). The resulting quotient is subtracted from 100 percent to show the percent of need that is served outside the state veterans home system. Table 18 demonstrates that, relatively speaking, Minnesota goes further toward meeting state nursing home bed demand of its veterans than 30 of the 50 states.

Need for new nursing home beds in the general long-term-care system

In its 1989 report, the Interagency Board for Quality Assurance concluded that there is no shortage of nursing home beds in Minnesota and that the present nursing home system will have adequate beds over the next four to six years. The report predicted that by 2010, Minnesota will need an additional 11,000 beds unless the state is able to divert more residents into alternative care. If the state sufficiently increases the availability of alternatives, the number of additional beds required could be minimal. The findings of the report pertain to all Minnesotans, including veterans [2].

Minnesota has a high nursing home bed supply relative to other states. The interagency board report shows that Minnesota ranks among the top states in nursing home beds per 1,000 elderly. By another measure, Minnesota ranks third nationally in total per capita expenditures for long-term care. Minnesota spent $927 per capita elderly in 1986, a figure 58 percent higher than that of the next highest state in the region, Wisconsin [2]. Minnesota's comparative commitment to institutional nursing home care is directly reflected in the difference between the VA Medical District 18 nursing home utilization rates and rates specific to Minnesota discussed in Part 3. The district rates are higher than the national rates and Minnesota's rates are higher than the district rates.

Based on the assumptions used in this analysis, the demographic growth in veterans' demand for nursing home beds does not, by itself, translate into need for additional nursing homes in the next five to 10 years.

References

1. Fletcher, Diane, Minnesota Veterans Home, Minneapolis, Oct. 4, 1989, telephone interview.

2. Interagency Board for Quality Assurance, *An Analysis of the 1987 Distribution of Nursing Home Beds in Minnesota,* January 1989.

Table 18. A comparison of VA-authorized* state veterans nursing home beds

State	VA-authorized nursing home beds (8/89)	VA limit on nursing home beds	% veterans not served in state veterans homes
Nebraska	750	764	2
Oklahoma	1133	1588	29
Vermont	160	256	38
Rhode Island	295	504	41
Iowa	692	1416	51
New Mexico	164	648	75
Wisconsin	552	2296	76
Indiana	614	2720	77
Montana	90	432	79
New Jersey	760	3700	79
Maine	120	616	81
New Hampshire	100	552	82
Missouri	458	2588	82
Georgia	444	2528	82
Michigan	765	4468	83
Idaho	80	484	83
Minnesota	346	2100	84
Washington	399	2512	84
South Dakota	50	320	84
Colorado	250	1604	84
Mississippi	150	980	85
Illinois	811	5392	85
Massachusetts	327	2880	89
South Carolina	150	1404	89
Louisiana	136	1812	92
Kansas	88	1200	93
Maryland	146	2176	93
Arkansas	70	1080	94

Table 18. A comparison of VA-authorized* state veterans nursing home beds (continued)

State	VA-authorized nursing home beds (8/89)	VA limit on nursing home beds	% veterans not served in state veterans homes
Ohio	350	5540	94
California	756	12012	94
Pennsylvania	277	6372	96
New York	124	7804	98
Alabama	0	1744	100
Alaska	0	200	100
Arizona	0	1532	100
Connecticut	0	1652	100
District of Columbia	0	260	100
Delaware	0	308	100
Florida	0	5568	100
Hawaii	0	396	100
Kentucky	0	1620	100
Nevada	0	548	100
North Carolina	0	2640	100
North Dakota	0	276	100
Oregon	0	1600	100
Tennessee	0	2172	100
Texas	0	6928	100
Utah	0	620	100
Virginia	0	2656	100
West Virginia	0	972	100
Wyoming	0	268	100

*"VA-authorized" are those funded through the VA State Home Construction Program.

Source: VA State Veterans Home Construction Program, August 1989.

EVALUATING THE NEED:

Appropriateness of care

A second consideration in evaluating the need for additional state veterans homes is whether nursing home care will be appropriate for veterans with long-term-care needs. Three aspects of appropriateness of care are considered:

(1) if the level of care meets the level of need, so that an individual's independence is maximized;

(2) if care is provided in a setting that is preferred by veterans; and

(3) if veterans have unique physical, mental and emotional needs that are best addressed in a facility specifically designed to serve veterans.

Maximizing independence

One of the most frequently cited goals of long-term care is that it promote an individual's independence [1, 2, 3]. A primary means of promoting autonomy is to provide persons with an array of long-term-care options ranging from in-home supportive care to skilled nursing home care, so they can choose a level of care that meets their level of need. In other words, care should be provided in the least restrictive environment, given the patient's level of need, so that nursing home care is reserved for people who cannot be reasonably cared for in noninstitutional settings.

The VA emphasizes the importance of maximizing independence and providing noninstitutional care in its publication *Caring for the Older Veteran* [4]:

> In providing health care to the elderly, promotion of the maximum level of functional independence is the fundamental goal....
>
> [T]he elements of a program directed toward the goal of supporting maximum potential for the older person are three:
>
> 1. To sustain them in independence, comfort, and contentment in their own homes and, when independence begins to wane, to support them by all necessary means;
>
> 2. to offer alternative accommodations (and other home care support) to

> those who by reason of age, infirmity, lack of a proper home, or other circumstances are in need of care and attention;
>
> 3. to provide hospital (and other institutional) accommodations for those who by reason of physical or mental ill health are in need of skilled medical or nursing attention or both.

In relating these goals to appropriate services for the elderly, the VA further states, "Whenever and wherever possible, the elderly should be able to stay in their own home or outside of institutions" [4].

In contrast to this goal of promoting individual autonomy, the current long-term-care system relies heavily on institutional care as a means of meeting long-term-care needs. Nationally, only a small fraction of Medicare's and Medicaid's budget is devoted to home- and community-based services, while in Minnesota approximately 91 percent of the state's long-term-care funds are expended on institutional care. In-home and community-based services, which assist persons in remaining independent in their community rather than entering a nursing home, receive relatively little funding.

Policy makers at many levels have articulated the system's overreliance on institutional care and the need for a greater number of home- and community-based choices that promote independence:

> One of the major problems confronting persons needing long-term care is the institutional bias in the current system . . . . States should be required to assure that a broad range of services are available to enhance the independent functioning of program beneficiaries [1].
>
> As individuals age, and as we increasingly deal with chronic degenerative disease in later life, the challenge is less one of cure and more one of maintaining the quality of function. This involves an appropriate mix of medical, rehabilitative and social care. The U.S. now invests a great deal in medical care for the elderly, but financing mechanisms are strongly biased toward inpatient services and a narrow conception of the health care role. There is a broad recognition of the value of distributing expenditures in a more balanced way and achieving a more reasonable distribution of expenditures for inpatient and community services [5].
>
> The goal of (long-term) care is to permit the recipients to function at the highest level of autonomy possible [2].
>
> Too often the type of (long-term) care chosen is overwhelmingly dictated by financial considerations rather than by the actual needs of the individual. It is widely acknowledged, for instance, that Medicare and Medicaid are strongly biased toward institutional care, and that many older persons have consequently received hospital and nursing home care when community-based services may have been more appropriate . . . . A reformed long-term-care system would include a continuum of care with

> services ranging from assistance with basic homemaking and chores to intensive skilled nursing and physician care [6].
>
> Many functionally impaired older people receive long-term-care services at home or at community centers. These services often play a critical role in helping older people to avoid institutionalizations and to maintain independence in the community [7].

The establishment of additional veterans homes would contribute to Minnesota's reliance on institutional care and do nothing to encourage the use of alternative services. This is true for several reasons. First, building additional homes would mean adding nursing home beds in a state that already has one of the highest rates of institutionalization in the country. There are nearly 45,000 licensed nursing home beds in 446 nursing homes in Minnesota [8]. As of 1986, Minnesota had 92.4 beds per thousand elderly, compared with a national average of 60.7 beds per thousand [9]. Also, more than 8 percent of Minnesota's elderly are nursing home residents, compared with a national rate of about 5 percent. Further, Minnesota spends approximately 91 percent of its long-term-care budget on institutional care. The national average is 81 percent.

The nursing homes in the regions under study are generally operating at less than full capacity. Average occupancy rates range from 92 percent in Region 5 to 97 percent in Region 6. All regions have at least two counties with an occupancy rate below 95 percent [8].

The 1989 study by the Interagency Board for Quality Assurance found that there already is an adequate supply of nursing home beds in Minnesota, and there is likely an oversupply [9]. Nursing home occupancy rates and utilization rates are falling in Minnesota even as the number of older persons is increasing. This is due in part to the aggressive action Minnesota has taken to reduce institutionalization and increase the use of alternative services. Concerns with quality of life and rising costs have led the state to impose a moratorium on nursing home construction, mandate preadmission screening of most nursing home applicants, and provide home- and community-based services under the state's Alternative Care Grant Program.

In contrast to these general state efforts, the Minnesota Veterans Homes Board offers only institutional care to veterans with long-term-care needs. Adding beds would strengthen and continue the institutional bias.

A second way in which the building of additional veterans homes would contribute to a bias toward institutional care is that applicants to the veterans home are exempted from Minnesota's Preadmission Screening Program.

The veterans home does have its own screening process. However, there are important differences between the two types of screening. First, statewide screening is extremely thorough, including face-to-face client assessments that are not necessarily included in veteran screening. Also, the statewide program is conducted in conjunction with Minnesota's Alternative Care Grant Program, which provides funding for alternative services to eligible individuals. The veterans home does not

offer similar services. Further, the purposes of the two screenings appear to be somewhat different. The intention of the statewide screening is to divert nursing home applicants to the community if possible. The veterans home screening, however, appears to be in place to ensure that the home can meet the needs of the client. This difference suggests that the statewide screening process is much more proactive in presenting alternatives to clients and helping them to obtain community-based care.

A third reason that the building of additional veterans homes would encourage institutionalization is that scarce state money designed to assist veterans in obtaining needed long-term care would be devoted to nursing home beds rather than to alternative services. In short, money spent to build additional nursing home beds is money not available for funding alternative care.

Nursing home care is an important piece of the long-term-care continuum, and should be available to veterans who need that level of care. At the same time, there are significant cost and quality of life advantages to providing home- and community-based care alternatives. By exempting the Minnesota Veterans Homes from its moratorium, and by exempting veterans home applicants from preadmission screening, the state encourages the institutionalization of veterans.

Minnesota has recognized its commitment to veterans by establishing and operating veterans homes. Minnesota has also recognized its commitment to persons with long-term-care needs by making efforts to provide a continuum of long-term-care services including home- and community-based care. Such care is generally preferred by persons with long-term-care needs, and assists them in avoiding the dependency and cost associated with institutionalization.

Veterans' preference for care

Veterans show a strong preference for noninstitutional care. In a 1983 national survey of more than 3,000 veterans, 92 percent agreed that "it's better to stay out of nursing homes as long as you can." More than three-quarters of the veterans also felt that people go to nursing homes only as a last resort, and more than two-thirds of those sampled felt that nursing homes were lonely places to live [10].

However, nursing home care is an appropriate choice for veterans with certain physical and mental needs. In evaluating the need for additional veteran homes, it is important to consider whether, and to what degree, veterans who need nursing home care might prefer a state veterans nursing home over a community nursing home.

A veteran might prefer a state veterans home for many reasons. Veterans in veterans homes may have fewer out-of-pocket costs than residents in community homes, may avoid the welfare stigma associated with Medicaid, may have access to special activities geared to persons with military service backgrounds, and may have a special camaraderie with other veterans in the home. Veterans also may have reasons for preferring community homes. There are many community homes to choose from, and they are likely to be closer to the resident's family, friends and previous home.

Recent and reliable data to support or refute the accuracy and strength of these reasons for preferring a veterans home or a community home is not available. One of the few sources of data on this topic is a 1982 study of 2,345 Minnesota veterans [11]. One of this study's survey questions concerned what factors were most important in choosing a nursing home. Results showed that the two factors most important to the largest proportion of veterans, each cited by 22 percent of the respondents, were that the home was located in the individual's county of residence and that the home was located near relatives. Eighteen percent reported that the most important factor was whether the facility was affiliated with the VA or was a state veterans home.

The preference for a veterans facility appears to be highly related to the real or perceived financial benefits of a veterans home. When asked, "If something happened so that you couldn't take care of yourself and your house, where would you go?", 24 percent indicated that they would go to a veteran-affiliated facility. When asked the same question, but with the additional condition that income and savings were lost, 47 percent indicated that they would go to a veterans home. As state veterans home income and asset requirements come to resemble those of Medicaid more closely, this expected preference for a state or VA facility might well decrease. A comparison of resident contributions in a veterans home and a community nursing home under Medical Assistance is presented in Table 19.

While the survey might provide some indication of veterans' preference for different types of long-term-care facilities, it is important to view the results cautiously because the survey was conducted seven years ago. Minnesota's long-term-care system has changed considerably since that time, and attitudes toward veterans' versus nonveterans' long-term-care options may also have changed considerably. Moreover, the survey measures the attitudes of persons who are theoretically considering the possibility of needing long-term care, rather than the attitudes of persons who are actively making long-term-care choices.

Another indication of veterans' preference is the number of persons on the waiting list for the Minneapolis veterans home. In theory, at least, any veteran who prefers a veterans home could either be residing at the home or be on the home's waiting list. As of August 1989, there were 20 veterans from Regions 1, 3, 4, 6 or 7 on the waiting list. As mentioned, however, the use of this list as an indicator of need or preference is not advisable. Persons on the list may not be seeking admission to the home at the present time (thus the list would overstate preference). Persons who would prefer admission to a veterans home if a home was closer to them, and persons who are not aware of the veterans home but who would prefer it if they knew they were eligible, are presumably not on the list (thus the list would understate preference).

In sum, there are many reasons veterans may prefer a veterans home or a community home when choosing a long-term-care facility. What little survey data is available suggests that while veteran affiliation is the most important factor for some veterans, other considerations, such as the home's proximity to family and community, are most important for a much larger proportion of veterans. Drawing conclusions from 1982 survey data and the existence of a waiting list for the Minneapolis home could under- or overstate veterans' preference.

Table 19. Comparison of resident contributions in a veterans home and a community nursing home under Medical Assistance

	Community nursing home (under Medicaid)*	Veterans home
Charge	$66.80/day	$67.72/day
Income eligibility requirements		
if single	$402/month	none
if married	$502/month	none
Contributions to cost of care	100% of income, minus $47 personal needs allowance	95% of income, minus $85 personal needs allowance
Asset limitations		
if single	$3,000	$2,500-$3,000
if married	$6,000 per couple	$2,500-$3,000 per person

*Skilled Nursing and Intermediate Care 2 facilities.

Sources: John Welch, Medical Assistance Program adviser, Department of Human Services, Nov. 3, 1989, telephone interview; Jay Inwood, director of social services, Minnesota Veterans Homes, Minneapolis, Oct. 12, 1989, telephone interview.

Meeting veterans' health- and long-term-care needs

The third factor related to appropriateness of care is whether the care provided meets physical, mental and emotional needs that may be unique to veterans. The building of additional veterans homes may be justified if these homes are meeting the special needs of veterans who cannot be served in community homes.

Interviews suggested that veterans homes might be serving persons with special needs. Specifically, veterans home staff indicated that they are serving a population with an unusually high incidence of behavioral problems. Also, staff indicated that the veterans home may be serving people with little family or community support and therefore with few alternatives to a veterans home.

Limited data related to case mix is available for a comparison of veterans home residents with male community nursing home residents. Table 20 shows age, overall case mix and behavioral case mix comparisons. This data needs to be interpreted cautiously for two reasons. First, the veterans data pertains to July and October 1989, whereas the data on all males is from 1988. Also, case mix assessments for all males have been conducted by independent evaluators from the Department of Health, while the veterans home case mix evaluations were conducted internally.

At present, a comparison of age and overall case mix measures shows that the veterans home is serving a younger, less physically impaired population than are community homes. The average age of a veterans home resident is 74, compared with 83 for males in community homes. A considerably larger proportion of veterans home residents are rated as A, B or C on the case mix scale than community nursing home males, indicating a higher level of functioning.

Veterans home residents exhibit more serious behavior problems in comparison with community nursing home residents. Half the veterans home population is rated as a 3 or 4, compared with 25 percent of the male community nursing home population. In brief, persons rated as a 3 are those who exhibit disruptive behavior such as verbally abusing others, wandering into private areas of the facility, or acting in a sexually aggressive manner, while persons rated as a 4 are physically abusive to themselves and others.

This data indicates that the veterans home is serving a different and behaviorally more difficult population than those in community nursing homes. This could indicate a need for additional veterans homes if veterans with behavioral problems cannot be served in the existing veterans and community nursing homes.

However, this does not appear to be the case. First, community nursing homes can and do serve patients with behavioral problems. While the proportion of community nursing home males with serious behavioral problems is considerably less than in the veterans home, community homes do report that a quarter of their male residents rate as 3s or 4s on the behavioral measure.

Second, any additional veterans home similar to the current home can be expected to serve a mix of patients who may or may not have behavioral problems. The veterans

Table 20. Age, overall case mix and case mix behavior ratings for residents of the veterans home and all males in community nursing homes

	Veterans nursing home resident 1989	Male community nursing home resident 1988
Average age	74	83
Case mix level		
A to C (least impaired)	41%	32%
D to F	16%	17%
G to I	19%	28%
J to K	24%	24%
Behavior rating*		
0	23%	35%
1	13%	22%
2	15%	17%
3	28%	15%
4	22%	10%

*"0" indicates that the behavior requires no intervention; "4" indicates that the resident is physically abusive to self and others.

Sources: Veterans data on age and case mix, the July 1989 Administrators Report; veterans data on behavior ratings, telephone conversation with David Carroll, psychologist at the Minneapolis veterans home; state community nursing home data, Quality Assurance and Review Program of the Minnesota Department of Health.

home does not limit admission to those with behavioral or mental health problems, or otherwise function as a psychiatric facility rather than a nursing home. It is not clear that the veterans home is better able to, or has the desire to, serve a population with greater mental health needs.

Third, there is no data to support a claim that veterans who have behavioral problems and who want to reside in a veterans home are not being sufficiently served

by the veterans home in Minneapolis. It is not known how many veterans residing in Regions 1, 3, 4, 6 and 7 both require nursing home care and have behavioral problems that would best be addressed in a veterans facility. A study examining the specific need for a psychiatric facility, rather than a nursing home, would be needed to fully address this issue.

Thus, while the current veterans home plays an important role in serving veterans who have both long-term-care needs and behavioral problems, this does not indicate a need for additional homes.

Summary

The building of additional veterans homes in Minnesota at this time would encourage institutional care, even though Minnesota already has very high rates of institutionalization, and even though veterans have indicated a strong preference for noninstitutional alternatives. Also, while the current veterans home appears to serve a population that has more serious behavioral problems than the male population in community homes, this does not suggest that there is a need for additional veterans homes. Community homes can and do serve persons with behavioral problems, and no data on unmet need was available for the HSA regions under consideration in this study.

References

1. National Association of State Units on Aging, Federal Long-term Care Reform: A Proposal by the National Association of State Units on Aging, Washington, D.C., 1988.
2. Kane, R., and Kane, R., "Transitions in Long-term Care," in *Aging and Health Care*, J. McKinlay, ed., Routledge Publishing, New York, 1989, Pp. 217-243.
3. *InterStudy's Long-term Care Expansion Program: A Proposal for Reform,* InterStudy, Excelsior, Minn., 1988.
4. U.S. Department of Veterans Affairs, *Caring for the Older Veteran*, Washington, D.C., 1984.
5. Mechanic, David, "Future Challenges in Health Care for An Aging Population," in *Aging and Health Care,* J. McKinlay, ed., Routledge Publishing, New York, 1989, Pp. 244-256.
6. Polich, C.P., Iversen, L., Owens, S., "Rethinking Long-term Care," *Compensation and Benefits Management*, Vol. 5, No. 4, 1989, Pp. 275-282.
7. American Association of Retired Persons, Changing Needs for Long-term Care: A Chartbook, AARP, Washington, D.C., 1989.
8. Mitchell, Sharon, Minnesota Department of Health, Health Resources Division, Survey and Compliance Section, August and September 1989 telephone interviews and unpublished data.
9. Interagency Board for Quality Assurance, *An Analysis of the 1987 Distribution of Nursing Home Beds in Minnesota*, January 1989.
10. Louis Harris and Associates, "Survey of Aging Veterans: A Study of the Means, Resources and Future Expectations of Veterans Aged 55 and Over," 1983.
11. Minnesota Department of Veterans Affairs, *Veterans Long-term Care Health Survey*, Minneapolis, 1982.

EVALUATING THE NEED:

Cost of care

A third consideration in analyzing the need for additional veterans homes is the overall cost, including the cost to the state, of providing care in such facilities. This section presents the construction and operating costs for 60- and 120-bed veterans nursing homes, and compares the cost of establishing a new veterans home with the cost of providing nursing home care in community nursing homes.

Cost to the state of a new state veterans home

The cost of a new state veterans home is made up of initial investment costs and ongoing operating costs. Initial investments include the cost of land and new construction or remodeling of an existing building.

Ongoing operating costs are broken down into staffing cost and other expenses, estimates of which are shown in this report. Importantly, this report also shows the level of expenses that will be paid by the U.S. Department of Veterans Affairs and the amount that can be expected to be paid by residents. The difference between the total costs and the reimbursement from these sources is the net cost to the state of building and operating a new state veterans home.

Costs were developed for a 60-resident and 120-resident home, the likely size range for such a facility. Interviews with VA state nursing home program staff indicated that 60 to 120 beds was an appropriate framework for analysis. The new veterans home in Silver Bay will be an 89-resident home, in the middle of the 60- to 120-bed range.

This analysis builds on a February 1989 report prepared by the Management Analysis Division of the Department of Administration titled "Potential Sites for a State Veterans Home." The analysis presented in that report was reviewed, updated and revised for this study.

Construction costs

COST OF BUILDING

The construction cost estimates shown on Table 21 were developed by the Building Construction Division of the Department of Administration. They are based on the budgeted construction costs for the proposed Luverne Veterans Home.

The Luverne home is proposed to be an 83-bed facility. As a starting point for

Table 21. Current (1989) cost estimate for construction of a 60-resident and 120-resident veterans home*

	60 residents	120 residents
Construction costs		
Building size (square feet)	43,730	67,275
Building cost (@ $80 per square foot)	$3,498,400	$5,382,000
Sitework (grading, drainage, landscaping, parking, drives, curb, gutter, walks, lighting and utilities: 8% of building cost)	$279,872	$430,560
Total construction costs	**$3,778,272**	**$5,812,560**
Other costs		
Furniture, fixtures and equipment	$244,888	$349,830
Design and construction administration (8% of construction costs)	$302,262	$435,942
Total other costs	**$547,150**	**$785,772**
Total budget estimate	**$4,325,422**	**$6,598,332**
Capital cost per bed	**$72,090**	**$54,986**

*Based on Luverne construction budget.

estimating the cost of this facility, the VA's minimum space requirements were determined. (U.S. Department of Veterans Affairs state veterans home space requirements are described in 38 CFR, Part 17, Sections 17.177(a)(3) and 17.177(x)(2), and in Minnesota Department of Health nursing home physical plant requirements contained in Minnesota Rules, Chapter 4660.) The Minnesota Veterans Homes Board, in conjunction with the Building Construction Division of the Department of Administration, programmed the space requirements for the new facility. In working through this process, the board determined that the VA minimum standards were not adequate for the type of program the board wanted to run.

The estimated costs for the Luverne home were used as the basis for estimated costs for potential 60- and 120-bed facilities.

There is a significant difference between the construction cost estimates shown in Table 21 and those presented in the February 1989 report. The February 1989 report estimated construction costs based on a site consultant's cost estimate for a facility of sufficient size to meet VA minimum standards. Those cost estimates for a facility of the size estimated in that report are accurate and reliable cost estimates. However, since that report was issued, specific construction budget figures were developed for the proposed Luverne site. The Luverne site cost data is considered to be the best cost estimate available because it is based on actual budgeted figures for a proposed veterans home.

VA grants will pay up to 65 percent of the cost of constructing state veterans homes. Therefore, using the cost estimates shown in Table 21, state or local entities would be responsible for funding building construction costs ranging from $1,513,898 (35 percent of the estimated $4,325,422 to build a 60-resident home) to $2,309,416 (35 percent of $6,598,332 for a 120-resident home). It is possible that a local community would be willing to pay some or all of this cost because of the potential beneficial impact that a state veterans home could have on the local economy.

LAND COST

Approximately three to five acres of land are needed for a 60-resident state veterans home, and six to 10 acres for a 120-resident home. These figures are based on the suggested building space guidelines outlined in the VA state veterans home space requirements and Minnesota Department of Health nursing home physical plant requirements, and on the site consultants' professional judgment on exterior property needs.

If land is purchased for a state veterans home, any acquisition cost must be paid by the state or local entity. The VA is prohibited by law from paying state veterans home land acquisition costs.

If suitable state-owned land is available, the state may choose to place a state veterans home on that site and share it with a regional treatment center or community college.

A review of the proposals submitted by cities in southwestern Minnesota found that 19 of the 22 proposals either called for the local community to donate land or proposed that the new veterans home be built on state-owned land as a shared facility with a regional treatment center or community college. In either case, there would be no land cost to the state.

Operating costs

COST ASSUMPTIONS

The annual operating costs in Tables 22 through 25 are based on assumptions that a new state veterans home would provide long-term skilled nursing care for elderly veterans; house veterans needing approximately the same average level of nursing care as residents in the state's nonveterans nursing homes, resulting in a 2.38 case mix; meet all Minnesota Department of Health and VA operating requirements and statutes; obtain substantially all resident outpatient medical care and inpatient hospital services from a VA Medical Center or under a public assistance program such as Medical Assistance; be a stand-alone facility away from existing state facilities; be housed in a newly constructed or remodeled building; and have all necessary equipment and furnishings available and in good operating condition when operations began.

These assumptions are critical to the estimation of operating costs for a new state veterans home. The cost estimates contained in this study are not projections of actual costs to the state to operate any specific facility. Rather, they describe cost considerations and provide representative estimated levels of the total costs of establishing a new state veterans home. Actual costs would depend on the services provided at the facility, the size and location of the facility, and the time period when the facility would be established.

STAFFING NEEDS AND COSTS

This section describes the staffing needs and associated costs for a 60- and 120-resident state veterans home. This includes a description of the care components needed to properly operate a veterans home, an estimate of the number of personnel needed to meet these needs and the estimated salaries for the needed employees (using estimated Fiscal Year 1990 personnel costs).

Minnesota state veterans homes typically provide long-term nursing care, including skilled nursing care, custodial care, terminal care and certain types of in-house treatment. The health care components include general nursing, special care, physician, social, pharmacy, rehabilitation, dietary and housekeeping services.

The number of employees and their estimated salary levels are shown in Table 22 for a 60-resident veterans home. The estimated Fiscal Year 1990 staffing cost for a 60-resident home is $1,942,704. Table 23 shows the same information for a 120-resident veterans home. The estimated Fiscal Year 1990 staffing cost for a 120-resident home is $3,366,820.

Table 22. Staff levels and costs for a 60-resident state veterans home

Employee classification	Positions (FTEs)	FY 90 salary* ($000s)	Extended salary ($000s)	Extended benefits** ($000s)	Total ($000s)
DIRECT CARE					
Dir. of Nursing	1	35.7	35.7	7.7631	43.463
Reg. Nurse Supr.	3	28.6	85.8	20.7142	106.514
Reg. Nurse	8	25.3	202.4	52.0462	254.446
Lic. Prac. Nurse 1	7	21.6	151.2	42.4091	193.609
Human Services Tech.	24	16.6	398.4	130.8945	529.295
Med. Records Tech. 1	0.5	22.4	11.2	3.0776	14.278
Physical Therapist 1	0.5	25.7	12.85	3.2771	16.127
Social Worker Sr.	1	24.9	24.9	6.4574	31.357
Social Worker	1	22.6	22.6	6.1793	28.779
Rec. Therapist Sr.	1	24.1	24.1	6.3607	30.461
Rec. Therapist	2	22.6	45.2	12.3587	57.559
Pharmacist	0	29.4	0	0	0
Subtotal	**49**		**1014.35**	**291.5379**	**1305.887**
INDIRECT CARE					
Dietician 1	0.5	27.5	13.75	3.3859	17.136
Chief Cook	0	23.2	0	0	0
Cook	2	19.5	39	11.6091	50.609
Food Service Supv.	1	27.6	27.6	6.7838	34.384
Food Service Worker	5	17.4	87	27.7533	114.753
Exec. Housekeeper	0	23.2	0	0	0
Gen. Maint. Worker 1	4	16.6	66.4	21.8158	88.216
Bldg. Serv. Supr.	1	20.6	20.6	5.9375	26.538
Plant Maint. Eng.	1	28.5	28.5	6.8927	35.393
Power Plant Ch. Eng.	1	32	32	7.3158	39.316
Gen. Repair Worker	0.5	26.1	13.05	3.3012	16.351
Groundskeeper	1	17.4	17.4	5.5507	22.951
Delivery Van Driver	1	19	19	5.7441	24.744
Subtotal	**18**		**364.30**	**106.0898**	**470.390**
ADMINISTRATION					
Ch. Exec. Officer NH	1	47.9	47.9	9.2381	57.138
Asst. Administrator	0	33.2	0	0	0
Admin. Secretary	1	21.6	21.6	6.0584	27.658
Vol. Serv. Coord.	0.5	22.6	11.3	3.0897	14.390
Acct. Technician	1	22.4	22.4	6.1552	28.555
Stores Clerk	0.5	18.6	9.3	2.8479	12.148
Personnel Aide	1	20.6	20.6	5.9375	26.538
Subtotal	**5**		**133.1**	**33.3268**	**166.427**
Total staff costs	**72**		**1511.75**	**430.9545**	**1942.704**

*Estimated minimum annual salary for Fiscal Year 1990.

**FICA 7.58%; MSRS 4.51%; employee and dependent health = $2,864; FY90 Delta Dental employee and dependent = $419.2; employee basic life insurance = $164.74.

Table 23. Staff levels and costs for a 120-resident state veterans home

Employee classification	Positions (FTEs)	FY 90 salary* ($000s)	Extended salary ($000s)	Extended benefits** ($000s)	Total ($000s)
DIRECT CARE					
Dir. of Nursing	1	35.7	35.7	7.7631	43.463
Reg. Nurse Supr.	6	28.6	171.6	41.4284	213.028
Reg. Nurse	12	25.3	303.6	78.0692	381.669
Lic. Prac. Nurse 1	14	21.6	302.4	84.8182	387.218
Human Services Tech.	40	16.6	664	218.1576	882.158
Med. Records Tech. 1	1	22.4	22.4	6.1552	28.555
Physical Therapist 1	1	25.7	25.7	6.5541	32.254
Social Worker Sr.	1	24.9	24.9	6.4574	31.357
Social Worker	2	22.6	45.2	12.3587	57.559
Rec. Therapist Sr.	2	24.1	48.2	12.7214	60.921
Rec. Therapist	4	22.6	90.4	24.7174	115.117
Pharmacist	1	29.4	29.4	7.0015	36.401
Subtotal	**85**		**1763.5**	**506.2021**	**2269.702**
INDIRECT CARE					
Dietician 1	1	27.5	27.5	6.7718	34.272
Chief Cook	1	23.2	23.2	6.2519	29.452
Cook	3	19.5	58.5	17.4137	75.914
Food Service Supv.	1	27.6	27.6	6.7838	34.384
Food Service Worker	10	17.4	174	55.5066	229.507
Exec. Housekeeper	1	23.2	23.2	6.2519	29.452
Gen. Maint. Worker 1	8	16.6	132.8	43.6315	176.432
Bldg. Serv. Supr.	1	20.6	20.6	5.9375	26.538
Plant Maint. Eng.	1	28.5	28.5	6.8927	35.393
Power Plant Ch. Eng.	1	32	32	7.3158	39.316
Gen. Repair Worker	1	26.1	26.1	6.6025	32.702
Groundskeeper	2	17.4	34.8	11.1013	45.901
Delivery Van Driver	3	19	57	17.2323	74.232
Subtotal	**34**		**665.8**	**197.6932**	**863.493**
ADMINISTRATION					
Ch. Exec. Officer NH	1	47.9	47.9	9.2381	57.138
Asst. Administrator	1	33.2	33.2	7.4609	40.661
Admin. Secretary	1	21.6	21.6	6.0584	27.658
Vol. Serv. Coord.	1	22.6	22.6	6.1793	28.779
Acct. Technician	1	22.4	22.4	6.1552	28.555
Stores Clerk	1	18.6	18.6	5.6957	24.296
Personnel Aide	1	20.6	20.6	5.9375	26.538
Subtotal	**7**		**186.9**	**46.7252**	**233.625**
Total staff costs	**126**		**2616.2**	**750.6205**	**3366.820**

*Estimated minimum annual salary for Fiscal Year 1990.

**FICA 7.58%; MSRS 4.51%; employee and dependent health = $2,864; FY90 Delta Dental employee and dependent = $419.2; employee basic life insurance = $164.74.

Table 24. First-year other expenses for 60- and 120-resident state veterans homes

	Column A Annual expense 60 residents ($000)	Column B Annual expense 120 residents ($000)
1. Food and drugs	100.7	201.5
2. Fuel and utilities	46.9	72.4
3. Repairs and replacements	0.0	0.0
4. Medical contracts	0.0	0.0
5. Prof., tech. services	106.1	172.2
6. Purchased services	73.3	125.6
7. Workers and unemp. comp.	67.8	135.8
8. All other	50.2	100.4
9. Total other expenses	**444.9**	**807.8**

Lines 1 & 2: Based on Fiscal Year 1988 disbursements of the Ah-Gwah- Ching and Oak Terrace Nursing Homes, adjusted to FY 1990 levels.

Line 3: Assumes no repairs or replacements during the first year of operations of a newly constructed or remodeled facility.

Line 4: Assumes all outpatient medical care and inpatient hospital care is provided at a VA Medical Center or by another Medical Assistance program.

Line 5A: Includes 0.5 FTE Physician, 0.5 FTE Pharmist, 0.5 FTE Occupational Therapist and 0.5 FTE Rehabilitation Therapy Specialist.

Line 5B: Includes 1.0 FTE Physician, 1.0 FTE Occupational Therapist and 1.0 FTE Rehabilitation Therapy Specialist. Pharmacist services provided by state employee rather than under a purchased service contract.

Line 6: Includes 1.0 FTE Security Guard and contract laundry service. Alternatively, in-house laundry service would require 2.5 FTE Laundry Workers for a 60-resident home and 3.5 FTE Laundry Workers for a 120-resident home.

Line 7: Based on Fiscal Year 1988 disbursements of the Ah-Gwah-Ching and Oak Terrace Nursing Homes, adjusted to FY 1990 levels.

Line 8: Includes advertising, communications, data processing, rent and leases, special equipment, supplies and travel.

OTHER OPERATING COSTS

State veterans homes also incur expenses to conduct and maintain daily operations, including costs of food, drugs, fuel, utilities, outside medical contracts, professional and technical services, purchased services and others. Table 24 describes these additional operating costs for 60- and 120-resident facilities.

RESIDENT AND VA PAYMENTS

The population of the state's existing veterans homes includes a mix of residents with and without private means of support. In Fiscal Year 1990, Minneapolis veterans home residents with private means of support will pay approximately 30 percent of the nursing home's operating costs. For purposes of this study, it is assumed that a new state veterans home would have the same mix paying the same portion.

Assuming a contribution rate of 30 percent, residents would pay $716,280 of the annual operating costs of a new 60-resident state veterans home, and $1,252,380 in a 120-resident home.

The VA will help support eligible veterans in state veterans homes with financial aid commonly referred to as VA per diem payments.

In the current federal fiscal year, the VA is paying $21.83 for each day a veteran resides in a state veterans home. It is estimated that the VA will contribute approximately $454,173 ($21.83 x 60 x 365 x 0.95) annually to support a 60-resident state veterans home and approximately $908,346 ($21.83 x 120 x 365 x 0.95) to support a 120-resident home.

These estimates assume that all residents in any new state veterans home would be veterans and that the home would operate at full capacity. Operating at full capacity does not, however, mean that every available bed is used by a resident every day. A small number of beds may be vacant at any given time due to the normal turnover of residents, residents visiting relatives and beds being held for hospitalized residents. This study assumes that temporary vacancies would average 5 percent of available beds in estimating VA per diem payments.

NET OPERATING COSTS

Table 25 calculates the state's net annual operating costs for 60- and 120-resident state veterans homes at approximately $1,217,100 and $2,013,900, respectively.

Total operating costs are the sum of staff costs and other expenses. In a 60-resident facility, this is $2,387,600. In a 120-resident facility, it is $4,174,600. Based on a 95 percent occupancy rate, this is a per diem expense of $114.76 in a 60-resident facility and $100.33 in a 120-resident facility.

Table 25. Estimated net state operating costs for 60- and 120-resident state veterans homes

	Annual operating costs 60 residents ($000s)	Annual operating costs 120 residents ($000s)
Staff costs	1,942.7	3,366.8
Expenses	444.9	807.8
Total operating costs	**2,387.6**	**4,174.6**
Less resident payments	(716.3)	(1,252.4)
Less VA payments	(454.2)	(908.3)
Net state annual operating costs	**1,217.1**	**2,013.9**

Construction and operating cost summary

This study estimated the construction costs of a new 60-resident veterans home to be $4,325,422 and of a 120-resident home to be $6,598,332. Because the VA would pay up to 65 percent of the construction cost, the state's share of the construction costs for 60- and 120-resident facilities would be $1,513,898 and $2,309,416, respectively. It is possible that the local community would pay some of these construction costs. While the VA will pay nothing toward land cost, it can reasonably be expected that a local community would donate suitable land, because of the potential beneficial economic impact that a new veterans home would have on the local community.

The annual operating costs of 60- and 120-resident facilities, including staffing and other operating costs, are estimated to be $2,387,600 and $4,174,600, respectively. The VA and residents would contribute $1,170,500 toward the cost of care for a 60-resident home and $2,160,700 for a 120-resident home. The state's net annual operating cost is estimated to be $1,217,100 for a 60-resident home and $2,013,900 for a 120-resident home. This is a net annual cost to the state of $20,285 per resident in a 60-resident home and $16,783 per resident in a 120-resident home.

Cost to the state of using community nursing homes to provide long-term care for veterans

An alternative to building and operating additional state veterans homes is to place veterans needing long-term care in existing community nursing homes. Estimates of the cost to the state of providing care for veterans in community nursing homes have been made in such a way that the cost of this alternative can be compared with the building option.

The Department of Human Services sets reimbursement rates for community nursing homes. Through its rate determination process, the department collects data and calculates the average costs for community nursing homes. The average costs for community nursing homes statewide will be used to estimate the cost of caring for residents in community nursing homes.

Table 26 shows the estimated average annual costs to the state of caring for veterans in community nursing homes statewide.

Line 1 shows that the average per diem cost for skilled nursing facility care in a licensed, certified community nursing home in September 1989 was $73.19 [1]. This is a reasonable estimate of the average annual statewide cost. Line 2 shows the calculation of the number of resident days available in a 60-bed nursing home, assuming a 95 percent occupancy rate (20,805 patient days) and a 120-bed nursing home (41,610 patient days). The statewide average occupancy rate in community nursing homes is approximately 95 percent. Multiplying the per diem cost by the resident days determines the estimated cost of direct care in a 60-resident home to be $1,522,718 (Line 3, Column A). The comparable amount in a 120-resident home is $3,045,436 (Line 3, Column B).

Line 4 shows the estimated amount that the residents would contribute, from private funds or other sources, toward the cost of their care. The estimated amount in a 60-resident home is $669,996, in a 120-resident home $1,339,992. This represents 44 percent of the cost of direct care [2]. It is estimated that Medicare will pay approximately 10 percent of the cost of care in community nursing homes. To determine the amount that will be paid under the Medical Assistance program, the amount contributed from private payments and from Medicare must be deducted from the cost of direct care. Line 6 shows that the so-determined Medicaid cost of direct care is $700,450 in a 60-resident home and $1,400,900 in a 120-bed home. To this amount, the cost of ancillary services for Medical Assistance residents must be added. Ancillary services include private physician services, physical therapy and occupational therapy. The estimated amount of ancillary services (Line 7) is $87,556 in a 60-resident home, and $175,113 in a 120-resident home. These amounts represent 12.5 percent of Medical Assistance costs [3].

The total Medical Assistance cost of providing care for residents in a 60-bed nursing home (Line 8, Column A) is $788,006. This is the sum of the Medical Assistance cost of direct care (Line 6) and the cost of ancillary services (Line 7). The comparable figure for a 120-resident home (Line 8, Column B) is $1,576,013.

Table 26. Annual cost to the state of caring for veterans in community nursing homes

	Column A Annual costs 60 residents	Column B Annual costs 120 residents
1. Average per diem statewide, skilled nursing facilities	$73.19	$73.19
2. Resident days in a 60-bed facility (60 x .95 x 365)	x20,805	x41,610
3. Cost of direct care	**$1,522,718**	**$3,045,436**
4. Resident contribution (44%)	($669,996)	($1,339,992)
5. Medicare contribution (10%)	($152,272)	($304,544)
6. Medical Assistance cost of direct care	**$700,450**	**$1,400,900**
7. Ancillary services	$87,556	$175,113
8. Total Medical Assistance cost	**$788,006**	**$1,576,013**
9. Federal contribution (53%)	($417,643)	($835,287)
10. Net state and county cost	**$370,363**	**$740,726**
11. County contribution (4.7%)	($37,036)	($74,073)
12. Net state contribution	**$333,327**	**$666,654**

Federal funds pay approximately 53 percent of the cost of Medical Assistance. This amount (Line 9) is $417,643 in a 60-resident home and $835,287 in a 120-resident home. The state and counties are responsible for paying the difference between the total Medical Assistance cost and the federal contributions. The amount for which the state and counties are responsible (Line 10) is $370,363 in a 60-resident home and $740,726 in a 120-resident home. The county's share of the cost, approximately 4.7 percent, is shown on Line 11. The balance is the state's share of the cost (Line 12), $333,327 in a 60-resident home and $666,654 in a 120-resident home.

The net annual cost of $333,327 in a 60-resident home under this option can be compared with the new veterans home option discussed above. The annual net cost to the state of operating a new 60-bed veterans home would be more than three and one-half times the cost to the state of paying for veterans' care for 60 veterans in community nursing homes. Table 25 shows that the net cost to the state of operating a 60-resident state veterans home is $1,217,100. The cost of operating a new 120-resident veterans home is more than three times the cost in a comparable-sized community nursing home. The cost of placing veterans in community nursing homes is substantially lower than the cost of operating a state-owned facility.

This is a conservative estimate of the cost difference between the two approaches for providing long-term care for veterans, for two reasons. First, this comparison does not consider initial construction costs of a new state-owned veterans home. As discussed earlier, the state portion of the construction cost is $1,513,898 for a 60-resident home and $2,309,416 for a 120-resident home. In contrast, the cost of the community nursing home option shown in Table 26 includes the cost of a property-related payment, which covers the community nursing home's mortgage costs. Removing property-related costs would reduce the cost of this option by approximately 10 percent.

Second, the cost to the state under the community nursing home option is overstated because it reflects the statewide average cost. The average per-day costs in HSAs 1, 3, 4, 6 and 7 are approximately 10 percent lower than the statewide average cost. Therefore, if the veterans were placed in existing community nursing homes in these areas, the cost to the state would be approximately 10 percent lower than the amount shown on Table 26.

Table 27. Per-resident-day costs of nursing home care

Nursing home	Per-day cost
Community nursing home (SNF)*	$73.19**
New veterans home (60 residents)	$114.76
Minneapolis veterans home (SNF)	$87.07***
Ah-Gwah-Ching (SNF)	$137.70
Ah-Gwah-Ching (ICF)	$106.80

*SNF = skilled nursing facility; ICF = intermediate care facility.

**$73.19 is the statewide average of rates established by regulation.

***Cost is based on expenses for the previous 12 months.

Taking these factors into account makes it clear that the option of placing veterans in community nursing homes is significantly less expensive to the state than the option of building and operating a new state veterans home.

Table 27 expands the comparison to include the per-day costs of nursing home care in other state-operated institutions.

There are two primary reasons why the community nursing home option is less expensive than the new veterans home option. First, the statewide average per-day expense in community nursing homes is $73.19, compared with an estimated per-day cost in a new 60-resident state-owned facility of

$114.76. Second, the federal government pays more than 50 percent of Medical Assistance costs, while the VA pays $21.83 per resident day for persons in state veterans homes, approximately 19 percent of the estimated per-day cost of operating a 60-resident veterans home.

Cost to the state of using alternative care grants to provide long-term care for veterans

The cost to the state of operating a new state veterans home can be compared with the cost of providing home- and community-based care through the Alternative Care Grant Program.

The average annual cost to the state of an alternative care grant is $2,823 [4]. This amount can be compared with the average annual cost to the state of providing nursing home care in a new veterans home of $20,285 per resident in a 60-resident home and $16,783 per resident in a 120-resident home. Providing home- and community-based care for veterans for whom such care would be appropriate would cost the state much less than operating a new veterans home.

References

1. Lunde, Eric, Long-term Care Management Division, Department of Human Services, Dec. 13, 1989.
2. Hoffman, George, director, Reports and Statistics Division, Minnesota Department of Human Services, Dec. 11, 1989.
3. Bergerson, Wally, Reports and Statistics Division, Department of Human Services, Oct. 6, 1989, telephone interview.
4. Grannes, Gina, Long-term Care Management Division, Department of Human Services, Nov. 15, 1989, telephone conversation.

EVALUATING THE NEED:

The impact of additional veterans homes on existing nursing homes

The establishment of new veterans nursing homes could affect community nursing homes in a variety of ways. This section discusses the potential impacts.

Community nursing homes could be affected by the opening of a new veterans home in at least two ways. First, nursing homes may lose trained and experienced staff (existing staff or potential new hires) to a new facility in the same vicinity. Second, a community nursing home may lose existing or future residents to a new veterans home.

This section discusses why the possibility of losing trained staff is threatening to community nursing homes. This involves three main issues: (1) the difference between salaries paid by community nursing homes and by the state; (2) shortages of health care workers and (3) community nursing homes' ability to pay health care workers competitive salaries.

Finally, this section discusses whether there is likely to be a loss of residents from community nursing homes to a new veterans home and whether this would have a significant negative impact on community nursing homes.

Salary comparison

Table 28 shows a comparison of salaries in community nursing homes in Minnesota with salaries offered by the state of Minnesota to its employees. For the community nursing homes, the salaries are shown for the 10th percentile (where 10 percent earn less and 90 percent earn more), 50th percentile (median level) and 90th percentile. For the state system, the minimum and maximum salaries are shown. Although directly comparable figures were not available, this data clearly indicates which employer pays higher salaries.

In every occupation shown except one, the state minimum salary is substantially greater than the 10th percentile salary level for nursing homes. For example, the minimum salary for a registered nurse (RN) in the state system is 25 percent higher than the 10th percentile level in nursing homes. The minimum salary for an RN in the state system is even higher than the median salary level for the same occupation in nursing homes, by a margin of approximately 5 percent.

The salary difference is significant at both the upper and lower ends of the wage scales. A community nursing home RN at the 90th percentile will earn $8,811 (33

Table 28. Salary comparison for selected occupations in community nursing homes and state government, 1988

	Community nursing home*			State system**	
Position	10th Percentile	50th Percentile	90th Percentile	Minimum	Maximum
Nurse, RN	$19,240	$22,880	$27,040	$24,054	$35,851
Nurse, LP	14,248	16,952	20,072	20,609	26,392
Nurse, director	22,235	26,811	32,240	26,309	36,644
Nurse assistant	9,360	11,918	15,080	15,848	16,913
Social worker	15,059	18,720	23,379	21,486	28,063
Physical therapist	23,920	33,280	41,600	23,678	31,153
Clerk typist	10,400	13,728	19,448	16,913	24,283
Cook	9,984	12,813	16,848	18,562	22,321
Janitor	10,026	13,541	19,094	15,848	16,537

*Figures for nursing home salaries in some instances are rounded to the nearest whole dollar.

**State salary minimums and maximums are for entry-level positions. In some cases, there are related promotional categories with higher salary ranges. For these, the maximum salaries at the top of the nonsupervisory promotional range (state job title in parentheses) are: RN (registered nurse principal), $40,319; LPN (LPN 2), $26,392; nurse assistant (human services technician senior), $23,553; social worker (social worker senior), $31,153; physical therapist (physical therapist 2), $37,208; clerk typist (clerk typist 4), $24,283; cook (cook coordinator), $23,553; janitor (general maintenance worker 4), $21,047. Maximum salaries for nurse director are $36,644 (registered nurse supervisor) and $40,987 (registered nurse administrative supervisor).

Sources: Nursing home figures, "Minnesota Salary Survey of Hospitals and Nursing Homes by Hospital District," Minnesota Department of Jobs and Training; state system figures, Minnesota Department of Employee Relations.

percent) less than a veterans home RN at the top of the pay scale. While not a direct comparison, the figures do show that an RN employed by the state would probably start at a higher salary and could look forward to a higher maximum salary.

A nurse assistant faces a wide discrepancy in salary at the lower end of the scale. A community nursing home nurse assistant at the 10th percentile will earn $9,360 per year, compared with a minimum salary of $15,848 for a nurse assistant in the state system. In fact, the starting salary for a nurse assistant in the state system is higher than the 90th percentile salary in the private system.

In general, salary comparisons for other job categories follow the same pattern of higher starting salaries and higher maximum salaries. An exception shown in Table 28 is the position of physical therapist.

These salary levels do not include benefits such as health and life insurance, vacation and sick time accrual or retirement benefits, which all state employees receive and which community nursing home employees may or may not receive.

Because the state pays higher wages, a new veterans home may draw some staff from community nursing homes if (1) the new veterans home is located sufficiently close to the community nursing home and (2) the nursing home does not raise its salary level to meet the new competition. How close a community nursing home needs to be to a new veterans home in order to be negatively affected cannot be determined beforehand; this will be determined by local labor market conditions and other factors.

The February 1989 Management Analysis Division report titled "Potential Sites for a State Veterans Home" discussed the impact that hiring a large number of nurses for a state institution had on the surrounding facilities. The report showed that when the Willmar Regional Treatment Center hired approximately 35 registered nurses and 18 licensed practical nurses, many were drawn away from neighboring facilities. It took up to six months for at least one nursing home to replace lost nursing staff.

Staff shortages

Interviews with associations representing operators of community nursing homes indicated that operators are concerned not only about their ability to pay staff competitive salary levels but also about staffing shortages.

The issue of whether a community nursing home is able to pay its staff on par with hospitals or state facilities in like classifications is intertwined with the issue of potential staffing shortages in critical occupations. To the extent that there are shortages in needed occupations, this exacerbates the problem of the community nursing homes' ability to attract and retain staff.

This section discusses the labor market for health care workers and other occupations needed by nursing homes. Particular attention is paid to HSA Regions 1, 3, 4, 6 and 7. However, it must be kept in mind that the labor market is somewhat

mobile; shortages of needed employees in one area can be filled by persons who relocate from another area.

The Minnesota Department of Jobs and Training collects quarterly supply and demand information for occupations with either a shortage or a surplus. The data is collected by region based on interviews with representatives in regional state job placement offices. While the data may not be systematically and consistently collected and processed, it provides one indication of shortage occupations by region.

Jobs and Training defines shortage occupations as those that are difficult to fill or that remain unfilled due to a lack of qualified applicants.

In northwestern Minnesota, an area including HSA Regions 1 and 3 and part of HSA Region 4, the following occupations were listed as shortage occupations in May 1989: registered nurse, licensed practical nurse, nurse's aide, medical technician, medical secretary, food service worker and electronic technician. With the exception of electronic technician, all these occupations have been listed by Jobs and Training as shortage occupations in at least two of the last three quarters. With the exception of electronic technician, all these occupations would be needed by community nursing homes and a new veterans home.

In central Minnesota, roughly corresponding to HSA Region 4, one occupation was listed as a shortage occupation in May 1989 — food service worker. It was listed as a shortage occupation in at least two of the last three quarters. Other sources indicate, however, that central Minnesota will face a severe shortage of registered nurses in the future [1].

In southern Minnesota, corresponding to HSA Regions 6 and 7, the following occupations were listed as shortage occupations in May 1989: registered nurses, licensed practical nurses, food service workers, retail sales clerks and truck drivers. All these occupations were listed in at least two of the last three quarters. Of these occupations, registered nurses, licensed practical nurses and food service workers would be needed by community nursing homes.

None of the occupations needed by community nursing homes or a veterans home was listed as a surplus occupation by Jobs and Training in May 1989. Surplus occupations are those in which the number of qualified applicants greatly exceeds the number of openings.

Jobs and Training also has begun to collect projected supply and demand information on a systematic basis for persons trained in selected occupation clusters. Using the Minnesota Occupational Information System, the department has developed a computer data base of projected employment needs (demand) and estimates of the number of persons recently completing training in those fields (supply), by Minnesota region and statewide.

Table 29. Shortage of persons in selected health care occupations

	Increase in demand 1986-93			Supply increase, 1987	Surplus or (shortage)
	Annual growth	Annual replcmnt	Tot annual increase	Tot annual increase	Supply - demand
Northwest area					
RN	52	70	122	144	22
LPN	24	28	52	147	95
Nurse assistants	64	133	197	NA	
Medical record tch	4	7	11	10	(1)
Southern area					
RN	108	91	199	92	(107)
LPN	52	42	94	112	18
Nurse assistants	64	133	197	118	(79)
Medical record tch	11	7	18	NA	
Central area					
RN	65	63	128	10	(118)
LPN	37	21	58	50	(8)
Nurse assistants	100	126	226	11	(215)
Medical record tch	5	7	12	NA	
Statewide					
RN	731	714	1,445	855	(590)
LPN	295	252	547	703	156
Nurse assistants	613	1,148	1,761	399	(1,362)
Medical record tch	50	49	99	48	(51)

Source: Minnesota Department of Jobs and Training, 1989.

Table 29 shows selected supply and demand information relating to health care workers in HSA Regions 1, 3, 4, 6 and 7 and statewide.

This data reflects initial efforts by Jobs and Training to quantify trends and potential shortages in selected occupation clusters. The supply portion does not indicate all sources of potential supply. It includes only the number of persons completing training for the indicated occupations in two-year public and private colleges in the areas studied. Other sources are available to employers, including people transferring from other areas, employees given on-the-job training for some occupations, or persons already working in the area who are either reentering the job market or changing occupations and who have previous training or experience in the needed occupations.

With these important qualifications, this data may be used as one indicator of potential future shortages in needed occupations. This data shows significant future shortages of registered nurses and nurse assistants in the southern (HSA Regions 6 and 7) and central (HSA Region 4) areas and statewide.

While the data from the two sources discussed above is not consistent in every respect, both sets support the general perception of shortages of needed medical professionals. The combination of shortages in needed occupations and some community nursing homes' inability to pay competitive salaries in some areas indicates the potential for negative impacts on community nursing homes.

Reimbursement for salary increases

Operating expense reimbursement

This section discusses the way that community nursing homes are reimbursed for their operating expenses relating to providing long-term skilled nursing care, and discusses whether community nursing homes could raise staff salaries and recover the higher level of expenses through payment rates.

The Minnesota Department of Human Services determines the maximum rates that community nursing homes may charge residents receiving care under the Medical Assistance program. State law provides that private-paying residents may pay no more than the Medical Assistance rate. Therefore, all community nursing home rates are subject to Human Services regulations. The purpose of Human Services' rate regulation is to control growth in the budget for Medical Assistance while ensuring that those in need have access to quality long-term care [2].

The legitimate, prudent and necessary costs that a nursing home incurs to provide care for its residents are used to determine the rates that nursing homes may charge (Minn. Rules 9549.0035, Subp. 8, 1987). Compensation for personal services is an allowable cost for purposes of determining the nursing home's operating cost portion of the total payment rate. Compensation for personal services includes

Table 30. Cost-recovery gap for Minnesota nursing homes

	Date	Elapsed time
Reporting year	Oct. 1 - Sept. 30	12 months
Submittal to DHS	Dec. 31	3 months
DHS rate determination	May 1	4 months
Effective date of rates	July 1	2 months
Total time		**21 months**

salaries, wages, bonuses, vested vacations, vested sick leave, fringe benefits and retirement plans.

Because costs of operating nursing homes change every year, Human Services adjusts the rates annually. Rates are based on historical costs, inflated by a forecasted adjustment factor to better match the rates with the cost during the time the rates are in effect. Nursing homes must submit a statement of their costs, in a format prescribed by the department, showing their costs for Oct. 1 to Sept. 30 of the reporting year. These cost reports must be submitted no later than Dec. 31 each year. By May 1 of the following year, Human Services must determine the total payment rate for each of the 448 nursing homes in Minnesota. The rates become effective the following July 1. Thus, as shown in Table 30, there could be as much as a 21-month delay between the time a cost is incurred and the time it is recovered. To compensate the nursing home for this delay, Human Services' reimbursement rules provide that the historical costs will be increased by a forecasted adjustment factor reflecting the expected increase in costs between the reporting year and the rate year.

Reimbursement limit

To provide community nursing homes with an incentive to operate efficiently and to control costs, Human Services' rules establish limits on the per diem rates. The limits are determined by case-mix class and by geographic areas in the state. For rate-setting purposes, the counties in the state are classified as either Group 1 (low cost), Group 2 (medium cost) or Group 3 (high cost).

There are several other complexities in the rate-setting formula. For example, operating costs are broken into three categories: case mix operating costs, other care-related operating costs and other operating costs.

The first two categories of operating costs — case mix costs and other care-related

costs — are combined to determine total care-related costs. The limits for total care-related costs are set at 125 percent of the median historical costs during the base year ending September 1984, adjusted for inflation. The limits, like the actual historical operating costs, are determined by geographic area and by case-mix class. The limits for other operating costs are set at 110 percent of the median historical costs during the reporting year.

The community nursing homes may charge residents the lower of either their actual operating costs, as adjusted, or the operating cost limit, as adjusted.

Salary costs for nursing personnel fall into the care-related categories. In rate year 1989, 406 (91 percent) of the 448 community nursing homes had costs below the care-related limit. Thus, more than 90 percent of the community nursing homes could increase nursing salaries and receive full or partial reimbursement through rates. Of the 448 community nursing homes, 348, or 78 percent, had costs below the other operating cost limit for the same year.

Efficiency incentive

Human Services' rules provide an efficiency incentive for community nursing homes that have below-limit other operating costs; the efficiency incentive does not apply to care-related operating costs. The rules are designed to encourage community nursing homes to be efficient in their operations without scrimping on care-related operating costs. The rules provide both positive and negative incentives. If actual other operating costs exceed the other operating cost limit, the community nursing home may charge no more than the limit. If actual other operating costs are less than the limit, the community nursing home may charge no more than actual costs plus an efficiency incentive. The efficiency incentive is the difference between the limit and the actual cost, up to a maximum of $2 per resident day.

For rate year 1989, 75 percent of all community nursing homes will receive an efficiency incentive; 39 percent will receive the maximum efficiency incentive. This rate feature will provide an estimated $19.1 million in extra revenue for community nursing homes in 1989. The extra revenue provides many community nursing homes with some financial flexibility; these funds could be used to supplement salaries or for other purposes.

Loss of residents to a new veterans home

This section discusses whether there is likely to be a loss of residents from community nursing homes to a new veterans home and whether this would have a significant impact on community nursing homes. Data is presented showing the number of veterans in community nursing homes that would potentially move to a veterans home. Statewide occupancy rates are reviewed to estimate the impact the transfer of residents would have on community nursing homes.

Table 31. Estimated impact on community nursing homes by HSA region

Region	Licensed beds	Present occupancy rate	60 beds/total licensed beds	Occupancy rate with new 60-bed home	120 beds/total licensed beds	Occupancy rate with new 120-bed home
HSA 1	2,196	92%	2.7%	89%	5.5%	87%
HSA 3	2,972	96%	2.0%	94%	4.0%	92%
HSA 4	5,084	96%	1.2%	95%	2.4%	94%
HSA 6	6,924	97%	0.9%	96%	1.7%	95%
HSA 7	5,252	95%	1.1%	94%	2.3%	93%

Impact by HSA region

Table 31 shows the number of veterans in a new veterans home as a percentage of the total licensed beds in each HSA. The percentage is shown for both a new 60-bed home and a 120-bed home.

This table also shows the present occupancy rates by HSA and the occupancy rates that would result after a new 60-bed or 120-bed veterans home was built. The present occupancy rates range from 92 to 97 percent. If a new veterans home was located in HSA 1, the occupancy rate would fall from 92 to 89 percent with a 60-bed home and to 87 percent with a 120-bed home. The occupancy rates in HSAs 4, 6 and 7 would be affected the least, dropping approximately one percentage point with a 60-bed home and two percentage points with a 120-bed home.

If a new veterans home was built in HSA 3, the occupancy rate would fall from 96 to 94 percent with a 60-bed home or to 92 percent with a 120-bed home.

This analysis assumes that there is no growth in the number of persons needing nursing home care. Therefore, these results overstate the likely impact on occupancy rates because the demand for nursing home care is increasing. Even making this assumption, the occupancy rate would drop below 94 percent in only one HSA with a 60-bed home or in three HSAs with a 120-bed home.

The addition of a veterans home would have a significant impact on the occupancy rate in any one HSA only if the demand for nursing home care does not increase. The impact would be more noticeable in those HSAs with fewer licensed beds and lower existing occupancy rates.

Impact on individual community nursing homes

There is a financial incentive for a veteran to choose a state veterans home over a community nursing home. State rules grant more generous personal needs and income allowances and provide a more generous treatment of some assets. In addition, a veteran may prefer a veterans home to a community home because of the camaraderie and shared experience with other veterans. On the other hand, the location of the nearest community nursing home may also play an important role in the selection process. A veteran may choose to live in a community nursing home because it is close to relatives and friends.

Approximately 8.6 percent of residents in community nursing homes are veterans. If it is assumed that those veterans are evenly distributed over all community nursing homes in Minnesota, then the maximum ratio of residents that would move to a new veterans home is 8.6 percent. In a 100-bed community nursing home, this would indicate a loss of up to eight or nine residents. While this is a relatively small number, this could have a significant impact on an individual community nursing home, at least in the short run.

For example, if a community nursing home with 100 beds and 95 percent occupancy rate lost eight residents, its occupancy rate would be cut to 87 percent. This would have a significant impact on the community nursing home if it was unable to replace the lost residents. However, given generally high occupancy rates as discussed below, this seems to be an unlikely circumstance. Certainly, factors such as the occupancy rates of the community nursing homes in the communities surrounding the new veterans home and the conditions and environments in those community nursing homes would influence whether affected community nursing homes would be able to replace lost residents.

Occupancy rates

As discussed in Part 2 of this report (Table 7), the HSA regions studied have generally high occupancy rates, although the occupancy rates show significant variation from county to county (Table 32).

High occupancy rates are an indication that the current demand for nursing home beds nearly matches the supply. This implies that a small increase in the supply of beds, particularly in light of forecast growth in demand, would not cause a major overcapacity problem. Of course, it is possible that an individual nursing home located near the new veterans home would be affected.

Table 32. Number of counties with nursing home occupancy rates greater than 95 percent, 1987

Region	Number of counties	Number of counties with occupancy rates >95 percent	County average
HSA 1	12	4	93.3%
HSA 3	9	6	95.5%
HSA 4	14	10	94.9%
HSA 6	27	25	97.3%
HSA 7	11	6	95.2%

Conclusions — staffing and resident impacts

A community nursing home located in the same general area as a new veterans home would be negatively affected by the competition for needed staff. It is likely that some staff would be drawn from community nursing homes in the general area because of the state's higher wage and benefit package and because of the general shortage of needed medical personnel.

Some community nursing homes would be unable to pay higher salaries to retain existing workers or attract new workers without exceeding the level of costs for which they are reimbursed. However, most nursing homes would be able to raise rates to cover a portion of higher labor costs. A community nursing home is able to recover those costs on a current basis if their costs are below the limits and if their total cost increases are within the allowed inflation adjustment.

A new veterans home could also negatively affect a community nursing home by drawing residents away from it. Whether a new veterans home would have a significant negative impact on occupancy rates in community nursing homes would depend on several factors.

The addition of a veterans home would have little impact on the overall occupancy rates in any one HSA region, primarily because the proportion of new nursing home beds compared with existing nursing home beds in any one region would be small.

The impact on any one community nursing home would likely be small. However, there are conditions under which an individual community nursing home could be significantly affected by a loss of residents. Factors such as the occupancy rates of the community nursing homes in the communities surrounding the new veterans home and the conditions and environments in those community nursing homes would influence whether affected community nursing homes would be able to replace lost residents.

Because a new veterans home would have the largest impact on community nursing homes in the surrounding communities, it cannot be determined which nursing homes would be most affected until a location decision is made. Conversely, this information on impact could be used to determine where in the state the placement of a new nursing home would have the least impact.

References

1. Painter, Jim, St. Cloud Hospital, Oct. 2, 1989, survey of 42 hospitals and nursing homes in central Minnesota.

2. Lunde, Eric, Long-term Care Management Division, Department of Human Services, Dec. 13, 1989.

EVALUATING THE NEED:

The availability of federal funding for veterans' long-term care

The future availability of funding for construction of new state veterans homes is another factor to be considered in analyzing the advisability of establishing additional state homes.

Federal funding for state veterans homes

Process for funding new veterans home construction

The VA decides annually which construction of new state veterans homes it will fund. States must propose nursing home projects to the VA by Aug. 15 of each year. According to VA regulations (38 CFR 1, 17.173), applications are ranked on the basis of the following tests:

- First, states must demonstrate that sufficient funds have been made available for the state and/or local match.
- Second, applications from states that have not received a state veterans nursing home construction grant from the VA in the past are given preference.
- Third, applications from states that provide relatively fewer beds as a proportion of the state's veterans population are ranked higher than other applications.

When Congress adopts the federal budget in the fall of the year, the VA applies the budget authority for nursing home construction to the priority list until all funds have been expended.

Future directions in federal funding for state veterans homes

Interviews with VA and congressional committee staff indicate that the VA's state veterans home program remains very popular with the federal government. It is the least expensive option, from the federal viewpoint, for providing nursing home care to veterans. It also offers the opportunity to share the delivery of veterans services with the states.

Funding for state veterans home construction has been relatively stable for the last four years. Table 33 indicates that funding has remained at approximately $42 million since federal Fiscal Year 1987.

Table 33. Budget authority - U.S. VA State Veterans Home Construction Grant Program

Federal fiscal year	State home construction budget
1990	$42,000,000
1989	$42,000,000
1988	$40,320,000
1987	$42,400,000
1986	$20,822,000
1985	$34,500,000
1984	$18,000,000

Source: U.S. House Committee on Veterans Affairs, October 1989.

Interviews also indicated that the state veterans home program budget accounts for an increasing proportion of the VA's overall construction budget. The priority of the state homes program, therefore, seems to be growing within the federal government.

However, indicators point to a potential unavailability of federal funding for new Minnesota veterans homes. Budget constraints have forced the VA to restrict the types of patients it will serve in VA Medical Centers. The decision to serve only Category A veterans may be a significant indication that the VA is moving toward serving a smaller proportion of veterans as the population of veterans needing acute as well as long-term care increases. The continuing federal budget crisis is likely to keep pressure on the VA to limit its commitments to veterans' health care.

In the VA's overall health care system, long-term care does not have the highest priority. In interviews, VA and congressional committee staff repeatedly asserted that federal provision of acute and ambulatory care for veterans is considered mandatory, while federal provision of long-term care is not.

Although funding for state home construction has remained fairly stable, if adjusted for inflation the figures would show a gradually declining commitment to state home construction. As competition for state home funds increases, the availability of money lessens. In this environment, it is likely that Minnesota, a state with 435

veterans nursing home beds approved for operation or construction, will find itself competing with states that have a higher priority in the VA's ranking process. Table 18 in Part 4 shows how Minnesota ranks with other states in serving veterans in state nursing homes.

Since Minnesota will soon provide 435 beds, other states without veterans homes or with greater need may have priority over Minnesota in VA funding decisions.

The future of federal funding for veterans homes may change for other reasons. The secretary of Veterans Affairs has proposed the creation of a commission to review the health care mission of the VA. The commission would have as part of its agenda the review of the VA's health care obligations to veterans. It may, for example, choose to expand the role that alternatives to nursing home care play in the VA's overall long-term-care system. What this means for the state veterans home program is not clear. However, a cabinet-level review of the VA's mission implies that the commitments and direction of VA policy may change in the near future.

Federal funding for state veterans' alternative care

As the general long-term-care system expands to include more alternatives to nursing home placement, the VA has also increased the long-term-care choices it makes available to veterans. At this point, however, the choices are limited to a relatively small number of veterans who are discharged from and reside near a VA Medical Center.

Interviews with congressional staff indicated that Congress would be reluctant to extend alternative care to all of the older veterans not currently receiving a VA long-term-care benefit. Similarly, Congress would be reluctant to expand the community nursing home contract program to include all veterans needing nursing home care. Congress and the federal Office of Management and Budget would reportedly perceive such a voucher system as creating a new entitlement program, with the prospect of uncontrollable costs as the older veterans population increases.

There is, however, some interest in providing federal support for a state-administered alternative care program for veterans as long as the number of recipients is limited.

An analysis of

The Need for Additional Veterans Nursing Homes in Minnesota

Recommendations

RECOMMENDATIONS

Based on the findings of this study, three recommendations are offered. The first addresses the need for additional veterans nursing homes, the second concerns alternatives to building such homes and the third deals with long-range planning.

Recommendation 1.

The State of Minnesota should not, at this time, construct and operate additional veterans nursing homes. The state should use the nursing home capacity already in place before building additional veterans nursing homes.

This recommendation is based on the study of several factors: veterans' population growth and nursing home use estimates, cost of building and operating a facility, the appropriateness of the care offered by such a facility, management of the current veterans nursing home system, and current fiscal problems within the U.S. Department of Veterans Affairs.

The data and analysis show that, with the construction of Silver Bay, there is no need for additional veterans nursing home beds statewide until the late 1990s. Since the legislature has authorized, but the VA has not yet funded, the Luverne home, this report has implications for Luverne. The legislature has the following options for dealing with the proposed Luverne home:

Option 1: Proceed with construction of the proposed 83-bed facility as soon as construction funds are available. If additional nursing home beds were needed, southwest Minnesota would have the greatest need. HSA Region 6 has a nursing home occupancy rate of 97 percent, the highest of any region in the state. Rock County, the location of the Luverne home, has a nursing home occupancy rate of 99.6 percent, the second highest of any county in Minnesota. The number of nursing home beds needed to serve veterans in the near term is higher in HSA Region 6 (474) than in any other region outside the Twin Cities area.

Since the Luverne proposal has already been approved for funding by the VA and awaits only the availability of funding, the legislature could proceed with construction and operation of the 83-bed facility. This option would ensure that the facility as envisioned by the Veterans Homes Board of Directors would be available to meet the expected growth in veterans' demand for nursing home care in the late 1990s. In the interim, the number of veterans home beds available would exceed that dictated by the 8.4 percent market share. The home would likely draw residents from community nursing homes, other veterans or VA homes, or prematurely from the community.

Option 2: Proceed with construction of the proposed 83-bed facility as soon as construction funds are available, but gradually phase in its operation. This would accomplish the same goal as Option 1: ensure that an 83-bed home is available by the end of the 1990s. The advantage is that operation would proceed more slowly. The market share of 8.4 percent for HSA Region 6 and the state could be more closely maintained by phasing in operation.

Option 3: Reduce the size of the Luverne home. The size of the Luverne home could be reduced to reflect the smaller number of beds needed in HSA Region 6 and the state. The size could be targeted to maintain or closely approximate the veterans homes' market share. Since the projected demand for state veterans home beds in HSA Region 6 never exceeds 75, an added advantage of this option is that it would avoid overbuilding to meet the *region's* peak demand.

Option 4: Withdraw the application for VA construction funds. The overall conclusion that additional state veterans homes will not be needed in Minnesota until after 1995 could lead to the withdrawal of the application for VA construction funds. The legislature could reopen the needs assessment and siting process in the mid-1990s and base selection on data available at that time. The disadvantage is that the planning for construction and operation of the facility has already proceeded to the point of VA approval. Potential host communities and the state would have to begin the process of siting and application for VA construction funds from square one.

Population growth and nursing home use estimates do not indicate a need for additional veterans nursing homes.

While the number of Minnesota veterans is steadily decreasing, the veterans population is aging. It can be expected that an increasingly large proportion of veterans will need nursing home care in the future.

However, in the next four to six years, additional beds devoted only to veterans will not be needed to meet demand. Current occupancy rates leave more than enough empty beds to accommodate those veterans within the existing long-term-care system. In the longer term, growth in veterans' demand can be met by reasonable and prudent expansion of the current long-term-care system.

In 1983, the legislature determined that Minnesota had too many nursing home beds. In response, it enacted a moratorium on the addition of beds or licensing of new facilities until a need could be demonstrated. No such need has been demonstrated and none is forecast by the Interagency Board for Quality Assurance in the next four to six years. (State veterans nursing homes are exempt from the moratorium.)

The interagency board also says that too many beds are currently used by Minnesotans who could better be served outside a nursing home. The board estimated that almost one-quarter of current nursing home residents could live outside the nursing home setting.

Since 1985, the state has pursued the use of alternative care services by requiring all potential nursing home residents to be screened before admittance. The screening diverts individuals who do not need the range of care offered in a nursing home into settings more appropriate to their needs. The effect of the screening process can be seen in declining nursing home use rates. Continued diversion of individuals into other care settings will slow the growing need for nursing home beds in the future, while providing more appropriate care for state citizens.

Currently, 8.4 percent of the state's veterans needing nursing home care are served at the Minnesota Veterans Home in Minneapolis. With the addition of 89 beds at the Silver Bay home, the state will not need more veterans home beds until sometime between the years 1995 and 2000 in order to maintain the 8.4 percent level of service. If the state-approved Luverne facility, providing an additional 83 beds, receives federal funding, the state will not need to add capacity to the system until after the year 2000.

In summary: An oversupply of nursing home beds, declining utilization rates, greater use of alternative care services and the addition of a veterans home in Silver Bay, combined with estimates of population growth and nursing home use, indicate that there is no need for additional veterans nursing homes at this time.

A state veterans home would cost more than using existing nursing homes or alternative care services.

Analysis of bed supply and veterans' population forecasts shows that veterans who need nursing home care can be served in existing nursing homes in the next four to six years. A number of veterans who in the past might have been placed in a nursing home can also have their needs met outside a nursing home setting. In both cases, the cost to the state would be less than the cost of operating a new veterans nursing home.

The federal government pays more than 50 percent of the daily Medical Assistance costs of a community nursing home resident, compared with 19 percent of the daily costs of a resident in a state veterans home.

The total per-day cost of skilled community nursing home care averages $73.19 for each resident. The per-day cost of a new veterans home would be $114.76 per resident (in a 60-resident home).

On average, it will cost the state $883,773 per year more to operate a new 60-resident veterans home than it would to care for the same number of veterans in an existing community nursing home.

In addition to the operating costs, it would cost the state $1,513,898 to construct a new 60-resident veterans nursing home that would, essentially, duplicate existing services and add to the state's oversupply of beds.

Placing people in a nursing home when they don't need the full array of nursing home services is also more expensive than providing alternative services. The

average annual cost to the state of an alternative care grant is $2,823. The average annual cost to the state of providing nursing home care in a new veterans home is $20,285 per resident in a 60-resident home and $16,783 per resident in a 120-resident home.

In summary: Using existing beds for veterans who need nursing home services, and providing alternative services to those who don't, would cost the state less than building and operating a new veterans nursing home.

A state veterans home may not provide care appropriate to the needs and desires of Minnesota's veterans or be the best use of the limited state resources allocated for veterans' programs.

A social contract exists between society and veterans. Veterans have come to expect that society will provide them with the best health care possible on both the federal and state levels. Construction of an additional state veterans home may not meet that test.

To fulfill the obligations of the social contract, the state of Minnesota should ensure that the care offered to its veterans is appropriate to their needs. A nursing home bed should be viewed as the last resort; only in the absence of other alternatives should an individual be placed in a nursing home. People capable of living on their own with some aid from family or the state should not have to face confinement in a nursing home and the loss of independence that can result in a decreased quality of life.

Because of the funding crisis being experienced by the U.S. Department of Veterans Affairs, it may fall to the state to provide leadership in offering veterans' care alternatives. Availability of state funds for veterans' programs is limited; development of alternative care programs for veterans would be a more appropriate use of state resources.

According to polls, 92 percent of veterans want to stay out of nursing homes as long as possible. Building a new state veterans home without attempting to find alternatives to nursing home care would ignore the desires of veterans and encourage their institutionalization. Emphasizing alternatives to nursing home care would allow many veterans to remain with their families in their communities.

Polls also indicate that veterans want to remain close to friends and family if they must live in a nursing home. Placing veterans in local homes would keep them near friends and family, in contrast to a state veterans home, which could be hundreds of miles away from home.

In summary: Before expending funds on an additional state veterans home, the state should ensure that veterans have access to all feasible alternatives to nursing home care so that their quality of life is not harmed. If nursing home care is required, it may be more appropriate for veterans to be admitted to a community facility near home, rather than in a state facility that could be many miles away.

Additional veterans homes may place difficult burdens on systems management.

In response to critical reports on the condition of the Minnesota Veterans Homes in Minneapolis and Hastings, the legislature created the Veterans Homes Board of Directors to oversee management of the homes. The board has been in operation since 1988.

While many improvements have been made, the board is still in the process of correcting problems at the current homes. To this job has been added establishment and operation of the Silver Bay facility.

With improvements at the Minneapolis home not yet complete and a 26 percent expansion of the veterans home system with Silver Bay, the board faces a strenuous task. The state should wait until the board successfully improves current homes and adds Silver Bay before further expanding the system.

In summary: Expansion of the state veterans nursing home system and the improvement of management at the Minneapolis and Hastings homes pose a stiff challenge for the Veterans Homes Board. These challenges should be met before further expansion of the system is considered.

Before building additional veterans nursing homes, the state should make use of the nursing home bed capacity that is already in place.

The VA Medical Center in Minneapolis operates 40 extended-care beds, but has the capacity for a total of 120 beds. Eighty beds are not being used because funding for their operation is not available. The state also has a surplus of community nursing home beds that the VA could make use of through its community nursing home contract program. The advantage of this approach is that it would bring federal funds into the state and would make use of excess capacity with little or no cost to the state. Before building additional state veterans homes, the state should urge the U.S. Department of Veterans Affairs to make operating funds available for VA extended-care beds and to expand the contract nursing home program.

The current fiscal crisis facing the U.S. Department of Veterans Affairs may affect future federal payments to the state.

Future funding for the U.S. Department of Veterans Affairs is uncertain. Recent budget problems have forced the department to cut back on the health care services it offers to veterans. The department now refuses care to some categories of veterans it formerly served.

Because funding for the department is a congressional decision, there is no way for the state to predict how the federal government will handle veterans' services in the future. There is a possibility of transfer of some federal health care services to local and state governments.

The uncertainty of federal funding for veterans' services makes it possible that state veterans' health care commitments made today may greatly exceed cost estimates that are based on historical analysis, and the more expensive the state program, the more severe the impact may be. Because of this, the state should wait until future federal supports are known and assured before committing to long-term veterans' program additions.

In summary: The state should not expand the state veterans health care system until it is known how Congress will address the crisis in funding for the U.S. Department of Veterans Affairs.

Based on this recommendation, the Department of Administration should not conduct site selection for another veterans nursing home.

Recommendation 2.

The State of Minnesota should expand the array of long-term-care services offered to veterans by:

- **requiring participation of potential nursing home residents in the Preadmission Screening Program;**
- **developing alternative care services for veterans, such as home supportive care, in cooperation with the U.S. Department of Veterans Affairs; and**
- **establishing a demonstration project to provide case management to a limited number of veterans with long-term-care needs.**

Beginning with a goal of using nursing home care as a last resort, the state, in considering the best use of resources allocated to veterans' programs, should provide veterans with reasonable alternatives.

Institutionalization is associated with dependency and decreased quality of life, and is generally the most expensive long-term-care option. Veterans (and older persons in general) desire alternatives to nursing home care and show a clear preference for home- and community-based care programs.

Noninstitutional services, however, are underfunded, compared with institutional programs. Local, state and federal long-term-care systems all allocate a very large proportion of their budgets for institutional care.

Requiring veterans home applicants to participate in the statewide Preadmission Screening Program would help divert veterans into more appropriate care settings.

At present, an applicant to the veterans home may not be subject to the state's preadmission screening process. This is unfortunate, because the program is designed specifically to assist persons in considering and obtaining alternative care services. It is conducted in conjunction with the Alternative Care Grant Program, which funds alternative services.

Participants receive a comprehensive screening that includes an examination of physical and mental health, social supports and financial status. The information is used to determine whether nursing home care is appropriate, or if the individual might be better served by home- and community-based care.

While the state veterans home has a preadmission screening process, it does not appear to be as comprehensive as the statewide screening, nor as useful in helping the individual obtain alternative care. The state could also use preadmission screening to identify and assist veterans whose incomes exceed alternative care grant eligibility limits and to help them obtain desired and necessary services.

Alternatively, the state veterans home could modify its screening program so that it is similar to the preadmission screening standard. However, such a duplication of effort might not be cost-effective and would require applicants to go through two screenings when only one is necessary, if they apply both to the veterans home and to a community nursing home.

In summary: Preadmission screening helps match the needs of nursing home applicants with appropriate care services. Requiring preadmission screening at the veterans homes would benefit Minnesota's veterans.

Funding selected alternative care services would de-emphasize institutionalization.

Noninstitutional long-term-care services are underfunded, despite a strong preference for them among veterans and older persons in general, and despite a correlation between institutionalization and dependence and a decreased quality of life. Less than 5 percent of either Medicare or Medicaid goes toward funding of home health care, for instance, while the state provides no funding for veterans-specific noninstitutional care. The U.S. Department of Veterans Affairs provides some alternative care, but these programs are limited in the number of sites and persons served.

The state could offer selected services for which there is an especially high need, for example, home supportive care from homemaker assistants, home health aides and personal care attendants.

Other services the state might consider funding include respite care (especially in a

noninstitutional setting, as opposed to the hospital-based respite care the U.S. Department of Veterans Affairs now provides) and adult day care.

In summary: Alternatives to institutional long-term care receive little government funding. The state could help to fill an important gap in the array of long-term-care options available to veterans by funding noninstitutional supportive care.

State-administered alternative services for veterans should build on the existing capacity of the VA Medical Centers and the state's Alternative Care Grant Program in delivering alternative long-term-care services.

The VA Medical Centers' alternative care services include home care, payment to public health nursing services, adult day health care, respite care, rural case management, geriatric evaluation units, Alzheimer's units and community residential care.

The state could learn from the experience of the VA Medical Centers in delivering these services to veterans by seeking to establish a cooperative pilot alternative care project with the VA. A cooperative pilot project offers the opportunity for sharing resources and for intergovernmental cooperation. The federal government would receive assistance from the state in serving veterans with long-term-care needs, while the state could learn from the federal experience.

The Minnesota Department of Human Services also has experience in administering alternative long-term-care services. By working with Human Services and the VA Medical Centers, the Veterans Homes Board could bring the best of both approaches together in building a state-administered alternative care program for veterans.

The state should propose a pilot alternative care project to the U.S. Department of Veterans Affairs. In proposing such a project, the state should consider the type of services to be provided, the cost of services and an appropriate division of costs between the federal and state governments, and the most appropriate geographic location for the pilot project. The choice of geographic location should be based on such factors as nursing home occupancy, availability of alternative care and proximity to VA Medical Center services.

Offering case management to veterans would help them find and choose appropriate long-term-care services.

Case management helps individuals to evaluate their long-term-care needs and options and to choose an appropriate plan of care. It goes beyond preadmission screening to include monitoring and adjusting the care plan to meet changing needs. Adjustments to care plans are commonly needed among persons with long-term-care needs because of frequent changes in physical and mental health, economic status and/or social support systems.

The current long-term-care system is fragmented. For example, veterans potentially can obtain services from the U.S. Department of Veterans Affairs, the state, Medicare, Medicaid and private vendors. Because these sources are rarely coordinated, the total package of care is not designed to best meet an individual's long-term-care needs. Case management to provide needed coordination is especially important for older persons, who often have multiple chronic and acute conditions.

Assistance is particularly important to persons with a long-term-care need because the need is often associated with a crisis such as the hospitalization or death of a spouse or other caregiver. That may not be the best time to make important choices among a confusing array of options.

In summary: Because of the importance of coordinating and monitoring care, the state should provide case management to veterans with long-term-care needs.

A demonstration project would give managers of state veterans' health care programs experience in case management.

The state does not offer case management to its veterans. Because of inexperience with such a program, and because demand for the service is unknown, a limited demonstration program would provide managers with needed experience.

Recommendation 3.

As the Veterans Homes Board develops its long-range plans, it should consider questions about whom it is going to serve and how it will best serve them. To assist in answering these questions, a comprehensive survey of veterans' needs and desires should be conducted.

The Veterans Homes Board is in the process of developing long-range plans for operation of the state veterans health care system. It is recommended that the board consider several fundamental issues:

- **How many veterans will be served?** The state does not offer long-term care to all its veterans. However, no official policy exists to determine who will be served and who will not. Currently, 8.4 percent of veterans needing nursing home care receive it in a state veterans facility. Will the state seek to maintain that proportion as the numbers of veterans who need nursing home care increase?
- **Who will be served?** If the state provides services to only a proportion of veterans, policies are needed to determine which veterans will receive them. Will care be available to any veteran on a first-come, first-served basis? Will homes draw only from specific geographical areas or statewide? Will care be limited to wartime or combat veterans, to veterans with service-connected disabilities, or to special populations, such as those with mental illness, chemical dependencies or Alzheimer's disease?

- **What type of services will be offered and how will they fit into the veterans health care system?** Recommendations have been offered on providing alternative long-term-care services to veterans. If these recommendations are followed, which services will the state offer? If the state adds skilled nursing facilities, will the homes continue to offer general long-term-care services, or will they become specialized facilities handling, for example, only mental illness cases?

A survey of Minnesota's veterans would help answer these and other questions. The survey could examine the physical and mental health, social supports, financial status and long-term-care preferences of veterans of all ages. It could determine how veterans' needs might differ from those of males in general, which would be particularly useful since projections of veterans' needs for nursing home services have been based on the needs of the general male population. Identification of veterans' status on statewide preadmission screening forms would also provide useful information.

An analysis of

The Need for Additional Veterans Nursing Homes in Minnesota

Appendices

APPENDIX A. Estimates of veterans population by county, 1989-2020

County	1989	1995	2000	2010	2020
HSA 1					
Kittson	595	498	428	326	260
Roseau	1158	977	840	690	587
Lake of the Woods	482	432	389	327	261
Marshall	1,083	917	806	657	552
Beltrami	3,785	3,612	3,399	3,001	2,609
Pennington	1,283	1,045	917	731	584
Red Lake	477	397	346	278	240
Polk	3113	2,628	2,294	1,814	1,502
Norman	746	610	535	407	331
Mahnoman	472	414	360	288	263
Clearwater	974	846	758	646	563
Hubbard	1,744	1,580	1,431	1,182	962
Total	**15,912**	**13,956**	**12,503**	**10,347**	**8,714**
HSA 2					
Koochiching	1,903	1,625	1,437	1,135	919
Itasca	4,987	4,272	3,828	3,089	2,537
Aitkin	1,566	1,388	1,249	1,009	832
St.Louis	24,596	21,137	18,831	14,581	11,463
Lake	1,612	1,350	1,204	945	731
Cook	598	542	512	418	340
Carlton	3,507	3,067	2,798	2,304	1,850
Total	**38,769**	**33,381**	**29,859**	**23,481**	**18,672**
HSA 3					
Clay	4,820	4,155	3,786	3,011	2,411
Wilkin	668	568	495	389	318
Traverse	474	404	358	283	231
Becker	3,023	2,673	2,429	2,023	1,688
Otter Tail	4,459	3,592	3,050	2,358	1,886
Grant	647	546	470	370	301
Stevens	813	696	623	534	414
Douglas	2,994	2,724	2,555	2,144	1,831
Pope	1,114	974	864	693	598
Total	**19,012**	**16,332**	**14,630**	**11,785**	**9,678**

Appendix A. Estimates of veterans population by county, 1989-2020, continued

County	1989	1995	2000	2010	2020
HSA 4					
Wadena	1,361	1,173	1,060	879	742
Todd	2,268	1,995	1,829	1,628	1,398
Stearns	11,415	10,349	9,557	8,827	7,163
Cass	2,668	2,328	2,080	1,676	1,391
Crow Wing	5,159	4,770	4,398	3,665	3,054
Morrison	2,721	2,393	2,197	1,892	1,686
Benton	2,688	2,527	2,405	2,133	1,909
Sherburne	3,599	3,453	3,291	2,923	2,583
Wright	6,205	5,654	5,224	4,588	4,030
Mille Lacs	1,953	1,751	1,596	1,317	1,153
Kanabec	1,266	1,133	1,041	881	738
Isanti	2,597	2,454	2,293	1,997	1,767
Pine	2,324	2,111	1,968	1,669	1,436
Chisago	3,200	3,036	2,844	2,477	2,235
Total	**49,424**	**45,127**	**41,783**	**36,552**	**31,285**
HSA 5					
Carver	4,342	4,060	3,777	3,179	2,772
Anoka	26,795	25,777	24,586	21,171	17,185
Hennepin	132,631	124,826	116,778	98,041	78,384
Scott	5,102	4,767	4,380	3,813	3,184
Ramsey	58,479	55,023	51,470	43,040	35,446
Washington	15,718	15,352	14,807	13,165	11,064
Dakota	28,510	27,783	26,637	23,468	19,696
Total	**271,577**	**257,588**	**242,435**	**205,877**	**167,731**
HSA 6					
Big Stone	668	603	555	437	354
Lac Qui Parle	879	744	657	521	412
Yellow Medicine	1,216	1,060	953	745	614
Lincoln	669	545	480	383	321
Pipestone	945	767	650	508	422
Rock	833	680	605	475	406
Lyon	2,236	1,943	1,741	1,431	1,199
Murray	982	815	711	578	469
Nobles	1,985	1,692	1,492	1,204	995

Appendix A. Estimates of veterans population by county, 1989-2020, continued

County	1989	1995	2000	2010	2020
HSA 6, continued					
Swift	1,010	856	764	611	515
Chippewa	1,273	1,025	876	684	553
Kandiyohi	3,531	3,175	2,936	2,508	2,181
Meeker	2,022	1,835	1,642	1,383	1,177
Renville	1,777	1,501	1,333	1,076	915
McLeod	2,850	2,482	2,177	1,846	1,541
Sibley	1,332	1,168	1,055	874	726
Redwood	1,757	1,523	1,348	1,091	890
Brown	2,596	2,263	2,034	1,621	1,342
Nicollet	2,670	2,464	2,297	1,882	1,600
Le Sueur	2,269	2,036	1,830	1,492	1,275
Cottonwood	1,098	902	772	616	511
Jackson	1,276	1,089	984	814	663
Watonwan	1,236	1,050	928	757	628
Martin	2,675	2,392	2,176	1,755	1,431
Blue Earth	5,133	4,563	4,080	3,373	2,805
Waseca	1,767	1,607	1,475	1,192	1,040
Faribault	1,647	1,360	1,189	907	738
Total	**48,334**	**42,140**	**37,740**	**30,764**	**25,723**
HSA 7					
Rice	4,429	4,049	3,741	3,220	2,791
Steele	2,858	2,506	2,234	1,809	1,549
Freeborn	3,689	3,218	2,910	2,340	1,894
Goodhue	3,929	3,516	3,128	2,611	2,154
Dodge	1,423	1,252	1,113	929	824
Mower	4,375	3,717	3,238	2,475	1,953
Wabasha	1,838	1,609	1,440	1,188	1,018
Olmsted	11,330	10,588	9,881	8,357	7,087
Fillmore	1,927	1,642	1,440	1,150	949
Winona	4,651	4,183	3,822	3,254	2,736
Houston	1,885	1,660	1,524	1,301	1,101
Total	**42,334**	**37,940**	**34,471**	**28,634**	**24,056**

Source: "Minnesota Veteran Population by County," U.S. Department of Veterans Affairs, Statistical and Policy Research Service.

APPENDIX B. Long-term-care services for veterans

VA Alternative care services

The VA offers a variety of home- and community-based services for persons needing long-term care, including home health care, adult day care, respite care, community residential care, support groups and case management.

Home care funded by the VA is provided through the VA's Hospital Based Home Care Program and, in more rural areas, through VA payments to county public health nursing services. Home health benefits include only skilled nursing care. Supportive or custodial care such as that provided by home health aides or homemakers is not included.

The VA Medical Center in Minneapolis is the only site offering hospital-based home care. In 1989, the program had an average daily census of approximately 80 persons. Patients must live within 30 miles of the hospital to be eligible for hospital-based home care. Consequently, veterans in Regions 1, 3, 4, 6 and 7 are not served by this program [1].

In addition to home-based health care, the VA will pay for some doctor-ordered public health nursing visits for persons who are discharged from the Minneapolis VA Medical Center and who are in need of skilled nursing. This benefit covers a maximum of three visits per week for up to three months. The Minneapolis VA Medical Center receives about 150 new referrals a month for this service. Well over half of these referrals are for persons who live outside the metropolitan area [2].

Eligibility for both hospital-based home care and public health nursing services is limited to patients discharged from the Minneapolis VA Medical Center and is therefore limited to Category A veterans. The hospital-based home care program, as noted, is also available only to veterans who live within 30 miles of the Minneapolis VA Medical Center. Home-based health care is generally available only to veterans who are homebound and in need of the services of at least two health care professionals. And in most cases, patients must have a spouse, relative or friend who is willing to be trained to help the veteran with care [3].

These services are described in more detail below:

Adult Day Health Care This care provides medical, social, rehabilitative, recreational and health education services to veterans with long-term-care needs in a congregate setting during normal working hours. It is available only to veterans who are discharged from a VA Medical Center and whose condition indicates that they are at risk of nursing home placement.

Adult day health care is currently provided through the Minneapolis VA Medical Center and six other sites. In addition to the Minneapolis program, located at the

Minnesota Veterans Home in Minneapolis, there are five contract sites in Duluth, Redwood Falls, Mankato, Austin and Caledonia. The Austin and Caledonia sites are in Region 7, the Redwood Falls and Mankato sites in Region 6 [4].

In mid-1989, the Minneapolis site had an average daily census of 35, while the average daily census was less than 10 at each of the other sites [1].

Alzheimer's Units St. Cloud is the only area VA Medical Center with an Alzheimer's unit. In 1989, this facility had 19 beds with an average occupancy rate of 84 percent [5].

Community Residential Care This care is available through the St. Cloud and Sioux Falls VA Medical Centers and is similar to adult foster care. Veterans with low-level need for care are placed in private homes. The St. Cloud program serves about 45 to 50 veterans at one time and the Sioux Falls program serves approximately 35.

Geriatric Evaluation Units (GEUs) GEUs are special units that "provide a comprehensive medical, functional, psychological and environmental assessment to improve treatment and discharge planning for elderly patients typically having multiple medical problems" [6]. GEUs can exist in both the inpatient and outpatient setting. All four VA Medical Centers have GEUs. The specific number of patients going through the GEUs is not known [7].

Geriatric Research, Education and Clinical Centers (GRECCs) Minneapolis is home to one of the VA's 10 GRECCs. The VA describes these facilities as "centers of excellence designed for the advancement and integration of geriatric and gerontological research, education and clinical achievements into the total VA health care system." The Minneapolis GRECC focuses on the treatment of Alzheimer's disease. In 1988, the GRECC treated 682 patients [7].

Respite Care "Respite care" refers to temporary care given to the impaired person by a substitute caregiver so that the usual caregiver can take a break. This program is to support the "informal care system," that is, the wives, daughters and other family members who give care to impaired veterans at home. In the VA system, respite care requires institutionalizing the elderly or disabled veteran. Eligible veterans may be hospitalized for a total of 30 days each year, with each stay lasting no more than 14 days. All four VA Medical Centers offer respite care, although the number of available beds is small: one bed in Fargo, five in Minneapolis, two to four in St. Cloud and two in Sioux Falls [7, 6]. The number of patients served in this program in the last year (August 1988 to August 1989) included 52 in Minneapolis, 32 in Fargo, 23 in St. Cloud and seven in Sioux Falls [7].

Rural Case Management The VA Medical Center in Minneapolis offers a rural case management program for medically disabled veterans "to assist [veterans] in remaining in their homes and preventing premature institutionalization" [8]. This program is available to persons in Region 7, to persons in several counties of Region 6, and to Dakota County residents (Region 5). In mid-1989, approximately 100

patients were active in this program, with about 10 new patients a month [1]. No other VA Medical Center serving Minnesotans offers this program.

Other Besides the programs listed above, the VA offers several other related programs to assist Minnesota veterans who need long-term care. These include mental health services (including support groups for caregivers and rural mental health care) and chemical dependency programs.

Long-term-care policy

Overview of Minnesota Policies and Programs

In the early 1980s, the state's rising nursing home expenditures, as well as concerns about the quality of life for older persons, led the legislature to take dramatic steps to discourage reliance on institutional care and to encourage the use of alternative services. Three major pieces of this policy include the nursing home moratorium, the Preadmission Screening Program and the Alternative Care Grant Program.

The Nursing Home Moratorium The Minnesota Legislature enacted a moratorium on the certification of new Medicaid nursing home beds in 1983. The moratorium was extended to the licensure of nearly all nursing home beds in 1985. The legislature cited the reasons for its action in the findings that precede the moratorium language:

a) Medical Assistance expenditures were increasing at a much faster rate than the state's ability to pay for them;

b) Nursing home and related costs amounted to more than half of all Medical Assistance costs, so controlling them was "essential to prudent management of the state's budget";

c) Construction of new nursing homes and the addition of new nursing home beds inhibited "the state's ability to control expenditures";

d) Minnesota led the state in nursing home expenditures per capita and had the fifth highest number of nursing home beds per capita in the country;

e) Private-pay patients and Medical Assistance recipients had "equivalent access to nursing home care";

f) The state's dependence on institutions to care for the elderly was "due in part to the dearth of alternative services in the home and community"; and, last,

g) "[I]n the absence of a moratorium, the increased numbers of nursing homes and nursing home beds will consume resources that would otherwise be available to develop a comprehensive long-term-care system that includes a continuum of care" [9].

The legislature also found that "further increases in the number of licensed nursing

home beds, especially in nursing homes not certified for participation in the Medical Assistance program, is contrary to public policy, because . . . it is in the best interests of the state to ensure that the long-term-care system is designed to protect the private resources of individuals as well as to use state resources most effectively and efficiently."

Moratorium Exceptions The only facilities exempt from the moratorium are the two state nursing homes — Ah-Gwah-Ching and Oak Terrace, a new nursing home on the Red Lake Indian Reservation, and the Minnesota Veterans Homes. While the moratorium generally prohibits the addition of new beds, one important exception allows the addition of new certified or new licensed nursing home beds "to address an extreme hardship situation in a particular county" [10].

To qualify for the hardship exception, a county must have fewer nursing home beds per 1,000 elderly than the number that is 10 percent higher than the national average of nursing home beds per 1,000 elderly. The "national average plus 10 percent" figure is to be the most recent one available from the federal Health Care Financing Administration. The county census figures are to be determined by the most recent federal census or the most recent estimate of the state demographer, whichever is more recent. According to the statute, the "elderly" are people 65 and older.

In addition, the county requesting the increase in certified or licensed beds must "document the existence of unmet medical needs that cannot be addressed by any other alternative."

According to the Interagency Board for Quality Assurance, "There is currently no county or county-region in the state that qualifies as an 'extreme hardship' case in terms of bed supply . . . . [T]he bed supply in Minnesota is so generous that *every* county-region has a bed supply at least 20 percent larger than the national average" [11].

The Health Department has not permitted any increase in the number of nursing home beds since the moratorium became law [12].

Moratorium Administration Moratorium administration is carried out by several agencies, including the departments of Health and Human Services, the State Planning Agency and, primarily, by the Interagency Board for Quality Assurance.

Preadmission Screening Minnesota has required preadmission screening of nursing home applicants since 1983. Under this program, all persons seeking nursing home admission are required to be evaluated by a screening team to determine whether nursing home care is appropriate and to arrange alternative community-based care if possible.

The purpose of preadmission screening, according to the Minnesota statute, is to prevent inappropriate nursing home placement for all persons seeking admission to MA-certified, licensed nursing homes. Preadmission screening legislation was also intended to obtain "further information about how to contain costs associated with inappropriate nursing home or boarding care home admissions" [15]. County

screening teams conduct preadmission screening for all people seeking admission to a nursing home (or board and care home) whenever an initial admission is planned, regardless of whether that person will be on Medical Assistance or will pay privately for care. Screening takes place within five days of a request, although there are exceptions to this rule.

The screening team recommends if the applicant should be admitted to a nursing care facility, could remain in the community with community services, or could remain in the community without services.

At the time of the screening, applicants may live in the community, may face discharge from a hospital, or may already be in a nursing home and considering transfer to another facility or discharge to the community. Applicants already in nursing or board and care facilities may be screened prior to discharge to the community to determine their eligibility for alternative care grants. The screening team also assigns the applicant a case-mix classification that indicates both the level of care the applicant requires and, for Medical Assistance-certified facilities, the level of reimbursement the facility will receive for the applicant.

The screening team must include a public health nurse and a social worker, and must have a physician available to, if not on, the team. Other people may participate, such as the person's physician and a hospital discharge planner (if the discharge planner does not have a conflict of interest by serving on the screening team).

The state has a standard form that counties are required to use for preadmission screening. Screening must include a face-to-face meeting with the applicant and, if possible, the applicant's family. Applicants with a mental retardation or a mental illness diagnosis must go through a second-level screening process, as required by federal statute.

The screening team must inform the applicant (or his or her family) that the applicant is not required to follow the screening team's recommendation. They must also tell the applicant that the applicant may appeal the screening team's recommendation.

If the screening team recommends that the applicant stay in the community with the help of community services, the team must develop an individual service plan for the applicant. This includes assigning the applicant a case manager to monitor the appropriateness of services if the applicant is eligible for an alternative care grant [16].

Preadmission screening programs exist in a majority of states, but most screen only persons who are eligible for Medicaid [17]. Minnesota's effort to divert persons from premature or unnecessary nursing home placement is evidenced by the state's requirement that both Medicaid-eligible and private-pay patients be given preadmission screening. There are some exceptions, however: Veterans entering the state veterans nursing homes or veterans entering community nursing homes on a VA contract are exempt from preadmission screening.

Overall, 20,863 persons went through preadmission screening in FY 1989. Of these, 72 percent entered a nursing home or were on a waiting list for nursing home admission. The other 28 percent had other outcomes, including being discharged into or remaining in the community, receiving alternative care grant services or entering a nursing home for less than 90 days. Most persons not entering a nursing home were diverted into the community.

Ninety-two percent of persons screened were over age 65. Of those screened, 13 percent were Medicaid-eligible, 39 percent were 180-day-eligible (that is, persons who have so few assets that they "spend down" to Medicaid eligibility levels within six months of their nursing home admission), and 48 percent were private-pay residents.

Not surprisingly, Medicaid eligibility is strongly linked to placement outcome. More than half (58 to 60 percent) of Medicaid-eligible or 180-day-eligible people screened entered a nursing home, while 94 percent of private-pay individuals entered a nursing home. This reflects the fact that Medicaid eligibility is necessary in order to receive alternative care grant services.

Data is not kept on the number of veterans going through preadmission screening. Of all persons screened in FY 1989, 7,602 or 36 percent were men, while 48 percent of all males 65 and older in Minnesota are veterans. Table 2 in Appendix B shows the number of men by age who enter nursing homes and those who are diverted to other outcomes. Among men 65 and older, the likelihood of entering a nursing home is related to age; 72 percent of men aged 65-74 entered a nursing home, compared with 75 percent of men 75-84 and 80 percent of men 85 years of age and older. Men have a lower diversion rate than women. More than three-quarters (77 percent) of men screened entered a nursing home, compared with 69 percent of the women [18].

The cost of preadmission screenings totalled $259,546 in FY 1989, while the cost of alternative care grant services totalled $5,009,751. This represents respectively 0.02 percent and 0.4 percent of Minnesota's 1989 Medicaid budget [19].

Alternative Care Grants The same Minnesota statute that established preadmission screening established alternative care grants. Participation in this program became mandatory for all Minnesota counties in July 1983. The grants are used to fund services that allow prospective nursing home residents to stay in their own homes. Individuals are eligible for grants if they are at risk for nursing home placement and if they meet income eligibility requirements. Minnesota operates this program as part of a waiver of the federal Medicaid program. Alternative care grants cannot exceed 100 percent of the cost of nursing home care.

Grant funds can be used for a variety of community-based or home-based services, including adult day care, the cost of a home health aide or personal aide, respite care, adult foster care, supplies and equipment and case management.

Some services are not permitted by grant rules, such as meals-on-wheels, congregate dining, transportation or skilled nursing. Transportation for medical purposes is

covered by Medicaid, and skilled nursing may be covered by Medicaid, Medicare or Community Health Services (public health nurses) [13, 14].

Long-term-care Policy Makers in Minnesota

Several state agencies make long-term-care policy or monitor its implementation in Minnesota. The Department of Human Services determines nursing home reimbursement rates for MA-certified homes. Its Long-Term Care Management Division is responsible for implementing and monitoring compliance with federal long-term-care legislation and collects data on MA-certified facilities. The Human Services Audit Division reviews homes' records and makes Medicaid payments to facilities.

The Department of Health monitors quality of care. Its Survey and Compliance Section performs licensing and other facility inspections and maintains records on correction orders issued to facilities as well as on the facilities' responses to the orders.

The Health Department's Office of Health Facility Complaints responds to calls from nursing home residents, family members, employees and others and issues correction orders for violations of the Vulnerable Adults Act or for other Department of Health rule violations.

Another important institution is the Interagency Board for Quality Assurance. The board consists of high-level staff members from the departments of Health and Human Services, the State Planning Agency and the Housing Finance Agency. The board has no budget of its own; member agencies contribute funds from their own budgets. The board has a staff of two.

Its original mandate was to:

1) "Identify long-term-care issues requiring coordinated interagency policies, . . . conduct analyses, coordinate policy development, and make recommendations to the commissioners [of Health and Human Services] for effective implementation of these policies";

2) develop appropriate methods and time frames for nursing home licensing inspections to ensure that they meet quality assurance requirements and to prepare an annual report to the legislature on the implementation of the inspection process;

3) develop definitions for levels of care and methods for determining resident care needs in order to adjust payments for resident care;

4) develop effective methods of enforcing quality of care standards, including a resident relocation plan when a nursing home is shut down or closes.

In its first years, the board focused on implementing its initial legislative agenda. More recently, the board is developing into a planning and policy coordinating group.

The board also participates in SAIL 1990 (Senior Agenda for Independent Living), along with the Minnesota Board on Aging. This is the governor's initiative to plan for the needs of older people in Minnesota, and its recommendations are due in October 1990.

Determining the long-term-care needs of older people is only part of SAIL 1990's task. So far, SAIL 1990 has not included either the federal Department of Veterans Affairs or the state Veterans Homes Board in its consideration of long-term-care providers and policy makers.

In general, the state and federal departments of Veterans Affairs are not involved in Minnesota's overall long-term-care planning, although there are some places where the systems intersect:

l) The VA draws on community services, particularly in rural areas, to provide some home- or community-based services to veterans, such as public health nurse visits or placing veterans in contracted community nursing homes [1].

2) The Department of Health licenses the Minneapolis veterans home's nursing facility. Health's Office of Facility Complaints investigates possible violations of the state's Vulnerable Adults Act at the veterans home. In addition, the VA conducts its own review of contract community nursing homes and investigates complaints.

3) The Minnesota Veterans Homes require residents to apply for all benefits and services to which they are entitled, including Medicaid, in case they need to get some services from Hennepin County Medical Center. The VA Medical Center is approached first to provide services.

4) The preadmission screening statute requires the Minnesota VA Medical Centers in Minneapolis and St. Cloud to participate in preadmission screening when they discharge patients to Medical Assistance-certified long-term-care facilities if the VA will not pay "indefinitely" for the veterans' cost of care.

It is important to remember that 76 percent of veterans in nursing homes do not rely on the VA or the Minnesota Veterans Homes for long-term care, and that 80 percent of long-term care is provided informally in the home by relatives and friends.

Table 1. Nursing home occupancy rates and number of beds by county, 1987

	Number of facilities	Number of beds	Occupancy rates
Region 1			
Marshall	1	102	99.1%
Roseau	3	153	98.8%
Pennington	2	165	97.9%
Clearwater	2	163	95.3%
Polk	8	621	94.6%
Red Lake	1	74	94.1%
Kittson	2	166	94.0%
Lake of the Woods	1	52	94.0%
Beltrami	4	297	92.0%
Hubbard	1	130	90.8%
Norman	3	225	86.2%
Mahnomen	1	48	83.5%
Total	**28**	**2,196**	
Regional weighted average			**93.7%**
Region 2			
Koochiching	3	198	95.7%
Itasca	5	309	97.9%
Aitkin	2	154	83.3%
Carlton	3	278	97.2%
St. Louis	20	2,330	95.9%
Lake	2	105	98.1%
Cook	1	47	98.6%
Total	**36**	**3,421**	
Regional weighted average			**95.7%**
Region 3			
Wilkin	1	124	99.7%
Becker	4	409	97.9%
Clay	4	426	97.7%
Ottertail	12	882	95.9%
Stevens	1	140	95.9%
Douglas	4	480	95.9%
Traverse	2	125	93.7%
Grant	3	192	91.4%
Pope	3	194	91.3%
Total	**34**	**2,972**	
Regional weighted average			**95.9%**

Table 1. Nursing home occupancy rates and number of beds by county, 1987 (continued)

	Number of facilities	Number of beds	Occupancy rates
Region 4			
Todd	2	201	99.4%
Wadena	3	306	98.5%
Mille Lacs	3	339	98.1%
Stearns	7	516	97.9%
Crow Wing	4	406	97.6%
Benton	3	478	97.5%
Sherburne	4	456	97.5%
Isanti	2	272	97.3%
Wright	7	573	96.3%
Morrison	3	378	95.8%
Pine	2	211	90.1%
Kanabec	1	87	88.7%
Chisago	5	339	88.5%
Cass	3	522	85.5%
Total	**49**	**5,084**	
Regional weighted average			**95.2%**
Region 5			
Anoka	7	697	97.6%
Washington	5	663	96.8%
Hennepin	80	10,945	90.9%
Carver	3	192	97.2%
Scott	4	466	96.4%
Dakota	9	1,143	98.1%
Ramsey	38	5,034	90.3%
Total	**146**	**19,140**	
Regional weighted average			**91.8%**
Region 6			
Big Stone	3	162	98.2%
Swift	2	147	96.1%
Lac Qui Parle	2	210	96.9%
Yellow Medicine	3	225	97.2%
Lincoln	3	150	97.6%
Pipestone	3	200	98.3%
Rock	2	118	99.6%
Nobles	2	258	98.7%
Murray	2	126	99.3%
Lyon	5	358	97.1%
Redwood	6	393	98.3%
Cottonwood	3	222	97.6%

Table 1. Nursing home occupancy rates and number of beds by county, 1987 (continued)

	Number of facilities	Number of beds	Occupancy rates
Region 6, continued			
Jackson	4	211	97.5%
Martin	4	335	96.2%
Faribault	3	302	98.3%
Waseca	3	199	96.6%
Blue Earth	6	503	96.9%
Lesueur	3	251	94.3%
Brown	4	358	98.8%
Nicollet	3	201	97.3%
Sibley	3	173	99.1%
McLeod	3	334	94.7%
Renville	5	359	95.6%
Kandyohi	5	439	96.9%
Chippewa	2	215	99.4%
Meeker	4	307	97.1%
Watonwan	2	168	99.2%
Total	**90**	**6,924**	
Regional weighted average			**97.3%**
Region 7			
Freeborn	4	468	98.7%
Dodge	2	156	98.7%
Fillmore	7	494	98.6%
Olmstead	8	774	96.8%
Houston	4	298	96.5%
Rice	7	580	95.8%
Mower	6	526	94.5%
Winona	6	574	94.3%
Goodhue	8	835	93.3%
Steele	3	300	92.7%
Wabasha	4	247	86.9%
Total	**59**	**5,252**	
Regional weighted average			**95.3%**

Source: Sharon Mitchell, Minnesota Department of Health, 1989.

Table 2. Preadmission screening outcomes for men, FY 1989

Age	Outcome: Nursing home		Other		Total
54 and under	461	(77%)	138	(33%)	599
55-64	352	(85%)	61	(15%)	413
65-74	1,096	(72%)	1,772	(23%)	7,602
75-84	2,246	(75%)	747	(25%)	2,993
85 and older	1,675	(77%)	409	(23%)	2,084
Total, all men	**5,830**	**(77%)**	**1,772**	**(23%)**	**7,602**
Total, all men 65 and older	**5,017**	**(76%)**	**1,573**	**(24%)**	**6,590**

Source: Department of Human Services, 1989.

APPENDIX B REFERENCES

1. Buran, Gretchen, director of social work, VA Medical Center, Minneapolis, interview, Aug. 1, 1989.
2. Wiard, Karen, supervisor, community health nurse coordinators, VA Medical Center, Minneapolis, telephone interview, Aug. 28, 1989.
3. VA Medical Center, Minneapolis, "Home Health Care" brochure, 1989.
4. VA Medical Center, Minneapolis, "Contract ADHC Program," December 1988, and "ADHC," undated.
5. Scorniak, Stan, administrative assistant to the chief of staff, St. Cloud VA Medical Center, telephone interview, Aug. 31, 1989.
6. U.S. Department of Veterans Affairs, *Caring for the Older Veteran*, Washington, D.C., 1984.
7. Weidner, Karen, planner, VA Medical District 18, Minneapolis, telephone interview, Aug. 28, 1989.
8. VA Medical Center, Minneapolis, "Rural Care Program: Case Management Services for Medically Disabled Veterans," March 1989.
9. M.S. 144A.31.
10. M.S. 144A.073, Subd. 3(a).
11. Interagency Board for Quality Assurance, *An Analysis of the 1987 Distribution of Nursing Home Beds in Minnesota,* January 1989, P. 90.
12. Anne Kane, Interagency Board on Quality Assurance, telephone interview, Oct. 5, 1989.
13. Barbara Colliander, supervisor of home and community care services, Long-term Care Management Division, Minnesota Department of Human Services, telephone interview, Sept. 8, 1989.
14. M.S. 256B.091, Subd. 8.
15. M.S. 256B.091, Subd. 1.
16. Department of Human Services, "PAS and ACG Policy and Procedures Manual," October 1988.
17. Iversen, Laura, *A Description and Analysis of State Preadmission Screening Programs*, InterStudy, Excelsior, Minn., 1985.
18. Minnesota Department of Human Services, Long-term Care Management Division, unpublished data, 1989.
19. Richardson, Donald, Minnesota Department of Human Services, Reports and Statistical Division, unpublished data, August 1989.
20. Adams, Lynda, Minnesota Department of Human Services, Long-term Care Management Division, unpublished data, August 1989.
21. U.S. Health Care Financing Administration (HCFA), research brief No. 88-4, "Use and Cost of Home Health Services Under Medicare: Selected Calendar Years 1974-1986," HCFA, Baltimore, Md., 1988.
22. Gordon, Nancy, Congressional Budget Office, preliminary calculations based on estimates from the Actuarial Research Corporation, used in the report, *Long-term Care Expansion Program: A Proposal for Reform,* published by InterStudy, Inc. Excelsior, Minn., 1988.

APPENDIX C. Estimates of veterans requiring nursing home care by county, 1989-2020

County	1989			1995			2000			2010			2020		
	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87
HSA 1															
Kittson	5	6	6	5	6	6	6	7	7	7	9	8	6	7	7
Roseau	8	10	10	9	11	10	10	12	12	15	18	17	13	17	16
Lake/Woods	5	7	6	7	8	8	9	11	10	14	18	17	12	15	14
Marshall	10	12	12	13	15	15	15	17	17	18	22	21	15	18	17
Beltrami	29	34	32	37	44	42	45	55	52	60	72	68	60	74	69
Pennington	9	10	10	9	11	10	11	13	12	14	17	16	12	15	14
Red Lake	5	5	5	5	6	6	6	7	7	8	10	9	7	9	8
Polk	25	30	28	27	33	31	32	39	37	43	53	50	40	50	47
Norman	8	10	9	9	11	10	10	12	11	12	15	14	9	11	11
Mahnoman	4	5	5	5	6	5	5	6	6	6	7	7	5	6	6
Clearwater	9	11	11	10	13	12	13	16	15	19	24	22	17	21	20
Hubbard	20	23	22	26	30	29	30	35	34	37	45	43	33	41	39
Total*	**137**	**165**	**155**	**160**	**194**	**183**	**191**	**232**	**220**	**251**	**309**	**291**	**227**	**285**	**268**
HSA 2															
Koochiching	17	20	19	21	25	24	25	30	28	32	39	37	29	37	35
Itasca	38	44	42	46	55	52	54	64	61	63	75	71	55	69	65
Aitkin	19	23	22	22	27	26	27	33	32	34	42	39	28	35	33
St. Louis	203	240	228	254	304	289	295	350	334	318	380	360	265	326	308
Lake	14	17	16	16	20	19	20	25	24	31	39	36	27	34	32
Cook	7	8	8	8	10	10	11	13	12	14	17	16	13	16	15
Carlton	29	34	32	36	43	40	45	53	51	61	75	70	57	72	67
Total*	**326**	**386**	**365**	**404**	**484**	**461**	**476**	**569**	**542**	**552**	**666**	**630**	**475**	**588**	**555**

*Sum of columns may not equal totals because of rounding.

Appendix C. Estimates of veterans requiring nursing home care by county, 1989-2020, continued

County	1989			1995			2000			2010			2020		
	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87
HSA 3															
Clay	31	36	34	38	45	43	46	55	52	55	66	62	51	62	59
Wilkin	5	6	5	5	6	6	6	8	7	7	9	8	6	7	7
Traverse	7	8	8	7	9	9	9	11	11	13	16	15	11	14	13
Becker	30	35	33	35	43	41	43	51	49	55	68	64	48	60	56
Otter Tail	50	60	57	53	65	61	63	76	72	81	100	94	71	90	84
Grant	8	10	9	9	11	10	10	12	12	13	16	15	11	14	13
Stevens	8	10	9	10	12	12	13	15	14	16	19	18	14	17	16
Douglas	26	31	29	33	40	38	41	48	46	49	59	56	44	53	50
Pope	11	13	12	13	15	14	15	18	17	17	20	19	14	18	17
Total*	**175**	**209**	**197**	**205**	**246**	**233**	**245**	**295**	**280**	**306**	**374**	**353**	**270**	**336**	**316**
HSA 4															
Wadena	15	18	17	18	21	20	22	26	25	29	35	33	26	32	31
Todd	27	32	30	32	38	36	40	49	46	63	79	74	51	64	60
Stearns	75	89	83	91	108	103	112	135	128	132	160	151	150	186	175
Cass	24	30	28	29	35	33	33	40	38	38	47	44	33	41	39
Crow Wing	53	64	61	66	80	76	82	99	94	100	123	116	89	111	105
Morrison	23	28	26	26	32	30	32	39	37	44	54	51	41	51	48
Benton	22	27	25	29	35	33	36	43	41	50	61	58	50	62	58
Sherburne	19	22	20	24	29	27	31	36	34	41	49	46	44	55	52
Wright	41	48	45	51	61	58	61	73	69	82	100	94	83	103	97
Mille Lacs	19	23	22	22	27	26	27	32	31	33	41	39	31	39	37
Kanabec	11	13	12	13	15	14	16	20	19	23	29	27	18	23	22
Isanti	18	21	20	24	28	27	29	34	33	37	44	42	39	47	45
Pine	26	31	29	33	39	37	40	48	46	53	65	62	47	59	55
Chisago	25	30	28	32	38	36	38	46	44	51	63	59	52	64	60
Total*	**398**	**475**	**448**	**489**	**587**	**557**	**600**	**721**	**684**	**778**	**949**	**896**	**753**	**936**	**882**

*Sum of columns may not equal totals because of rounding.

Appendix C. Estimates of veterans requiring nursing home care by county, 1989-2020, continued

County	1989			1995			2000			2010			2020		
	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87
HSA 5															
Carver	25	29	27	32	39	37	41	50	47	54	65	62	55	68	65
Anoka	111	122	115	158	183	173	209	243	231	264	307	293	268	320	306
Hennepin	1,002	1,198	1,128	1,314	1,601	1,516	1,723	2,075	1,973	2,433	2,956	2,793	2,381	2,989	2,816
Scott	27	30	29	33	39	37	42	49	47	65	79	75	75	93	88
Ramsey	475	570	538	627	764	725	796	962	915	1,052	1,274	1,205	978	1,222	1,153
Washington	91	104	98	125	148	140	170	205	195	285	346	327	332	411	388
Dakota	138	158	149	194	231	218	252	299	284	356	428	406	392	485	459
Total*	**1,869**	**2,212**	**2,084**	**2,483**	**3,004**	**2,845**	**3,240**	**3,882**	**3,692**	**4,510**	**5,456**	**5,161**	**4,481**	**5,589**	**5,274**

*Sum of columns may not equal totals because of rounding.

Appendix C. Estimates of veterans requiring nursing home care by county, 1989-2020, continued

County	1989			1995			2000			2010			2020		
	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87
HSA 6															
Big Stone	8	10	10	11	13	12	13	16	15	16	20	19	14	17	16
Lac Qui Parle	10	12	12	12	14	14	15	18	17	19	23	22	16	20	19
Yellow Medicine	13	15	14	15	18	17	17	20	20	19	23	22	16	19	18
Lincoln	7	8	7	7	9	8	9	11	10	12	14	14	10	13	12
Pipestone	6	7	7	7	8	8	7	9	8	8	9	9	6	8	7
Rock	7	9	8	7	9	8	9	11	11	15	19	17	13	16	15
Lyon	15	17	16	16	19	18	19	23	22	24	30	28	22	27	25
Murray	10	12	11	12	14	13	14	17	16	19	23	22	16	20	19
Nobles	16	19	18	18	22	20	23	27	26	31	39	36	29	36	34
Swift	10	12	11	11	14	13	13	16	15	17	21	20	14	18	17
Chippewa	9	11	10	9	11	10	11	13	12	13	16	15	11	14	13
Kandiyohi	32	38	36	40	47	45	50	59	56	69	85	80	66	82	77
Meeker	19	23	22	23	28	27	28	34	32	39	48	46	35	44	42
Renville	20	23	22	22	26	25	26	32	31	36	45	42	33	42	39
McLeod	19	23	21	23	26	25	27	33	31	39	48	45	34	43	40
Sibley	15	18	17	19	23	21	23	27	26	29	36	34	27	34	32
Redwood	18	22	21	22	26	25	25	31	29	33	40	38	29	36	34
Brown	21	24	23	24	29	28	28	34	32	36	44	41	33	40	38
Nicollet	21	24	23	26	32	30	33	40	37	42	51	48	42	52	49
Le Sueur	19	22	21	24	28	27	28	32	31	30	35	34	27	33	31
Cottonwood	11	13	12	12	14	13	13	17	16	19	24	23	16	20	19
Jackson	13	15	15	15	18	18	19	23	22	27	33	31	23	29	27
Watonwan	13	15	14	14	17	16	17	20	19	24	30	29	23	29	27
Martin	25	30	28	32	38	36	38	45	43	43	52	49	37	46	44
Blue Earth	39	46	43	47	57	54	57	68	65	70	84	80	65	81	77
Waseca	14	16	16	20	24	23	24	28	27	24	28	27	20	24	23
Faribault	14	16	15	15	18	17	17	21	20	19	23	22	16	19	18
Total*	**422**	**502**	**474**	**500**	**601**	**570**	**604**	**725**	**689**	**774**	**944**	**891**	**691**	**861**	**811**

*Sum of columns may not equal totals because of rounding.

Appendix C. Estimates of veterans requiring nursing home care by county, 1989-2020, continued

County	1989			1995			2000			2010			2020		
	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87	VA	MN 85	MN 87
HSA 7															
Rice	39	46	43	49	58	55	62	73	70	88	107	101	88	109	103
Steele	21	26	24	25	31	29	30	36	34	39	49	46	36	46	43
Freeborn	39	47	44	47	57	54	60	72	68	84	104	98	74	93	87
Goodhue	34	41	38	39	48	45	48	58	55	68	85	80	62	79	74
Dodge	9	10	10	9	11	11	11	13	13	17	21	20	15	19	18
Mower	39	47	44	46	57	54	56	68	65	73	91	85	56	70	66
Wabasha	15	19	18	17	21	20	21	25	24	28	35	33	27	34	32
Olmsted	72	85	80	92	110	104	117	141	134	176	216	204	193	243	228
Fillmore	18	22	21	21	25	24	25	30	28	31	38	35	27	34	32
Winona	45	53	50	55	66	62	67	81	76	89	109	103	84	104	98
Houston	21	25	24	23	29	27	31	38	36	46	58	54	46	59	55
Total*	**352**	**421**	**396**	**424**	**513**	**486**	**525**	**635**	**602**	**741**	**913**	**860**	**708**	**889**	**836**

*Sum of columns may not equal totals because of rounding.