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North Dakota Veterans Home

RE: Summary of Strategic Planning Efforts

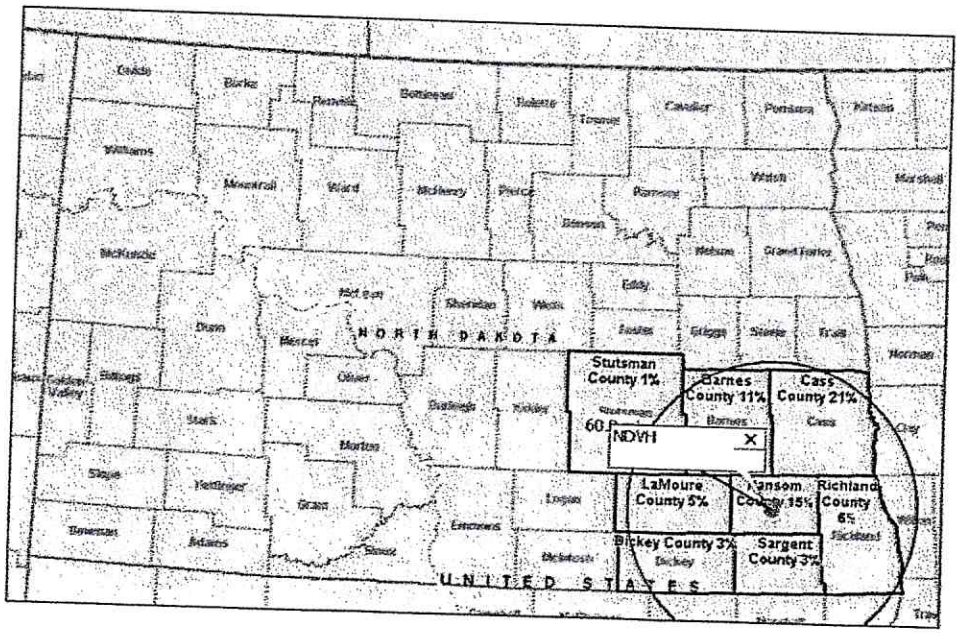
This document will summarize work completed so far in three pieces:

I. Current state
II. Challenges
III. Next steps & Items for Consideration

I. Current State

The Veterans Administration (VA) provides or pays for long-term care, ranging from assistance with activities of daily living to clinical care for spinal injuries or dementia, through three institutional and 11 noninstitutional programs. All Veterans enrolled in the VA health care system are eligible for VA's basic medical benefits package, which includes coverage for certain institutional and noninstitutional long-term care services. Veterans' access to noninstitutional care programs will likely increase as it is less costly than institutional care, and Veterans prefer to delay or reduce the amount of institutional care they receive[1].

The majority of North Dakota Veterans Home (NDVH) residents originate from eight North Dakota counties: Cass, Ransom, Barnes, Richland, Lamoure, Sargent, Dickey, and Stutsman. These counties are considered the primary service area (PSA).



The 65+ Veteran population of the PSA is projected to decline 18% from 2020 to 2030. The 65+ Veteran population of the State of North Dakota is projected to decline 16% from 2020 to 2030. NDVH annual admissions are projected to decline 17% from 2021 to 2030.

As the analysis has anticipated, the census at NDVH continues to decline. Budget cuts may lead to staff reductions which in turn may lead to staffing violations. Private industry long term care (LTC) presents significant competition for workforce and LTC eligible residents. The absence of hospice care is causing some NDVH residents to leave for care elsewhere.

A staffing analysis and benchmarking review was conducted in August 2020. The intent of the analysis was to identify opportunities for improved facility wide productivity. A high-level review was completed for all departments. Departments shown to have a significant difference from industry standards were further reviewed with areas of opportunity identified in a separate, detailed report.

Overall findings indicated a potential for adjustment of current staffing patterns to align with current service levels provided to residents. It was noted that the reported case-mix is reflective of lower acuity levels in the current resident population. This low acuity level was noted for further review and training to ensure proper documentation and acuity levels are achieved.

In consideration of the census, case-mix, and current staffing patterns, there is potential for operational improvement that will need further review to be confirmed and plans developed. A Minimum Data Set (MDS) and documentation audit was employed to identify if the documentation is an accurate reflection of the resident population. Information revealed from an MDS and documentation audit is often utilized to properly establish staffing patterns that are in line with the services provided and flex based on the needs of the residents at any time. A copy of this audit's findings can be requested from NDVH management. No follow-up meetings have taken place to confirm improvement efforts based on MDS audit findings.

NDVH has engaged in strategic planning discussions, looking at programmatic, financial, and organizational issues in efforts to ensure long term viability. Outreach strategies are needed to engage Veterans statewide. NDVH needs to identify how it is unique and build upon this as it creates more service differentiation and becomes branded as era-specific, targeted care and programming with new perspectives on mental and behavioral health. The area of greatest concern and attention is utilization of the NDVH building and *right sizing* the facility, services, and organization.

II. Challenges

- Age 65+ Veteran population is declining in NDVH's service area, the State of North Dakota, and the United States.
- Veterans can go to private industry long term care providers and receive Veteran benefits.
- Continued shift from institutional Veterans services to noninstitutional Veterans services.
- No hospice program at NDVH leads to residents leaving for care at other sites.
- Personnel limitations of VA smoke free campuses; no alcohol on grounds without doctor's order; admission requires 9-12 months of sobriety.
- Limited NDVH mental/behavioral health service offerings.
- High cost of medicine: VA pushes costs to NDVH - high-cost drugs, oxygen.

- Veterans in long term care likely have higher and more complex needs. Regulations dictate VA patients can't get coverage for/if they have greater needs, where in conventional nursing homes, coverage follows to higher need / more intensive care arrangements.
- Limited advertising/marketing budget.
- Cannot fall under 75+ Veteran threshold for building; loss of per diem payments; approximately 1/3 of revenue funding.
- $14.7m recapture clause of VA block grant: State will have to pay back VA dollars from block grant if building designated use is changed.
- VA calculation for bed growth based on percentage of Veterans living in North Dakota, not tied to service area.
    - VA funded 121 bed built at 65+.
    - State funded 121 bed build growth at 35% and 29 beds at 100%.
- Revenue restrictions:
    - Century Code
    - Administrative Rules
    - Domiciliary rents; sliding fee vs. Medicaid eligibility; fear losing current residents; residents would have to go through asset review.
- High cost of staff turnover.
- Benefit disparity (and cost) between NDVH and private industry LTC providers.
- NDVH is a Veteran's Home providing LTC to veterans but is expected to operate like a LTC nursing home and follow the LTC reimbursement system. NDVH has a unique and specific case mix due to life experiences of veterans, predominantly male and with unique mental and behavioral health needs, requiring a specific staff skill set not available in other LTC settings.
- From U.S. Government Accountability Office[1]
    - VA Geriatric & Extended Care Office (GAC) has not established measurable goals to address workforce shortages, such as staffing targets to address the waitlist for the Home-Based Primary Care program.
    - GEC has not established measurable goals for its efforts to address the geographic alignment of care, such as specific targets for providing long-term care within the Home Telehealth and Veteran Directed Care programs.
    - GEC has not established measurable goals for its efforts to address difficulties meeting Veterans' needs for specialty care, such as number of caregivers educated to help Veterans with dementia.

[1]*VA Health Care: VA Faces Challenges in Meeting Demand for Long-Term Care, Statement of A. Nicole Clowers, Managing Director, Health, U.S. Government Accountability Office, 3/3/202*

III. Next Steps and Items for Consideration

The unique nature of NDVH and the distinctive needs of its clientele affect its financial conditions. The following initiatives were developed during strategic planning work sessions. This is a list of *possible* initiatives to explore:

- Identify all ways NDVH is unique. Gain legislative buy-in to identify/recognize NDVH as unique and essential. Assess NDVH's ability to care for all eras of Veterans. Innovate more in these areas, along with mental and behavioral health.
- Explore a different rate-setting system/structure due to the unique care NDVH provides and specific needs of its clientele.

- Advance initiatives to enhance statewide awareness within the Veteran community of the services NDVH provides that are unique and specifically designed for Veterans and spouses.
- Make known to public that spouses can come to NDVH and stay long-term.
- Investigate collaborative hospice. Make business plan.
- Assess demand for campus continuum, specifically assisted and independent living. Make business plan.
- The Domiciliary payment model is not adequate or aligned with the services required for this clientele. A review of this reimbursement model should be considered to more adequately compensate for services provided to veterans.
- Consider implementing a level of services consistent with the North Dakota basic care program and its reimbursement model.
- Implement recommendations from MDS and documentation audit.
- Market to CBOCs (Bismarck, Dickinson, Grafton, Jamestown, Monti, Williston, Devil's Lake)
- Consider merger/buyout with other senior living provider.
- Explore/expand how NDVH can be more engaged in providing community-based services to Veterans statewide.

A recommended next step is to engage State of North Dakota Representative Nelson and Senator Dever with the following message:

The main issues we currently see with the North Dakota Veterans Home (NDVH) is utilization of the building, and right sizing the facility/services/organization. We're looking at some creative avenues to improve the situation, but they would require collaboration and flexibility from the State. Without creativity, collaboration, and support from the State in these areas, NDVH will be forced to continue to focus our strategy and energy on staff retention, with outcomes not likely being significantly different from current. New efforts in this area are ongoing, with NDVH's new HR Director. To facilitate a strong strategic plan and ensure that any strategy developed will be open for exploration, we have a few questions we would like to visit with you on. A general outline is below:

General questions:

1. *What would you like to see as the future of NDVH?*
2. *What is the State's/Legislature's main concerns with the future operations of NDVH?*
3. *What is the State willing to consider as to what services can be offered or expanded to Veterans?*

Specific questions:

1. *Would the State be willing to support efforts to increase state-wide exposure of NDVH and the services it provides?*
2. *Innovation around new and Veteran-specific mental health/behavioral health services is an opportunity but will be expensive. Is the State supportive of expanding these services to the Veterans across the State?*
3. *Would the State be willing to consider some level of merger with another facility to improve operational performance? (given need to meet VA criteria)*
4. *Would the State consider a $15m federal grant repayment?*